

REPORT OF MARKET CONDUCT EXAMINATION

SHELTER MUTUAL INSURANCE COMPANY

SHELTER GENERAL INSURANCE COMPANY

1817 W. BROADWAY

COLUMBIA, MO

AS OF

DECEMBER 31, 2003

BY

KANSAS INSURANCE DEPARTMENT

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

Dear Commissioner Praeger:

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

Shelter Mutual Insurance Company

Shelter General Insurance Company

1817 W. Broadway

Columbia, MO

hereafter referred to as “Shelter” or “the Company”, and the following report as such examination is respectfully submitted,

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

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID or Department) received allegations about possible discriminatory practices from a former Shelter agent. The Department accordingly performed a targeted market conduct examination of the Shelter Insurance Group.

The examiners reviewed the company underwriting, claims, and rating manuals. The exam team reviewed underwriting, claim, and complaint files in the Company's home office in Columbia, MO. A series of meetings were held separately with the former agent and Shelter staff, focusing on the allegations and current operations. To supplement and verify the understanding of how the company does business, a series of samples were selected for review to verify the Company's procedures and practices in claims, underwriting and rating. A two-day hearing also was held to allow the former agent and Shelter to present evidence related to the former agent's allegations.

The exam team found no systemic discriminatory practices towards minority policyholders. The Company's overall practices met the controlling statutory standards. The examiners found one underwriting practice they believed failed to meet the controlling statutory standards, thus, creating a practice of unfair rate discrimination against certain tier groups of Shelter's auto population.

Based on all the evidence presented throughout the examination and in connection with the two-day hearing, a conclusion of systemic discrimination is not appropriate in this instance. While there may or may not be any discrimination, an investigation of this nature is beyond the scope of this examination.

Recommendations:

1. At the time of the on-site review of Shelter's operation, a meeting was held with various Shelter executives regarding their use of credit scoring in the underwriting/rating process. At that time, the Company indicated to the exam team that Shelter did not have a program to automatically re-evaluate an individual's credit score every 36 months on renewal per:

Kansas Insurance Score Act–

K.S.A. 40-5104: Prohibited practices

No insurer authorized to do business in the state of Kansas which uses credit information to underwrite or rate risks, shall:

(g)(1)...use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report.

It was recommended by the exam team that Shelter take the necessary steps to insure that they have the programs and procedures in place to conform to the Kansas Insurance Score Act. The Department understands Shelter has the recommended programs and procedures now in place.

2. The Company should review their underwriting nonrenewal procedures to insure that they are in compliance with K.S.A. 40-276, K.S.A. 276a and K.S.A. 40-277. Although Shelter met the requirements set forth in the NAIC Market Handbook guidelines, the exam team notes that there were a total of 9 errors in this category.

3. The Department is limited in its ability to handle factual investigations regarding alleged discrimination. Although no systemic discrimination was found, the Department will forward a copy of this report to another agency for further consideration to the extent that agency deems appropriate.

SCOPE OF REVIEW

A targeted market conduct examination of the Group's underwriting, claims and complaints 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.

A former agent presented allegations of discrimination to KID. Part of the exam, accordingly, focused on whether the Company displayed any systemic discrimination against certain parties. The former agent alleged:

1. The Company cancelled and non-renewed auto policies after the initial 60 day underwriting period for certain minority groups. The cancellations were a violation of K.S.A. 40-277, and the non renewal of auto policies was a violation of 40-276a.
2. The Company discriminated against certain minority groups in the adjusting and settlement of claims.
3. The company reinstated 100% of the non minority group that bounced checks but 0% of certain minority groups had their coverage reinstated after they bounced checks.
4. The Company discouraged agents to write certain minority groups and serviced these accounts differently than the remainder of their book of business. This was a corporate attitude.
5. The company terminated certain minority groups after the initial 60 day underwriting period upon later discovering an individual's driving record. For other groups, the company left the insured in their preferred tier and applied a surcharge for their driving record.

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

COMPANY OVERVIEW

Certificates of Authority

COMPLAINT HANDLING

Record Keeping
Timely Response

UNDERWRITING & RATING

Proper Rating
Underwriting Acceptance/Termination
Use of Appropriate Forms
Promptness of Policy Issuance
Proper Maintenance of Underwriting Files

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 Shelter's underwriting, complaint and claim handling. The testing and file review consisted of sampling from the Company's underwriting and processing center in Columbia, MO. The claim processing for the Company is also handled out of their home office in Columbia, MO.

The examination included a review of the Company's complaint, underwriting and settled claim files from January 1, 2001 to December 31, 2003.

General topics were covered in Interrogatories submitted to Shelter for their written response. Subjects covered were Complaints, Underwriting and Claims. The response received adequately addressed the issues presented.

A two-day hearing was held to gather additional evidence from the former agent and the Company.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History

The origin of Shelter Insurance Companies dates back to the formation of the lead company, Shelter Mutual Insurance Company (SMIC), in 1946. The company was originally chartered as MFA Mutual Insurance Company and operated as such until 1981, at which point the present title was adopted. Countryside Casualty Company was organized in 1957. In 1981 the name was changed to Shelter General Insurance Company (SGIC).

SMIC was incorporated under the laws of Missouri on August 31, 1945 and began writing automobile and homeowners risks on January 1, 1946. The Missouri Farmers Association, Inc., Columbia, Missouri, sponsored the company in 1946. The organization's business expanded in 1949 to include fire and allied lines of insurance.

SMIC is a wholly owned mutual insurance company. The policyholders elect a nine-member board of directors that oversee the management of the company. SGIC is a stock company owned by SMIC, and a nine-member board of directors oversees the management of SGIC. SMIC writes primarily personal lines automobile and property coverage for both preferred and standard risks.

Tests for Company Operations/Management

Standard 7

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

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

Standard 8

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 9

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

Shelter follows the definition of a complaint as established by each particular state in which they operate. For Kansas, a complaint is considered “any written complaint primarily expressing a grievance.” Shelter’s Customer Service Manual defines a complaint as an expression of dissatisfaction or protest.

As a complaint comes in (telephone or written), it is logged into the Consumer Affairs Tracking System (CATS) by a Customer Service Representative. The Customer Communications Department handles serious complaints as well as all Department of Insurance complaints, communications to the CEO, and other written complaints that most states require to be logged. This department then researches the complaint per procedures written in the Customer Service Manual. This manual gives general information regarding handling complaints, who to contact or refer to when researching a complaint, how to handle customers, and how to follow up and close a complaint in CATS. After investigation, the Customer Communications Department responds to the inquirer with supporting documentation. Copies of complaint-related correspondences are maintained by Customer Communications per guidelines of each state.

Summaries are produced monthly focusing on the volume of complaints handled, who handled them, and a breakdown by department and state. An Executive Vice President to whom the Director of Customer Communications reports reviews these summaries. Reports required by K.S.A. 40-2404 (10) are produced at the end of each year to reconcile records for retention purposes.

There were sixty-nine miscellaneous complaints on the complaint log for the exam period that were not Department of Insurance complaints. Of these, twenty-five were responses to surveys that Shelter routinely sent out to policyholders after a claim was processed. If the policyholder responded negatively in the survey, Shelter regarded this as a complaint and it was logged accordingly. The other miscellaneous consumer complaints mainly consist of letters from policy holders. Thirty-two of these complaint files were examined and are listed under the appropriate Standards.

Tests for Complaint Handling

Standard 1

All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404, (10).

The Company did provide a complaint register. It was up-to-date and contained all columns as required by Kansas statute. The register was essentially accurate; only one typographical error on a file close date was noted with the miscellaneous consumer complaints. The examiners reviewed eighty-three Department complaint files and thirty-two consumer complaint files.

Shelter passed Standard 1.

Standard 2

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

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

Shelter passed Standard 2.

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.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI Complaints	83	2	98%
Consumer Complaints	32	0	100%

– One complaint file failed to correct an improper nonrenewal of an auto policy. This was in violation of K.S.A. 40-265a, (a)(4).

– One complaint file was settled without a reasonable investigation being conducted. This was in violation of K.S.A. 40-2404, Section 9(d) & (f).

Shelter 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, Sections 6, 8(a) & 8(c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI Complaints	83	0	100%
Consumer Complaints	32	0	100%

Shelter passed Standard 4.

UNDERWRITING

The company's underwriting process and policy issuance (auto)

Shelter's processing system

Shelter utilizes both SMIC and SGIC for the writing of their auto business. A private passenger auto can qualify for one of six tiers at Shelter. The first 4 tiers are written in SMIC and the fifth and sixth tiers are in SGIC. These latter 2 tiers are considered their non-standard auto business.

New business auto applications can be submitted in two manners.

1) Paper applications are completed and bound in the agent's office and mailed to the Home Office. The paper application is initially routed to the Application Specialist Unit for entry into Shelter's mainframe system. After entry, all edit errors are corrected. The application goes through their EXPERT Underwriting System where it can be issued or routed to an underwriter or underwriting assistant for review. (After entry, unbound applications are sent immediately to the underwriter for review, bypassing EXPERT.) If the application is routed to the underwriting assistant, he/she will review the application based upon the EXPERT consultation codes and issue if possible. If the underwriting assistant can't issue the application, it will be routed to the underwriter. Applications routed to the underwriter are reviewed for issue, modification, or decline.

2) Auto applications can also be submitted electronically. The applications are completed, bound, and submitted electronically from the agent's office. Application notification is transmitted to a Home Office Lotus database while simultaneously the application information is produced on the Company's mainframe system. During this process an application without edit errors goes through the EXPERT system, and can be issued without producing any application notification on the Lotus database. Applications not issued at this point by EXPERT produce the same possible routing or issue outcomes described above. (Unbound applications are treated the same as paper applications and are routed direct to the underwriter.) The underwriter or underwriting assistant reviews the electronic application information with the same potential routing and outcomes as with a paper application.

Underwriting is involved in the renewal process when a policy is nonrenewed outright, or nonrenewed with an alternate coverage offer. Any nonrenewal involves issuance of a notification letter. For those policies being offered alternate coverage, the notification letter will contain a premium quote. If the insured accepts the offer and remits premium, the coverage offer change is made to the policy.

Credit scoring is one of several factors used in determining tier placement both for new business and insured requested re-tiers. Shelter uses the CP Attract Standard Auto model provided by ChoicePoint.

Individual tier placement criteria for new business are verified through: 1) comparison of tier information with corresponding application information, 2) verification of CP score by comparing it against the CP Attract document, and 3) verification of accident and violation history submitted by comparing it against MVR and CLUE reports ordered after policy issue. For the electronic applications, the system derives tier placement based on application information entered. Underwriting sees the resulting tier placement value, but verification of the tier information is handled by the system. If information is received which deviates from information on the system application, it is verified by comparison with the generating report such as MVR and CLUE reports.

An individual's score is not reviewed by anyone at Shelter Insurance at any pre-determined interval. The CP Attract score can be reviewed by Underwriting at the time application is made or re-tier requested. This review involves verification of the score being used to determine tier placement matches the score received from Choice Point. No review into actual derivation of the score is performed at any time.

Individual tier placement criteria for retiers requested by the insured are verified through: 1) comparison of tier information with corresponding change request information, 2) verification of CP score by comparing it against the CP Attract document, and 3) verification of accident and violation history submitted by comparing it against current policy file information.

The tier placement value is not the sole determinant of a new premium rate, but instead works in conjunction with other rating factors. A retier request is completed by the agent and submitted to Home Office Underwriting. Since retiering is performed at the insured's request the notification sent to the insured involves declaration confirmation of the completed change.

Tests for Underwriting and Rating

The tests for the Underwriting and Rating portion consisted of a random sample from the entire state population and a separate sample of the group that was allegedly discriminated against.

Standard 1: Rating Practices

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	1	98%

Shelter passed Standard 1.

Standard 2: Rating Practices

Disclosures to insureds concerning rates and coverage are accurate and timely. K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Bsns. Sub-Std. Auto	16	0	100%

Shelter passed Standard 2.

Standard 3: Rating Practices

Credits and deviations are consistently applied on a non-discriminatory basis. K.S.A. 40-953 & K.S.A. 40-954.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	2	96%
Select Group	39	2	95%

Shelter passed Standard 3.

– Three accounts had a multi-policy credit for a companion HO-4 policy. The filed rate pages did not indicate that an HO-4 policy was eligible for a credit on the auto. When the company filed their 10/02 rates and rules, they inadvertently left this credit out of their rules page. The pages were corrected when the company filed their 2004 rates and rules pages.

Standard 4: Rating Practices

Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation. K.A.R. 40-3-32(d), K.A.R. 40-3-12, K.S.A. 40-953 & K.S.A. 40-954.

This standard was not specifically tested. In the sample, there were no policies with either a limiting coverage endorsement, schedule rating or individual risk premium modification plan.

Standard 5: Underwriting Practices

The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks. K.S.A. 40-953, K.S.A. 40-954, K.S.A. 40-955 & K.A.R. 40-3-44.

Shelter failed Standard 5.

Shelter indicated the following change in the use of underwriting tools for new business and renewal process:

2001

No automatic orders of MVR and Clue reports were done on new or renewal business

2002

Feb 8 Began automatic MVR orders on all new business in tiers 5 & 6

May 2 Began automatic CLUE reports on all new business in all tiers

Nov 27 Began automatic MVR orders on all new business in tiers 3 & 4

2003

May 29

Began automatic MVR orders on all new business in tiers 1 & 2

Shelter uses driving record in the development of their tier assignment. The tier is subsequently used in the rating of the policy. Therefore, Shelter is required to be consistent in the verification of this information if they are using it in the development of their rates. While Shelter is now ordering MVRs and Clue reports on all new business in all tiers, during the period in 2002 and early 2003 where MVRs were only being ordered on certain tiers, this created the potential for unfair rate discrimination against certain classes of business within the Shelter book of business. By ordering MVRs for only certain tiers of individuals to verify their driving record and thus adjust their rate based on this information and not the remaining population, Shelter was practicing unfair rate discrimination against certain tier groups of their auto population. Per K.S.A. 40-943 rates are unfairly discriminatory if the loss exposures and the expenses are the same but different rates result.

K.S.A. 40-953. Same; excessive, inadequate or unfairly discriminatory rates or rates resulting in destruction of competition, standards. Rates shall not be excessive, inadequate or unfairly discriminatory, nor shall an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly. Rates are presumed not to be excessive if a reasonable degree of market competition exists at the consumer level with respect to the class of business to which they apply. Rates in a noncompetitive market are excessive if they are producing or are likely to produce unreasonably high profits for the insurance provided or if expenses are unreasonably high in relating to services rendered. A competitive market in a type of insurance subject to this act is presumed to exist unless the commissioner after notice of hearing determines and orders that a reasonable degree of competition does not exist in the market. Such order shall expire no later than one year after issuance unless the commissioner renews the rule after a hearing and a finding of the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of market competition exists, the commissioner shall consider all relevant tests, including: (1) the number, market share, and concentration of insurers, as measured by the 1992 Horizontal Merger Guidelines published in the Federal Register September 10, 1992 (57 FR 41552), actively engaged in the class of business, (2) the existence of rate differentials in that class of business, (3) ease of entry into the market, and (4) whether long-run profitability for insurers in that class of business is unreasonably high in relating to its riskiness. If such competition does not exist, rates are excessive if they are likely to produce a long run profit that is unreasonably high in relating to the riskiness of the class of business, or if expenses are unreasonably high in relating to the services rendered.

Rates are inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

One rate is unfairly discriminatory in relating to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not

unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, mass marketed plan or blanket policy.

This practice is also in conflict with K.S.A. 40-955(f), which requires that the companies use their filed material. As Shelter did not use MVRs or CLUE reports, there was not an independent verification of the driving record of the person applying for coverage, and the applicant for coverage may have been quoted a premium for which he or she was not eligible under the rating plan.

K.S.A. 40-955. Same; rate filings; review and approval of certain lines; effective dates; exemptions from filing.

(f) No insurer shall make or issue a contract or policy except in accordance with filings which have been filed or approved for such insurer as provided in this act.

From our review sample, there were three new business policies in Tier 3, three policies in Tier 4 and one policy in Tier 2 that had MVRs ordered prior to 5/29/03. This created a practice of unfair rate discrimination against certain tier groups of Shelter's auto population by verify the driving record of only certain classes and adjusting their rates based on this information and not the remaining population.

Standard 6: Underwriting Practices

All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the department of insurance (if applicable). K.S.A. 40-216.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	0	100%

Shelter passed Standard 6.

Standard 7: Underwriting Practices

Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim. K.S.A. 40-953.

This standard was not specifically tested. In the sample tested, there were no policies with either a limiting coverage endorsement, schedule rating or individual risk premium modification plan.

Standard 8: Underwriting Practices

File documentation adequately supports decisions made. K.S.A. 40-953 & K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	2	95%

Shelter passed Standard 8.

Standard 9: Underwriting Practices

Policies and endorsements are issued or renewed accurately, timely and completely. K.S.A. 40-216, K.S.A. 40-953 & K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	0	100%

Shelter passed Standard 9.

Standard 10: Underwriting Practices

Company verifies that VIN number submitted with application is valid and that the correct symbol is utilized. K.S.A. 40-953 & K.S.A. 40-954.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	1	98%

Shelter passed Standard 10.

Standard 11: Rejections/Declinations

Rejections and declinations are not unfairly discriminatory. K.S.A. 40-054 (c) & K.A.R. 40-3-40.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	49	0	100%
Select Group	39	0	100%

Shelter passed Standard 11.

Standard 12: Termination Practices

Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract. K.S.A. 40-276a, K.S.A. 40-277, K.S.A. 40-278, K.S.A. 40-2,111, K.S.A. 40-2,112, K.S.A. 40-2,120, K.S.A. 40-2,121, K.S.A. 40-2,122, K.S.A. 40-3118, K.A.R. 40-3-23, K.A.R. 40-3-28 & K.A.R. 40-3-15.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Random Business	50	6	88%
Select Group	65	3	95%
Total	115	9	92%

- Four policies did not show substantial change in exposure since the last renewal to warrant non-renewal per K.S.A. 40-276a(a)(4).

- Three policies the company failed to substantiate the exposure existed to non-renew the policy to warrant non-renewal per K.S.A. 40-276a (a)(4).
- One policy was not non-renewed on the 5-year anniversary per K.S.A. 40-276a(a)(5).
- One policy was cancelled and the reason did not conform to K.S.A. 40-277.

Overall Shelter passed Standard 12.

Standard 13: Termination Practices

Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations. K.S.A. 40-2,112(d)(1).

This Standard was not specifically tested.

Standard 14: Terminations

Rescissions are not made for non-material misrepresentation.

This standard was not specifically tested. In the regular file review, there were no rescissions taken in the 50 files reviewed.

Recommendations

1. At the time of the on-site review of Shelter's operation, a meeting was held with various Shelter executives regarding their use of credit scoring in the underwriting/rating process. At that time, the Company indicated to the exam team that Shelter did not have a program to automatically re-evaluate an individual's credit score every 36 months on renewal per:

Kansas Insurance Score Act–

K.S.A. 40-5104: Prohibited practices

No insurer authorized to do business in the state of Kansas which uses credit information to underwrite or rate risks, shall:

(g)(1)...use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report.

It was recommended by the exam team that Shelter take the necessary steps to insure that they have the programs and procedures in place to conform to the Kansas Insurance Score Act. The Department understands Shelter has the recommended programs and procedures now in place.

2. The Company should review their underwriting nonrenewal procedures to insure that they are in compliance with K.S.A. 40-276a and K.S.A. 40-277. Although Shelter met the requirements set forth in the NAIC Market Handbook guidelines, the exam team notes that there were a total of 9 errors in this category.

CLAIM HANDLING

Company claim processing procedures:

When the claim is received in the branch office, it is assigned to the appropriate adjuster by the claims Supervisor. If a liability investigation is needed, the claim is assigned to a casualty adjuster for investigation and determination of liability. If no liability investigation is needed, then it is assigned to a field adjuster.

The adjuster attempts contact with the insured and claimant normally within 24 hours of the claim being reported to Shelter Insurance.

Upon making contact with the vehicle owners and/or parties involved, all pertinent coverages are explained to them. The owner is given the option to take their vehicle to a SOS (Shelter's direct repair program) shops for an estimate and repairs. If the vehicle owner does not want to go to an SOS shop, then a field adjuster inspects and writes an estimate for the damages to the vehicle and the owner can choose a repair shop of his choice.

If it is determined that the insured or claimant was injured in the accident, a casualty adjuster handles the injury claims that arise and the appropriate coverages are explained to the insured and/or claimant.

Shelter also has an agent paid claims program, which allows our agents to handle small dollar claims under the program's procedures.

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

CLAIMS

The tests for the Claims portion consisted of a random sample from the entire state population of paid claims and a separate sample of claims with no payment. A third sample of claims was drawn from the alleged discriminated group. This consisted of 42 paid and 8 no payment claims from that group.

Standard 1

The initial contact by the company with the claimant is within the required time frame. K.A.R. 40-1-34 Section 6(a) & (d).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	2	96%
Paid	94	0	100%
Selected Group	50	1	98%

– Three no Pay Claims violated Section K.A.R. 40-1-34 Section 6(a) by not acknowledging the claim within 10 working days.

Shelter passed Standard 1.

Standard 2

Timely investigations are conducted. K.A.R. 40-1-34 Section 7.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	1	98%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 2.

Standard 3

Claims are resolved in a timely manner. K.A.R. 40-1-34 Section 8(a) & (c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	1	98%

Shelter passed Standard 3.

Standard 4

The company responds to claim correspondence in a timely manner. K.A.R. 40-1-34 Section 6(b) &(c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 4.

Standard 5

Claim files are adequately documented. K.A.R. 40-1-34 Sections 4, 8(b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	1	98%

Shelter passed Standard 5.

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. K.A.R. 40-1-34 Sections 4, 5(a), 5(b), 5(c), 5(d), 5(e), 8(e), 8(f), 8(g), 9(a)(1), 9(a)(2)(A)(B), 9(a)(3), 9(b), 9(c), 9(e), 9(f), 9(g) K.S.A. 40-3110, K.S.A. 40-2,126.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	2	100%
Selected Group	50	0	98%

- One Paid Claim violated Section 9(a)(2) by not including taxes and fees in the cash settlement
- One Claim violated K.S.A. 40-3110(b) by not paying a PIP claim within 30 days.

Shelter passed Standard 6.

Standard 7

Company uses the reservation of rights and excess of loss letters, when appropriate.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 7.

Standard 8

Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. K.A.R. 40-1-34 Section 9(a)(3)(d).

This standard was not specifically tested. In the normal review of the paid auto claims, any subrogation activity would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9

Company claim forms are appropriate for the type of product.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 9.

Standard 10

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 10.

Standard 11

Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	1	99%
Selected Group	50	1	98%

– One no-pay claim and one paid claim violated K.A.R. 40-1-34 Section 8(a) by not sending a denial letter to the insured.

Shelter passed Standard 11.

Standard 12

Canceled benefit checks and drafts reflect appropriate claim handling practices, K.A.R. 40-1-345(f).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Claim Checks	44	0	100%

Shelter passed Standard 12.

Standard 13

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)(g).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	94	0	100%
Selected Group	50	0	100%

Shelter passed Standard 13.

Standard 14

Loss statistical coding is complete and accurate.

This Standard was not tested during the exam.

GENERAL COMMENTS

A former agent presented allegations of discrimination to KID. Part of the Department's targeted market conduct exam, accordingly, focused on whether the Company displayed any systemic discrimination against certain parties. The following issues were presented to KID:

1. The former agent alleged that the Company cancelled and non-renewed auto policies after the initial 60 day underwriting period for certain minority groups. These actions were in violation of Kansas auto cancellation and non-renewal laws.

The exam team found:

Policy A*

The policy was non-renewed on 10/14/03 due to accidents on 5/2/02 and 5/17/03. Shelter presented evidence that a standard policy was applied to all insureds, resulting in this nonrenewal. With only one accident in over a year, KID believes Shelter's action was inconsistent with the statutory requirement that a substantial change in exposure must have occurred before the non-renewal action can be taken. KID believes this policy was in violation of K.S.A. 40-276a(a)(4). It is beyond the scope of this exam to determine the ultimate cause of this action, discrimination or otherwise.

Policy B*

The policy was non-renewed based on lack of complete underwriting information on all members/drivers in the household. The new business application passed the Company's automated underwriting system. The company did not take any action to non-renew until over a year and a half later. In that year and a half, there was no substantial change in exposure. Shelter presented evidence that this nonrenewal was the result of various miscommunications and that this insured is a current policyholder with Shelter. This policy was in violation of K.S.A. 40-276a(a)(4). It is beyond the scope of this exam to determine the ultimate cause of this action, discrimination or otherwise.

Policy C*

This policy was cancelled due to lack of underwriting information on the spouse, not misrepresentation as indicated in the Company's original response to the exam team. Shelter presented evidence that there was some confusion related to the actual reason for cancellation. Since misrepresentation was not the charge stated in the notice of termination and lack of information was, the notice did not set forth a valid reason for terminating the policy. This policy was in violation of K.S.A. 40-2, 112(a). It is beyond the scope of this exam to determine the ultimate cause of this action, discrimination or otherwise.

Conclusion

Shelter's actions with respect to Policies A and B were inconsistent with the statutory requirement that a substantial change in exposure must have occurred before a non-

renewal action can be taken and the notice of termination in Policy C set forth the incorrect reason for terminating the policy. It is beyond the scope of this exam to determine the ultimate cause of these actions, discrimination or otherwise.

2. The former agent alleged that the Company discriminated against certain minority groups in the adjusting and settlement of claims.

The exam team found:

Table 1 Shelter Claim Profile – Selected Counties

This table summarizes the claim database that the company provided to KID for the exam. This Table shows the number of claims in the state and several key counties that were paid, percentage of paid claims to the total claim population for that county, average dollar pay out per claim in that county and how long it took from the day the claim was opened until it was closed.

The counties selected represented rural and urban areas within the state and a minority population higher than the state average per the 2000 U.S. census reports. Two counties represent the rural portion of Kansas with a high percentage of a minority group. Two counties are urban areas with a percentage of minorities above the state average. The final county was a rural area with a low percentage of minority population.

Policy D*

There was an allegation of mishandling on the company's part because of the policyholder's ethnic background regarding a hail loss on 4/15/03 for this account, and it was not paid properly. The claim was originally settled for a lesser amount, and the company reinspected the property after the agent contacted the Company about the settlement. The final payout was \$852.77.

Conclusion

There was no evidence of systematic discrimination against any one minority group or that the Company violated the Kansas Unfair Claims Practice Act in the servicing and settlement of claims for one or more minority groups. While there may or may not be discrimination, there was no conclusive evidence to substantiate this allegation, and a more thorough investigation into this activity is beyond the scope of this examination.

3. The former agent alleged that the Company reinstated 100% of the non minority group that bounced checks, but 0% of certain minority groups had their coverage reinstated after they bounced checks.

Policy E*

The Company refused to reinstate this policy after 2 checks bounced. The agent alleged that the declination to reinstate was based on the policyholder's ethnic background.

Conclusion

The Company provided documentation to support their decision not to reinstate the specific example provided to the exam team. There were no other examples provided to KID of this alleged discrimination, and the exam team did not find any other situations to support this allegation.

4. The former agent alleged that the Company discouraged agents to write certain minority groups and serviced these accounts differently than the remainder of their book of business. The former agent alleged that this was a corporate attitude.

Policy F*

This auto account was written as new business effective 12/8/02. It qualified for the Company's Tier 2 price. An MVR was ordered on 12/5/02. The policyholder's name was Hispanic.

Conclusion

As noted on pages 9-11 under "Standard #5 Underwriting Practices" in this report, the Company only ordered MVRs on certain segments on their book of business. At the two-day hearing, the Company indicated that all policies for this former agent had MVRs ordered. In December of 2002 Shelter's new business guidelines did not call for ordering MVRs on new auto accounts that qualified for Tier 2. It is beyond the scope of this exam to determine the ultimate cause of this action, whether it was due to certain deficient performance issues on the agent's part or motivated by discriminatory animus.

5. The former agent alleged that the Company terminated certain minority groups after the initial 60 day underwriting period upon later discovering an individual's driving record. For other groups, the company left the insured in their preferred tier and applied a surcharge for their driving record.

Conclusion

The exam team did a rating sample and found no examples of the company applying an illegal surcharge for driving record and subsequently violating K.S.A. 40-053.

*Specific Company policy numbers are on file with the Department and available to authorized persons on request.

Recommendations:

1. At the time of the on-site review of Shelter's operation, a meeting was held with various Shelter executives regarding their use of credit scoring in the underwriting/rating process. At that time, the Company indicated to the exam team that Shelter did not have a program to automatically re-evaluate an individual's credit score every 36 months on renewal per:

**Kansas Insurance Score Act –
K.S.A. 40-5104: Prohibited practices**

No insurer authorized to do business in the state of Kansas which uses credit information to underwrite or rate risks, shall:

(g)(1)...use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report.

It was recommended by the exam team that Shelter take the necessary steps to insure that they have the programs and procedures in place to conform to the Kansas Insurance Score Act. The Department understands Shelter has the recommended programs and procedures now in place.

2. The Company should review their underwriting nonrenewal procedures to insure that they are in compliance with K.S.A. 40-276, K.S.A. 276a and K.S.A. 40-277. Although Shelter met the requirements set forth in the NAIC Market Handbook Guidelines, the exam notes that there were a total of 9 errors in this category.

3. The Department is limited in its ability to handle factual investigations regarding alleged discrimination. Although no systemic discrimination was found, the Department will forward a copy of this report to another agency for further consideration to the extent that agency deems appropriate.

GENERAL ACKNOWLEDGMENT

I would like to acknowledge the cooperation and courtesy extended to the examination team by John Clark and the staff of Shelter Insurance Group.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Michael Grover
Market Conduct Examiner

Mary Lou Maritt
Market Conduct Examiner

Stacy Rinehart
Market Conduct Examiner

Lyle Behrens
Supervisor
Market Conduct Unit

Respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM

**TABLE 1
SHELTER CLAIM PROFILE
SELECTED COUNTIES**

	State	% Hispanic Population 7%			County Finney 051	% Hispanic Population 43.3%	Major City Garden City		County Ford - 057	% Hispanic Population 38%	Major City Dodge City	
Year	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close
2001-2003	39,035	81%	\$2,852	42.4	715	80.3%	\$3,006	47.3	1,459	89%	\$3,300	26.3
2002	13,611	81%	\$2,898	41.9	238	84.5%	\$3,167	44.6	377	90%	\$2,577	32.6
2003	10,301	81.6%	\$2,858	33.7	286	77.6%	\$2,694	41.6	353	91%	\$1,828	23.3

	County Wyandotte - 209	% Hispanic Population 16%	Major City KCK		County Sedgwick 173	% Hispanic Population 8%	Major City Wichita		County Ellis - 051	% Hispanic Population 2.4%	Major city Hays	
Year	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close	Tot Claims Pd	% All Claims Pd	Amt / Pd Claim	Avg # Days Open to Close
2001-2003	579	80%	\$3,977	60.6	7,839	76%	\$2,975	42.6	1,073	77%	\$2,579	34
2002	198	78%	\$3,003	55.2	2,720	77%	\$3,399	43.1	404	78%	\$2,930	40.5
2003	149	80%	\$5,382	39	1,984	77%	\$2,591	33.3	339	74%	\$2,736	31.9

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

Section 1.	Authority
Section 2.	Scope
Section 3.	Definitions
Section 4.	File and Record Documentation
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. K.S.A. 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. K.S.A. 40-2404. Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- (b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
- (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- (h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;
- (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
- (j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;
- (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- (l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

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.