

MARKET CONDUCT EXAMINATION REPORT

COVENTRY HEALTH CARE OF KANSAS, INC.

NAIC # 95489
Kansas Domiciled Company
8535 East 21st Street North
Wichita, KS 67206

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

NAIC #81973
Delaware Domiciled Company
2751 Centerville Road, Suite 400
Wilmington, DE 19808

NAIC Group # 1137

ETS # KS057-M7

As of

October 31, 2010



KANSAS INSURANCE DEPARTMENT

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The 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:

Coventry Health Care of Kansas, Inc.
8535 East 21st Street North
Wichita, KS 67206
NAIC #95489

Coventry Health and Life Insurance Company
2751 Centerville Road, Suite 400
Wilmington, DE 19808
NAIC #81973

Hereafter referred to as “CHCKS”, and “CHLIC”, respectively, or the “Company” or “Companies”, the following report of such examination is respectfully submitted,

Mary Lou Maritt
Market Conduct Examiner
Examiner-in-Charge

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of Coventry Health Care of Kansas, Inc. (CHCKS) and Coventry Health and Life Insurance Company (CHLIC), also referred to as the “Company” or “Companies”, was conducted pursuant to, but not limited to K.S.A. 40-222. In a legal order, Docket #4069-ACQ, issued by the Kansas Insurance Department on December 24, 2009, Coventry Health Care, Inc. was required to report to KID on a quarterly basis, and for a period of no less than one year, its progress relevant to “improving the performance of its wholly owned subsidiary MHNet with regards to the timely and accurate administration and payment of claims”. This exam was conducted in response to issues highlighted in the referenced order as well as an internal complaint analysis performed on MHNet.

The Kansas Insurance Department (KID) reviewed the Companies’ operations and management, and mental health claims processed by MHNet (#901623) to determine compliance with applicable statutes, regulations and bulletins of the State of Kansas. File reviews were conducted for three days at the MHNet offices in Bismarck, North Dakota, and continued until their conclusion at the KID offices through electronic claims access.

The review was conducted according to the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2010 (MRH). The exam team utilized the standards and tests recommended in the Handbook which allows an error tolerance of 7% for claim procedures. The examination report is written by test rather than by exception, which means all standards used are described and the results indicated. Applicable statutes and regulations cited throughout the report may be found in Appendix A.

Due to the narrow scope of this examination, not all NAIC standards applicable to a health examination were tested. Therefore, the reader will notice gaps in the numbering of these standards throughout the report. Additionally, silence on any NAIC standard or Company practice not tested does not imply KID acceptance or endorsement of such practices.

The examination included reviewing samples of claims handled by MHNet from June 1, 2008 through October 31, 2010. Interrogatories were submitted to the Companies prior to the on-site segment of the examination, and written responses were provided.

The examination included, but was not limited to company operations and management, history and profile, prior market conduct examination reports, fines and penalties, Certificates of Authority, internal audit procedures, third party administrators (TPAs), and claims processing.

EXECUTIVE SUMMARY

A targeted market conduct examination of Coventry Health Care of Kansas, Inc. (CHCKS) and Coventry Health and Life Insurance Company (CHLIC), also referred to as the “Company” or “Companies”, was conducted pursuant to, but not limited to K.S.A. 40-222. The examination period was from June 1, 2008 through October 31, 2010. The primary focus of the exam was operations and management as well as the processing of mental health claims by MHNet, a wholly owned subsidiary of Coventry Health Care, Inc.

As it pertains to Operations and Management, the exam team recommended to more closely monitor the performance of MHNet to improve claim processing timelines and accurate payment of interest.

Regarding claims handling, the Company failed five (5) of the eight (8) claim standards tested which included: not sending acknowledgements when more time is needed to process a claim; not completing claim investigations within thirty days; not paying clean claims within thirty days; not adequately documenting claim files; not applying interest as required by statute or policy; and not sending an Explanation of Benefits (EOB) unless the policyholder had a financial responsibility relevant to the claim. Additionally, either no denial reason was listed or an incorrect reason was listed on some EOBs.

The Company has acknowledged these violations and has agreed to implement corrective procedures. The exam team will follow-up with the Company to ensure the new procedures are in place. The exam team issued a mandated review of claims to guarantee that interest was applied correctly to all claims from June 1, 2008 through the present and that a process is in place for all claims going forward to automatically apply interest as prescribed by K.S.A. 40-2442.

Recommendations

OPERATIONS AND MANAGEMENT

1. The exam team recommends closer monitoring and oversight to assure MHNet complies with Kansas statues and regulations involving claim processing requirements, particularly the Kansas Health Care Prompt Pay Act (K.S.A. 40-2442) and the Unfair Claims Settlement Practices (K.A.R. 40-1-34). The Company should ensure that claims are investigated and processed timely, interest is applied as appropriate, and acknowledgments are sent when claims are delayed beyond thirty days.

CLAIM HANDLING

1. The Company must send an acknowledgement if a claim cannot be processed within thirty days. [Note: The Company implemented a temporary manual review to send such notices until notices will be sent automatically when their new claims processing system is online, which is currently scheduled for August 28, 2011.]

2. The Company must complete claim investigations within thirty days from the date of receipt.
3. The Company must pay clean claims within thirty days.
4. The Company must ensure claims notes are adequate so that the claim files can be reconstructed. [Note: The Company is scheduled to implement a new claims processing system August 28, 2011.]
5. The Company must pay interest on clean claims delayed beyond thirty days.
6. The Company must issue EOBs when a claim is denied in whole or in part. [Note: The Company has initiated a program update to begin issuing EOBs regardless of member responsibility.]
7. The Company must list all specific reasons for denying a claim in whole or in part on EOBs. [Note: The Company has implemented corrections, and denial reasons will now be included on EOBs.]
8. The Company must conduct a self-audit on all MHNNet claims *reprocessed* between June 1, 2008 and May 31, 2009, and all MHNNet claims that took more than thirty days to *process* between June 1, 2008 and the present. They should identify and pay the appropriate benefits and interest for any mental health claims that were denied or adjudicated incorrectly. The Company must notify the Examiner-in-Charge when this review is complete and provide documentation of the results, including any interest paid to providers, no later than 90 days following the issuance of the Final Order.

The examiners are of the opinion that these recommended actions are critical for the Company to implement as tools to guarantee all Kansas certificate and policyholders are treated with uniformity and fairness.

DESK EXAMINATION/ON-SITE EXAMINATION

OPERATIONS AND MANAGEMENT

I. History and Profile

Coventry Health Care of Kansas, Inc.

Healthcare America Plans, Inc was incorporated in Kansas on January 2, 1976 under the name Bethel Clinic Family Health Plan Corporation. On November 15, 1978, Bethel Clinic Family Health Plan Corporation changed its name to Family Health Plan Corporation. On August 12, 1991, Family Health Plan Corporation changed its name to Healthcare America Plans, Inc. On December 21, 1998, Healthcare America Plans, Inc. was acquired by Coventry Health Care, Inc. Principal Health Care of Kansas City, Inc., a Missouri incorporated Health Maintenance Organization whose parent company was Principal Health Care, merged into Healthcare America Plans, Inc. and the new entity retained the name Principal Health Care of Kansas City, Inc. Principal Health care of Kansas City, Inc. changed its name to Coventry Health Care of Kansas, Inc. on November 10, 1999. On December 2, 2002, Mid America Health Care Plans, Inc., a Missouri corporation, was merged into Coventry Health Care of Kansas, Inc., with Coventry Health Care of Kansas, Inc. as the surviving corporation. On December 31, 2010, Preferred Plus of Kansas, Inc., a Kansas corporation, merged into Coventry Health Care of Kansas, Inc., with Coventry Health Care of Kansas, Inc. as the surviving corporation.

Coventry Health and Life Insurance Company

Coventry Health and Life Insurance Company began as a Delaware health and life insurance company incorporated on April 24, 1968 and formerly known as American Service Life Insurance Company. American Service Life Insurance Company was acquired by Coventry Corporation on October 10, 1987 and changed its name to Coventry Health and Life Insurance Company on December 29, 1995. The company re-domesticated from Texas to Delaware on May 14, 1999. On August 14, 2008 Vista Insurance Plan, a Florida corporation, was merged with and into Coventry Health and Life Insurance Company with Coventry Health and Life Insurance Company as the surviving corporation. On December 31, 2010, Preferred Health Systems Insurance Company, a Kansas stock life and health insurance company, merged into Coventry Health and Life Insurance Company with the latter as the surviving corporation.

MHNet (Overview)

MHNet Behavioral Health (MHNet) was founded by clinicians in 1985; MHNet is a national behavioral health care company offering a comprehensive suite of behavioral health products for employers, health plans, and public programs. MHNet provides management of comprehensive mental health and substance abuse treatment under contract with managed care organizations and employers as well as a fully integrated approach to EAP, Work-Life, and Behavioral Health Disease Management solutions. MHNet has corporate headquarters and National Service Centers located in Orlando, Florida; Austin, Texas; and St. Louis, Missouri. In 2008, MHNet

merged under Coventry Health Plans as MHNet Specialty Services, LLC, a wholly owned subsidiary.

II. Prior Market Conduct Examination Reports

The Company provided the examiners with two market conduct examination reports: a report for the exam period of 2006-2008 for CHCKS and for the exam period of 2003-2005 for CHLIC. These reports did not reveal areas that warranted additional inspection beyond the scope of this targeted examination.

III. Fines and/or Penalties

The KID examination team reviewed the actions from other states regarding fines and penalties and found nothing that warranted additional inspection beyond the scope of this targeted examination.

IV. Tests for Company Operations and Management

Standard 1

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

The Company conducts internal claims audits and provided documents detailing the steps used to call, conduct, and follow-up on each audit. An internal audit of appeals received by MHNet between May 1, 2009 and October 31, 2009 was provided by the Company. It tracks the processing accuracy of manually adjudicated claims and submits the results to specific examiners for regular feedback and counseling. Auditors are looking for all types of errors, including how the claim is entered into the system, data received, examiner comments or instructions, cost containment standards, and claim adjudication.

Result: Pass

Recommendation: None

Standard 5

Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, MGA's, GA's, TPA's and management agreements must comply with applicable licensing requirements, statutes, rules and regulations.

The exam team reviewed a network participation agreement for mental health and substance abuse claims processing between MHNet (TPA) and Coventry Health Care Inc. and its listed subsidiaries. This is a comprehensive agreement which defines the services, responsibilities, compensation, reporting, ownership of certain records, confidentiality, claims processing, termination and post-termination duties of all parties.

Result: Pass

Recommendation: None

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

The participation agreement between Coventry subsidiaries and MHNet require regular reports on various business operations including claims processing. However, the number and types of claims processing errors found during our examination indicate that these reports either do not provide enough detail to discover these errors or they are not interpreted correctly.

Result: Fail

Recommendation:

The exam team recommends closer monitoring and oversight to assure MHNet complies with Kansas statues and regulations involving claim processing requirements, particularly the Kansas Health Care Prompt Pay Act (K.S.A. 40-2442) and the Unfair Claims Settlement Practices (K.A.R. 40-1-34). The Company should ensure that claims are investigated and processed timely, interest is applied as appropriate, and acknowledgments are sent when claims are delayed beyond thirty days.

Standard 8

The regulated entity is licensed for the lines of business that are being written.

The Kansas Certificates of Authority were reviewed and were in compliance with Kansas law.

Result: Pass

Recommendation: None

Standard 9

The regulated entity cooperates on a timely basis with examiners performing the examinations.

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

Result: Pass

Recommendation: None

CLAIM HANDLING

I. Claim Processing

MHNet Claim Procedures

Prior to July 2009

Prior to July 2009, paper claims were received on-site in Austin, Texas. Claims were opened and date stamped daily. All claims were batched by date received and forwarded to the claims team for manual entry.

Claims were keyed into the QMACS system and audited for accuracy. QMACS is the claim processing system currently utilized by MHNet. Once the claims had passed auditing it was processed to completion. Completed claims were batched and filed on-site for sixty days. After sixty days, claims were boxed and sent to an off-site storage vendor (Safe Site) for retention.

July 2009 to Present

Claims are received by MHNet in three ways. The providers may submit paper copies of claims, electronic copies of claims, or they may sign up with MHNet to submit claims via the internet.

Paper Claims

Paper claims are submitted to the MHNet keying/scanning vendor, ACS (Affiliated Computer Systems). ACS prepares and sorts all mail for imaging. Claims are imaged and standard claim forms are keyed into a QMACS emulation screen. The keyed claims are input into an electronic file format and sent to MHNet. The files are sent three times per day.

MHNet pulls the electronic files and loads the file to a processor which validates information on the member and provider prior to loading to QMACS. If the member can be matched to eligibility in QMACS the processor will load the claim to QMACS. If the member cannot be matched to eligibility, the claim pends as a member fatal, for a claim representative to manually match the eligibility. This will also load the claim to QMACS if there is a match. If there is no match the claim is printed to paper and returned to the provider.

Once the claim loads to QMACS it will either pend against system edits for manual processing or it will process through auto adjudication and either pay or deny. Claims that pend for manual adjudication are monitored daily via a pend database to insure that the claim does not age inappropriately. Inventory is monitored daily and distributed for processing based on the type of edit the claim pended for, and the age of the claim. Claim age is calculated from the clean date field to the current day calendar date.

Electronic Claims

Electronic claims are received via an external vendor Emdeon. The files are received at MHNet and are loaded daily. Once the file is loaded, the claim follows the same process as above.

Claims via the Internet

Providers who participate with MHNet are given the option of entering claims via the internet at MHNet.com. The provider keys the claim into an online program. The information is extracted and fed to a file format for loading to QMACS. Once the file is loaded the claim follows the same process as above.

II. Tests for Claims Handling

“Paid Claims 1” is a sample of paid claims from June 1, 2008 through June 30, 2009. “Paid Claims 2” is a sample of paid claims from July 1, 2009 through October 31, 2010. “No Pay Claims” is a sample of claims denied between June 1, 2008 and October 31, 2010. A breakdown of the claim violations by company may be found in Appendix B. Below are the combined violations by sample. The “Number of Errors” included in the samples below are defined as the total number of claims in the sample which contained errors. The Standard is considered to be failed if any one of the samples did not meet the compliance threshold as indicated above in Purpose and Scope of Review.

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	5	95%
Paid Claims 2	109	26	76%
No Pay Claims	109	30	72%

Sixty-one (61) claims did not include acknowledgements sent when the claim was paid beyond thirty days as required by K.S.A. 40-2442(a).

Result: Fail

Recommendation:

The Company must send an acknowledgment if a claim cannot be processed within thirty days.

Standard 2

Timely investigations are conducted.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	5	95%
Paid Claims 2	109	21	81%
No Pay Claims	109	22	80%

Forty-eight (48) claim investigations were not completed within thirty days from the date of receipt as required by K.A.R. 40-1-34, Section 7.

Result: Fail

Recommendation:

The Company must complete claim investigations within thirty days from the date of receipt.

Standard 3

Claims are resolved in a timely manner.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	5	95%
Paid Claims 2	109	27	75%
No Pay Claims	109	31	72%

Sixty-three (63) clean claims were not paid within thirty days as required by K.S.A. 40-2442(a).

Result: Fail

Recommendation:

The Company must pay clean claims within thirty days.

Standard 4

The regulated entity responds to claim correspondence in a timely manner.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	0	100%
Paid Claims 2	109	0	100%
No Pay Claims	109	0	100%

The exam team found no instances of delayed communication.

Result: Pass

Recommendation: None

Standard 5

Claim files are adequately documented.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	0	100%
Paid Claims 2	109	0	100%
No Pay Claims	109	10	91%

Ten (10) claims were in violation of K.A.R. 40-1-34, Section 4, as the Company was unable to reproduce or verify whether EOBs had been sent.

Result: Fail

Recommendation: The Company must ensure claims notes are adequate and claim activity is documented such that the claim files can be reconstructed.

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	12	89%
Paid Claims 2	109	10	91%
No Pay Claims	109	4	96%

Twenty-six (26) claims did not include interest when delayed beyond thirty days, as required by K.S.A. 40-2442(b).

Result: Fail

Recommendation:

The Company must pay interest on clean claims delayed beyond thirty days.

Standard 9

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

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	N/A	N/A	N/A
Paid Claims 2	N/A	N/A	N/A
No Pay Claims	109	92	16%

Ninety-two (92) claims were in violation of K.S.A. 40-2442(a). Some claim files were found to be in error for multiple reasons, which is why the descriptions below sum to more than the total number of violations. Below is a breakdown of the issues noted:

- Sixty-seven (67) claims did not send an EOB or other notice upon denying the claim.
- Twenty-four (24) claims provided an EOB which did not list each specific reason for denial.
- Four (4) claims were incorrectly denied, and should have been paid within thirty days.
- Two (2) claims were denied with invalid denial reasons.

Result: Fail

Recommendation:

The Company must issue EOBs when a claim is denied in whole or in part.

Recommendation:

The Company must list all specific reasons for denying a claim in whole or in part on EOBs.

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Sample Type	Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	109	0	100%
Paid Claims 2	109	0	100%
No Pay Claims	109	0	100%

Result: Pass

Recommendation: None

General Claim Handling Recommendation

The Company must conduct a self-audit on all MHNet claims *reprocessed* between June 1, 2008 and May 31, 2009, and all MHNet claims that took more than thirty days to *process* between June 1, 2008 and the present. They should identify and pay the appropriate benefits and interest for any mental health claims that were denied or adjudicated incorrectly. The Company must notify the Examiner-in-Charge when this review is complete and provide documentation of the results, including any interest paid to providers, no later than 90 days following the issuance of the Final Order.

SUMMARIZATION

This examination was conducted to review the operations and management activities and the files of the mental health and substance abuse claims administered by the wholly owned subsidiary, MHNet, on behalf of the Coventry companies. The tests and standards were applied to create uniformity in the reporting of passes and failures. The following items are stated in the specific standards above as violations and recommendations.

Recommendations

OPERATIONS AND MANAGEMENT

1. The exam team recommends closer monitoring and oversight to assure MHNet complies with Kansas statues and regulations involving claim processing requirements, particularly in K.S.A. 40-2442, the Kansas Health Care Prompt Pay Act and K.A.R. 40-1-34, Unfair Claims Settlement Practices. The Company should ensure that claims are investigated and processed timely, interest is applied as appropriate, and acknowledgments are sent when claims are delayed beyond thirty days.

CLAIM HANDLING

1. The Company must send an acknowledgement if a claim cannot be processed within thirty days. [Note: The Company implemented a temporary manual review to send such notices until notices will be sent automatically when their new claims processing system is online, which is currently scheduled for August 28, 2011.]
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7. The Company must list all specific reasons for denying a claim in whole or in part on EOBs. [Note: The Company has implemented corrections, and denial reasons will now be included on EOBs.]
8. The Company must conduct a self-audit on all MHNet claims *reprocessed* between June 1, 2008 and May 31, 2009, and all MHNet claims that took more than thirty days to *process* between June 1, 2008 and the present. They should identify and pay the appropriate benefits and interest for any mental health claims that were denied or adjudicated incorrectly. The Company must notify the Examiner-in-Charge when this review is complete and provide documentation of the results, including any interest paid to providers, no later than 90 days following the issuance of the Final Order.

The examiners are of the opinion that these recommended actions are critical for the Company to implement as tools to guarantee all Kansas certificate and policyholders are treated with uniformity and fairness.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by the Coventry staff: Steve Robino, Director of Regulatory Compliance; Lisa Foos, Manager, Regulatory Compliance; MHNet staff Deborah Hager, Director, Service Center Ops; and Sandy Bauer, Supervisor, Service Ops.

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

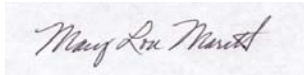
Market Conduct Division

Stacy Rinehart
Market Conduct Manager

Mary Lou Maritt
Market Conduct Examiner

Amber Whitlock
Market Conduct Examiner

Respectfully submitted,



Mary Lou Maritt,
Examiner-in-Charge

APPENDIX A

Related Kansas Insurance Statutes and Administrative Regulations

K.S.A. 40-222. Examinations

(a) Whenever the commissioner of insurance deems it necessary but at least once every five years, the commissioner may make, or direct to be made, a financial examination of any insurance company in the process of organization, or applying for admission or doing business in this state. In addition, at the commissioner's discretion the commissioner may make, or direct to be made, a market regulation examination of any insurance company doing business in this state.

(b) In scheduling and determining the nature, scope and frequency of examinations of financial condition, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiner's handbook adopted by the national association of insurance commissioners and in effect when the commissioner exercises discretion under this subsection.

(c) For the purpose of such examination, the commissioner of insurance or the persons appointed by the commissioner, for the purpose of making such examination shall have free access to the books and papers of any such company that relate to its business and to the books and papers kept by any of its agents and may examine under oath, which the commissioner or the persons appointed by the commissioner are empowered to administer, the directors, officers, agents or employees of any such company in relation to its affairs, transactions and condition.

(g) The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the provisions of the Kansas administrative procedures act.

K.S.A. 40-2442. Same; claims; procedures; rules and regulations; erroneous payment of claims by insurer, limitation on recovery of; audit of pharmacy records, limitations on

(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of accident and sickness insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:

- (1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or

(2) Additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of accident and sickness insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(c) After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give such information within such time, provided such proof is furnished as soon as possible as defined (within the time prescribed) in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.

(d) Within 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:

- (1) Such insurer refuses to reimburse all or part of the claim; and
- (2) Specifies each reason for denial. Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of 1% per month.

(e) The provisions of subsection (b) shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently.

(f) In the event that an insurer erroneously pays a claim providing benefits to which the insured person or provider is not entitled, the insurer shall not initiate a request for reimbursement or refund of that erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within 18 months after the end of the month in which the erroneous payment was made. In cases of fraud by the insured person or provider, such action may be initiated within the applicable statute of limitations pursuant to K.S.A. 60-513, and amendments thereto. In the case of an audit of the records of a pharmacy by a managed care company, insurance company, third party payor or the representative of the managed care company, insurance company or third party payor, the period covered by the audit shall not exceed two years from the date the claim was submitted to or adjudicated or as otherwise provided by state or federal law.

(g) Any violation of this act by an insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions of this act or with such frequency as to constitute a general business practice shall be considered a violation of the unfair trade practices act in K.S.A. 40-2401 et seq. and amendments thereto.

(h) The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of the Kansas health care prompt payment act.

K.A.R. 40-1-34. Unfair Claims Practices Act (Revised 1/03)

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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.

APPENDIX B

Breakdown of Claim Violations by Company

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	5	94%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	24	71%
	CHLIC	27	2	93%
No Pay Claims	CHCKS	88	26	70%
	CHLIC	21	4	81%

Standard 2

Timely investigations are conducted.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	5	94%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	19	77%
	CHLIC	27	2	93%
No Pay Claims	CHCKS	88	18	80%
	CHLIC	21	4	81%

Standard 3

Claims are resolved in a timely manner.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	5	94%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	24	71%
	CHLIC	27	3	89%
No Pay Claims	CHCKS	88	27	69%
	CHLIC	21	4	81%

Standard 4

The regulated entity responds to claim correspondence in a timely manner.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	0	100%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	0	100%
	CHLIC	27	0	100%
No Pay Claims	CHCKS	88	0	100%
	CHLIC	21	0	100%

Standard 5

Claim files are adequately documented.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	0	100%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	0	100%
	CHLIC	27	0	100%
No Pay Claims	CHCKS	88	6	93%
	CHLIC	21	4	81%

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	10	89%
	CHLIC	22	2	91%
Paid Claims 2	CHCKS	82	5	94%
	CHLIC	27	5	81%
No Pay Claims	CHCKS	88	4	95%
	CHLIC	21	0	100%

Standard 9

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

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	N/A	N/A
	CHLIC	22	N/A	N/A
Paid Claims 2	CHCKS	82	N/A	N/A
	CHLIC	27	N/A	N/A
No Pay Claims	CHCKS	88	77	13%
	CHLIC	21	15	29%

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Sample Type		Sample Size	Number of Errors	Percent Compliance
Paid Claims 1	CHCKS	87	0	100%
	CHLIC	22	0	100%
Paid Claims 2	CHCKS	82	0	100%
	CHLIC	27	0	100%
No Pay Claims	CHCKS	88	0	100%
	CHLIC	21	0	100%