

REPORT OF MARKET CONDUCT EXAMINATION

PREFERRED PLUS OF KANSAS INC.

8535 E 21ST ST. NORTH

WICHITA, KS 67206

AS OF

JUNE 30, 2001

BY

KANSAS INSURANCE DEPARTMENT

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June 6, 2002

Honorable Kathleen Sebelius
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Sebelius:

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:

Preferred Plus of Kansas, Inc.

8535 E. 21st St. North

Wichita, Ks 67206.

hereafter referred to as "PPK" or the "Company" and the following report as such examination is respectfully submitted.

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

SCOPE OF REVIEW

A Market Conduct Examination of PPK's operation was completed to determine compliance with applicable statutes, regulations and bulletins 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

- History and Profile
- Company Operations and Management
- Management Agreements
- Fines and/or Penalties
- Prior Examination Report
- Certificates of Authority
- Reinsurance
- Disaster Recovery Procedures
- Internal Audit Procedures
- Computer Security
- TPA
- Independent Quality Review
- Quality Assessment
- Utilization Review

COMPLAINT HANDLING

- Consumer complaints
- Appeal Process
- Grievance Process

UNDERWRITING

- Use of Appropriate Forms
- Promptness of Policy Issuance
- Proper Maintenance of Underwriting Files

POLICY HOLDER SERVICE

- Member information
- Provider information
- Credentialing
- Network Adequacy

LICENSING

- Appointment And Termination of Agents
- Agency Management

CLAIMS

Claim Processing
Use of Outside Pricing Entities
Timeliness and Accuracy of Claim Payment
Proper Maintenance of Claim Files

MARKETING

Certificate Of Compliance – Advertising
Buyer Guides
Sales And Advertising
Internet

SUMMARY OF REVIEW

The Market Conduct Examination focused on PPK. The testing and file review consisted of sampling from the Company's underwriting and processing center in Wichita, Ks. The claim processing for PPK was also reviewed at their claims operation in Wichita, Ks.

The examination included a review of the Company's underwriting and settled claim files from January 1, 1999 to June 30, 2001.

General topics were covered in Interrogatories submitted to PPK for their written response. Subjects covered were Company Operation, Policyholder Service, Agency Licensing, Complaints, Sales and Marketing, Underwriting and Claims. The response received adequately addressed the issues presented.

This report is primarily written as a report by exception. The tests listed in this report primarily address those areas where the examiner felt the company was out of compliance.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

HISTORY

Preferred Health Systems, Inc. (PHS) is owned by Via Christi Regional Medical Center and is experienced in managed care operations and group health insurance. PHS offers employers and their employees a broad array of health plan products, including HMO and PPO programs

In 1994, PHS acquired Preferred Plus of Kansas, Inc., a Health Maintenance Organization, and Kansas Health Plan, a provider network of high quality physicians and hospitals. In 1995, PHS acquired Preferred Health Care, Inc. (a PPO). The preeminent tertiary hospital systems associated with PHS is Via Christi Health System. In 1995, the Via Christi Health Systems was formed through

the merger of two prestigious Wichita hospitals, St. Francis Regional Medical Center and St. Joseph Medical Center.

The goal of PPK is to provide communities with benefit plans, health care services, and health education programs that are designed to curtail rising health costs by establishing a strong relationship between primary care physicians and their patients. These physicians direct members through a cost and care conscious service delivery system.

KHP (Kansas Health Plan) was incorporated in October 1985 as a for-profit organization by St. Francis and St. Joseph hospitals on behalf of many of their physicians to function as a network in a manner similar to most IPAs. In the mid- 1980s, KHP contracted with the Blue Cross and Blue Shield of Kansas HMO (HMO Kansas). The service area of KHP was limited primarily to Sedgwick County; however, its contracts did include several surrounding counties. Blue Cross and Blue Shield of Kansas terminated this agreement in 1990. KHP then funded the development of its own HMO, PPK.

PPK is a Kansas corporation incorporated on September 6, 1991. PPK obtained its certificate of authority from the Kansas Insurance Department to transact HMO business in Kansas on November 22, 1991. PPK commenced HMO enrollment and offering its HMO products to employers and their employees/dependents in the South Central Kansas service area in January 1992. PPK is an Individual Practice Association (IPA), open panel model where participating physicians provide medical services in their own offices. PPK contracts KHP to provide all physician and hospital services to the HMO. KHP contracts with hospitals, primary care physicians as well as with specialty physicians to provide medical care to PPK members. PPK negotiates provider payment rates and payment schedules with KHP for the PPK products. The KHP network consists of approximately 371 primary care physicians, approximately 1394 referral/specialty providers, and 28 hospitals.

PPK's enrollees (and/or their employer groups) pay predetermined periodic premiums to PPK. In return, PPK's enrollees generally receive a comprehensive range of health care services at no additional cost (except for applicable co-payments, such as \$10.00 per physician office visit) when members seek care within the network of contracting providers.

Medical care is managed through a primary care physician (PCP) selected by the subscriber and each dependent.

Most of PPK's enrollees receive health benefits from PPK under agreements between their employers and PPK. PPK discontinued writing their Medicare + Choice product, Preferred Senior Care,

effective December 31, 2001. PPK also offers an individual conversion plan to enrollees whose employer group coverage terminates. The products offered to employer groups are traditional HMO plans, and HMO point of service (or self-referral) plans. PPK's agreements with employers reflect a tier pricing structure (for example, employee, employee/spouse, or family coverage) as desired by the employer. The agreements fix premium rates for all enrollees within a particular group for a 12-month period.

As of July 2001 there are approximately 83,964, (399 employer groups) enrolled lives in PPK.

CorTech, Inc. effective, August 1, 1994 acquired all of the outstanding shares of PPK. On October 1, 1995, CorTech, Inc. changed its name to Preferred Health Systems, Inc. PHS owns PPK 100%. PHS is 100% owned by Via Christi Regional Medical Center

COMPANY OPERATIONS AND MANAGEMENT

Board Structure

The current officers of PPK are:

<u>Name</u>	<u>Office</u>
Marlon Royce Dauner	President
Walter Dale Whitchurch	Treasurer
Randall Gene NYP	Secretary
Board of Directors	

Last Name	First Name	Middle Name	Position	Position Held	City	State
Dauner	Marlon	Royce	2	01/01/1994	Wichita	KS
Nyp	Randall	Gene	3	01/01/1997	Wichita	KS
Rheault	LeRoy	Edward	1	01/01/1993	Wichita	KS
Whitchurch	Walter	Dale	3	07/20/2000	Wichita	KS
Lentell	John	Vinton	1	07/02/1998	Wichita	KS
Cohlma	Jerry	Bebe	1	01/01/1994	Wichita	KS
Dakhil	Shaker	Radi	1	01/01/1994	Wichita	KS
Davis	Paul	Harvey	1	01/01/1997	Wichita	KS
Robl	David	Albert	1	01/01/1994	Wichita	KS
Hesse	James	Francis	1	01/01/1994	Wichita	KS
Hite	Richard	Cecil	3	02/01/1998	Wichita	KS
Elrick	Patricia	Louise	1	07/20/2000	Wichita	KS
Klingman	Diane	DeFever	1	07/20/2000	Wichita	KS
Vaught	Richard	Hamilton	1	07/20/2000	Winfield	KS
Austerman	Gary	Michael	1	02/28/2001	Wichita	KS

TERRITORY AND PLAN OF OPERATION

The following counties comprise the service area: Brown, Butler, Chautauqua, Cowley, Harvey, Jackson, Jefferson, Kingman, Marlon, Nemha, Pottawatomie, Sedgwick, Shawnee and Sumner.

PPK is an IPA model HMO that markets commercial coverage exclusively to employer groups on a fully insured basis. PPK contracts with Kansas Health Plan, Inc., a network of physicians and

hospital service providers, for use of its network of providers. Under the Kansas Health Plan, Inc. (KHP) contracts, Primary Care services are paid for under a capitated arrangement. Primary Care capitation is age/sex and benefit plan adjusted and paid on a per member per month basis. KHP offers certain incentive arrangements to its contracting providers. The incentives generally include an established percentage of targeted Hospital costs per member per month payable if actuarially established fund targets are achieved. Additionally KHP physicians have the opportunity to share with the health plan in fund savings generated from a positive difference between actuarially established cost targets and actual medical cost incurred.

Intrust Bank; N.A. has been engaged by PPK to manage its investments. The parent company of PPK, PHS, offers administrative and management services support through an agreement filed with the Kansas Insurance Department. All employees are employees of the parent company, PHS. PPK's books and records are maintained at its corporate offices in Wichita, Kansas.

REINSURANCE

- Reinsurer: Employers Reinsurance Corporation of Overland Park, Kansas
- Contract Year: Both (PPK) & Preferred Health Systems Insurance Company (PHSIC) January 1, 2001 through December 31, 2001
- Covered Services: Both PPK & PHSIC
Inpatient hospital services
Sub acute facility, skilled nursing facility, hospice, inpatient rehabilitation facility and home health care agency services
Other services covered under Catastrophic Coverage only
- Limitations: Both PPK & PHSIC -
Average daily maximum of \$3,000 for first 45 days and then \$2,000 a day thereafter
Sub acute facility, skilled nursing facility, hospice, inpatient rehabilitation facility and home health care agency services limited to \$500 per day for a maximum of 31 days
Outpatient Prescription drugs including blood and blood products limited to \$500,000 per agreement period for Catastrophic Coverage only
- Carryover: Both PPK & PHSIC -
For each member, loss incurred during the last 31 days of an agreement period for which the retention amount was not satisfied will be reinsured as if incurred during the next agreement period.
- Retention or Stop Loss Amount

- | | | |
|----|--|-----------|
| 1. | Non-catastrophic coverage: | |
| | Preferred Plus of Kansas_ | 100,000 |
| | Preferred Health systems Insurance Company | 75,000 |
| 2. | Catastrophic coverage: | |
| | Preferred Plus of Kansas - | \$300,000 |
| | Preferred Health Systems Insurance Company - | \$300,000 |
- Reinsurance Limitations:

Each member for each agreement period	\$2,000,00
Each member lifetime	\$2,000,000
 - Experience Refund:

Reinsurer will pay the reinsured an experience refund in the amount of 35% of the net profit under the agreement for the agreement period is equal to or less than 70%.

FINES AND/OR PENALTIES

The Regulatory Information Retrieval System (RIRS) database of the NAIC was reviewed.

There were no regulatory actions taken against PPK during the exam period.

AUDITS

PPK provided a summary of their audit process.

PRIOR MARKET CONDUCT EXAMINATION REPORT (S)

The Financial exam team was planning to do a financial exam later in 2001.

COMPUTER SECURITY

The financial exam team reviewed the company computer security program

CERTIFICATE OF AUTHORITY

The certificate of authority was reviewed to insure that PPK was complying within the scope of authority granted to them by the Kansas Insurance Department.

INDEPENDENT QUALITY REVIEW

On file with the Kansas Insurance Department is the most recent report by a quality of care review organization giving a written opinion concerning compliance with the quality care guidelines per KSDA 40-3211 (b). The Kansas Foundation for Medical Care, Inc. submitted their finding of the report on 9/28/00 to Kansas Insurance Department. The review took place between 7/17/00 to 9/27/00.

COMPLAINT HANDLING

Complaint and Appeal Policy

PPK's complaint procedure is spelled out in the text of the their members' policies:

The Health Plan recognizes that from time to time Members may encounter situations where the performance of the Health Plan and/or Health Plan providers does not meet their expectations. When this occurs, the Member may wish to call the matter to the attention of the Health Plan management. A provider or member representative may act on behalf of the Member. It is the policy of the Health Plan to promptly and fairly consider all Complaints and Appeals. The procedure outlined in this section is established to define and assure this policy.

A. DEFINITIONS

For the purposes of this Complaint and Appeal section, the following terms and their definitions will apply:

1. Adverse decision means in the case other than an Emergency Medical Condition, a utilization review determination by the Health Plan, that a proposed or delivered health care service which would otherwise be covered under a Member's contract is not or was not Medically Necessary or the health care treatment has been determined to be experimental or investigational and, (1) if the requested service is provided in manner that leaves the Member with a financial obligation to the provider or providers of such services, or (2) the adverse decision is the reason for the Member not receiving the requested services.
2. Complaint means a verbal or written expression of dissatisfaction about a situation in the Health Plan's operation or Health Plan providers.
3. Appeal means a verbal or written request for reconsideration of a decision made by the Health Plan relative to the Member.
4. Expedited Appeal may be requested if the Member feels his health or ability to function could be seriously harmed by waiting for a standard action or decision. If the Appeal is expedited, the Health Plan will make the decision and notify the Member and provider(s) as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the appeal.
5. External Review means the review of a Final Adverse Decision by an External Review Organization.
6. External Review Organization means an entity that conducts independent external reviews of Final Adverse Decisions pursuant to a contract with the Kansas Insurance Department.
7. Final Adverse Decision means an Adverse Decision that has been upheld by the First and Second Level Appeal Committees of the Health Plan, at the completion of the Health Plan's internal appeal procedures.

B. HANDLING OF COMPLAINTS

In most cases, Complaints are handled on an informal basis at the time they are brought to the Health Plan's attention by the Member. If the timely resolution of a Complaint does not occur or if the Member wishes to express the Complaint to a higher level of authority, then the Member may decide to pursue matters through the formal appeals process.

C. APPEALS PROCESS

A Member may appeal a decision made by the Health Plan by:

- calling Member Services at 316-609-2390 or 1-800-660-8114; or
- calling Mental Health Network, Inc. at 1-800-456-5641 for appeals regarding Behavioral Health and Substance Abuse Services; or
- sending a fax to 316-609-2327; or
- sending an e-mail to phsimail@phsystems.com; or
- submitting the appeal in person or in writing to 8535 E. 21st Street North, Wichita, Kansas 67206.

The Member should convey the specific information relating to the Appeal and their expectation for resolution. Appeals must be filed within ninety (90) days of the first decision made by the Health Plan.

All levels of the appeals process will be handled by individuals not involved in a previous determination. Clinical issues will be reviewed by at least one practitioner of the same or similar specialty that typically manages the medical condition, procedure or treatment in question.

The Health Plan will acknowledge receipt of the Member's Appeal in writing within 5 working days.

The Health Plan will conduct a complete investigation of the Appeal within 20 working days after its receipt. If the investigation cannot be completed within 20 working days after the receipt of the Appeal, the Health Plan will notify the Member in writing within 20 working days time. The Member will continue to be notified in writing every 30 days until the investigation is complete. The notice will state the reasons for the additional time needed for the investigation. Expedited Appeals will be decided as expeditiously as the medical condition requires, but no later than 72 hours after receipt of the appeal. Upon completion of the initial investigation of an Appeal, the Member will be notified in writing of the Health Plan's decision regarding the Appeal and the Member's right to a second Appeal. If the Member is dissatisfied with the decision regarding the first Appeal they may submit a final Appeal, within 30 days of the decision, to the Second Level Appeals Committee. The Member may attend the Second Level Appeals Committee meeting to present their case or communicate via a conference call. The Committee will notify the Member in writing of its decision regarding the second Appeal.

D. EXTERNAL REVIEW PROCESS

The Member has the right to request an External Review after a Final Adverse Decision has been rendered, or when the Member has not received a Final Adverse decision within 60 days of seeking such review, unless the delay was requested by the Member. In the case of a request for an External Review involving an Emergency Medical Condition, such request may be made before the Member has exhausted all other available review procedures. The Health Plan will notify the Member in writing regarding a Final Adverse Decision and of the opportunity to request an External Review.

Within 90 days of receipt of the notice of the Final Adverse Decision, the Member, the treating Physician or health care provider acting on behalf of the Member with written authorization from the Member, or a legally authorized designee of the Member must make a written request for an External Review to the Kansas Insurance Department.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Member and other involved parties as to whether the request for External Review is granted.

For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Department within 30-days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Health Plan was Medically Necessary or in the case of the reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Health Plan was covered or excluded from coverage under the terms of this Certificate.

If any party is not satisfied with the decision of the External Review Organization, they may pursue normal remedies of law. Prior to the institution of any legal proceeding or suit against the Health Plan, the foregoing Complaint and Appeal Policy shall be utilized by any party alleging a claim against the Health Plan. In all events, such suit or proceedings must be commenced no later than five (5) years after the date of the written decision of the External Review Organization is transmitted to such party.

The right to External Review shall not be construed to change the terms of coverage under this Certificate. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts. A Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law, the Member shall have the option of designating which External Review process will be utilized.

COMPANY COMPLAINTS

There were 25 files examined for the test period from 1/99 thru 6/01 that were registered directly with PPK. The following tests were applied to that group.

-KSA 40-3228 (1) Acknowledge. Receipt within 10 working days.

PPK responded to 24 of 25 grievance letters within 10 days. PPK was 96% compliant

-KSA 40-3228 (2) Complete the investigation within 20 working days.

PPK conducted an investigation within 20 days on 20 of 25 letters. PPK was 80% compliant

-KSA 40-3228 (3) Notify the member within 5 working days after a decision has been reached.

PPK failed to do this on one file out of twenty-five. PPK was 96% compliant.

KID COMPLAINTS

PPK maintains a complaint log in accordance with K.S.A. 40-2404 (10). The complaints for 1999, 2000 and 2001 were reviewed. They matched with the complaint list maintained by KID. The company was compliant in timely response and all the files were well documented and handled in a timely manor.

EXPEDITED APPEALS

In PPK's Complaint Handling Procedures, the company's standard for responding to Expedited Appeals was "two" working days for sending a written response. Per K.A.R. 40-4-41d: (6) The utilization review organization shall notify the health care provider of its decision regarding the expedited appeal by telephone at the time the decision is made and shall notify the health care provider and the enrollee in writing within one working day.

PPK met the 1-day standard in the 7 files that the exam team reviewed, and they have since corrected their procedures.

RECOMMENDATIONS

1. When handling a formal complaint, PPK must complete the investigation within 20 working days or notify the member in writing of the reason for delay. Per K.S.A. 40-3228 (2).

UNDERWRITING

POLICY FORMS

The forms that PPK used in 1999 and 2001 were reviewed to see that they conformed to Kansas' statutes and regulations. The following are comments on the forms and certificates that PPK used.

2001 Forms

Item 1: All the forms for 2001 had the following wording under XIII COMPLAINT AND APPEAL POLICY, D. EXTERNAL REVIEW PROCESS, The fourth paragraph reads " For those

requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Department within 30 days.’ The text should read 30 “business” days. Per KSA 40-22a15(c)

The external review organization shall issue a written decision to the insured and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within 30 business days.

Item 2: VCHS 1/01, PPK-19-LJ 2/01, PPK-STKS 1/01, PPK-25W 1/01, PPK-19W 1/01, PPK-25T 1/01, PPK-19T 1/01, Summary of Medical Benefits & Services-PPK COCSUM [AW or AT] 1/01, these captioned forms are covering diabetic medical equipment and supplies under Durable Medical Equipment. This is a violation of K.S.A. 40-2215(d)(2) which prohibits unfair and unjust policy provisions, the coverage listed in the Diabetes Mandate should not be included under Durable Medical Equipment”.

There is no limitation in the law for diabetic supplies and equipment. The forms listed above are out of compliance with KSA 40-2,163(c) because of the internal policy limits called for under “Durable Medical Equipment” and “Durable Medical Supplies” in these contracts. The coverage of “insulin pumps” under "Durable Medical Equipment" with a \$1000 limitation and “diabetic hypodermic needles and associated supplies” under "Disposable Medical Supplies" with a \$500 per Calendar Year limitation does not conform to KSA 40-2,163 (d)(1).

(d) (1) The benefits provided in this act shall be subject to the same annual deductible or co-insurance and the same requirement of medical necessity established for all other covered benefits within a given policy. In the case of a policy requiring that services be provided by or upon referral from a primary care physician, the benefits provided by this act shall be subject to such requirement.

UNDERWRITING NEW BUSINESS

The exam team met with the underwriting manager and spent considerable time having her explain the new business procedures of reviewing and quoting or reviewing and declining a new submission. She also did several quotes on their rating system to explain how it worked and how it blended the elements necessary to develop a group quote.

The underwriting team reviewed 9 new business declinations/cancellations from PPK's plan submissions. All of the action conformed to Kansas's statutes and regulations.

RECOMMENDATIONS:

1. The text for all forms should have the following wording under XIII COMPLAINT AND APPEAL POLICY, D. EXTERNAL REVIEW PROCESS, The fourth paragraph should read " For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Department within 30 business days." Per KSA 40-22a15(c).
2. The reference to a limitation on diabetic equipment and supplies under Durable Medical Equipment and Supplies should be removed so the contracts conform to KSA 40-2,163 (c).

AGENT LICENSING

AGENT/AGENCY LICENSING

A sample of 50 agents was taken from PPK's list of appointed producers. 5 were in violation of KSA 40-241i:

(a) Any company authorized to transact business in this state may...appoint such agent as the agent of the company under the license in effect for the agent. The appointment shall be made to the commissioner annually on a form prescribed by the commissioner at the same time the company files its returns under K.S.A. 40-252, and amendments thereto. A nonrefundable appointment or certification fee set forth in K.S.A. 40-252...and failure of the company to certify an agent shall subject the company to a penalty of not more than \$25 per calendar day from the date the appropriate return was required to the date proper certification is recorded by the insurance department.

Of these 50 agents, 1 of them wrote business prior to their being appointed by PPK with KID. This is a violation of KSA 40-241 which states that no agent shall have "authority to transact business in this state until the agent has been certified by a company pursuant to KSA 40-241i".

All of the agents were from the same agency. Upon verification from the Kansas Insurance Department, Agents & Brokers Division, this agency Did not have an appointment with PPK. This agency has 39 producers on the company appointed list, and the Kansas Insurance Department did not show any of them as having an appointment. PPK is in the process of correcting this item.

RECOMMENDATIONS:

1. All agents/brokers must have a company appointment per K.S.A. 40-241i and certified by the company prior to receiving commissions for the business they produce per KSA 40-241.

CLAIMS

CLAIM PROCESSING

The exam team spent some time with the Vice President of claims and went over PPK's claim processing procedures. The meeting covered the entire process of from receipt of a claim until it was adjudicated and paid.

CLAIM REVIEW

The purpose was to see that regulation 40-1-34, Unfair Claims Settlement Practices, and other laws on claim handling practices were adhered to. The tests included:

- File and Record Documentation, Sec. 4:
- Misrepresentation of Policy Provisions, Sec. 5 a
- 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. 8a&c

The exam team reviewed ER claims to see if the company was applying the "prudent lay person" rule regarding how an ER claim was covered. The exam team reviewed 100 paid claims and 50 denied claims.

The exam team reviewed 100 paid and 50 denied other hospital claims.

The exam team reviewed 100 paid and 100 denied doctor and other provider claims.

-ER

Out of a sample of 100 ER Paid claims, twenty claims failed KAR 40-1-34 (7). The company was 80% in compliance. One claim failed KAR 40-1-34 (8a). The company was 99% in compliance.

Out of a sample of 50 ER denied claims, PPK had one claims fail 40-1-34 (5)(a). The company was 98% in compliance. PPK had fifteen claims fail KAR 40-1-34 (7). The company was 70%% in compliance. One claim failed 40-1-34 (8)(a). The company was 98% in compliance.

-OTHER HOSPITAL CLAIMS

Out of a sample of 100 paid claims, PPK failed five claims KAR 40-1-34 (4). The company was 95% in compliance. PPK had one claims fail 40-1-34 (5)(a). The company was 99% in compliance. Twenty-two claims failed KAR 40-1-34 (7). The company was 78% in compliance. Four claims failed 40-1-34 (8)(a). The company was 96% in compliance.

Out of a sample of 50 denied claims, Twenty-six claims failed KAR 40-1-34 (7). The company was 48% in compliance. Three claims failed 40-1-34 (8)(a). The company was 94% in compliance.

-DOCTOR AND OTHER PROVIDER CLAIMS

Out of a sample of 100 paid claims, eighteen claims failed KAR 40-1-34 (7). The company was 82% in compliance. 2 claim failed 40-1-34 (8)(a). The company was 98% in compliance.

Out of a sample of 100 denied claims, Forty claims failed KAR 40-1-34 (7). The company was 60% in compliance. Two claims failed 40-1-34 (8)(a). The company was 96% in compliance.

-BENEFIT SCHEDULE

The exam team reviewed the sample claims and compared the payment to the benefit schedule that was part of the contract. This was to insure that the schedule of benefits paid was the same as indicated in the member's certificate. The exam team compared the hard copy of what was provided to the member verses what was on the claim system for that group number and used to adjudicate the claim.

The company was 100 % compliant with this test.

-MENTAL HEALTH CLAIMS

PPK terminated their contract with their third party provider that handled their mental health claims as of 12/31/01. While the company provided PPK with a stat run of their claims, access to their claim files was impossible without going to their home office in Texas. Based on a sampling of claims from their data run of 75 cases, there were 14 claims that were not adjudicated within 30 days. The company was 84 % in compliance. Since PPK has decided to handle their mental health claims in house and through their own network of providers, the exam team decided that any additional investigation would not be that beneficial.

-PROVIDER CONTRACTS

PPK has their own schedule that they use for their in network providers. The exam team reviewed 7 provider contracts for appropriateness.

The exam team spent some time with the Vice President Provider/Payor services to verify how the claims system used the schedule of payments and calculated the amount of eligible reimbursement. 4 claims were reviewed to show PPK's system developed their final payment for the services provided.

-UTILIZATION REVIEW

The Quality Resources Management Department (QRM) is responsible for administering the utilization review program. The exam team reviewed a series of utilization review policies, and procedures that spelled out the duties of PPK's QRM to understand how the utilization review activities and practices are applied to individual cases.

RECOMMENDATIONS:

1. PPK shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 Section (7).

2. If PPK needs more time to investigate the claim to determine if the claim should be accepted or denied, PPK shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, PPK shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per K.A.R. 40-1-34 (8)(c).

MARKETING AND SALES

PPK addressed their procedures for advertising and agency advertising in the interrogatories. The producers are provided material that has been approved by PPK's advertising department. If an agent has any custom material, it has to be cleared by PPK before it can be used.

GENERAL COMMENTS

In discussions with the PPK management, they felt the high percentage of claims that were not adjudicated within 30 days were a reflection of some backlogs they were experiencing in 2000. They felt that the turn around time is now within the prompt pay act (KSA 40-2440 through 40-2442) requirements. The data sample did not give the exam team sufficient examples to test their compliance with KSA 40-2442 that was enacted on 1/1/2001. The Kansas Insurance Department will continue to monitor the timely adjudication of claims to insure that the company is conforming with the prompt pay statute KSA 40-2442 and KAR 40-1-34 Sec 7 & 8a.

The following summarizes those areas that the examiners feel that PPK needs to improve on:

1. COMPLAINT HANDLING

a. When handling a formal complaint, PPK must complete the investigation within 20 working days or notify the member in writing of the reason for delay. Per K.S.A. 40-3228 (2).

2. UNDERWRITING

a. The text for all forms should have the following wording under XIII COMPLAINT AND APPEAL POLICY, D. EXTERNAL REVIEW PROCESS, The fourth paragraph should read “ For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Department within 30 business days.” Per K.S.A. 40-22a15(c).

b. The reference to a limitation on diabetic equipment and supplies under Durable Medical Equipment and Supplies should be removed so the contracts conform to KSA 40-2,163 (c).

3. AGENT/BROKER LICENSING

a. All agents/brokers must have a company appointment per K.S.A. 40-241i and certified by the company prior to receiving commissions for the business they produce per KSA 40-241.

4. CLAIMS PROCESSING

a. PPK shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 Section (7)

b. If PPK needs more time to investigate the claim to determine if the claim should be accepted or denied, PPK shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, PPK shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per K.A.R. 40-1-34 (8)(c).

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by the PPK Compliance Unit and employees of the Company.

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

Respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM