

**REPORT OF MARKET CONDUCT EXAMINATION**

**LIBERTY MUTUAL GROUP  
Group #111**

**LIBERTY MUTUAL INSURANCE COMPANY  
FEIN# 041543470  
NAIC# 23043  
NAIC ETS# KSO23-M25**

**LIBERTY MUTUAL FIRE INSURANCE COMPANY  
FEIN# 041924000  
NAIC# 23035  
NAIC ETS# KS023-M26**

**175 BERKLEY STREET  
BOSTON, MA 02116**

**AS OF**

**December 31, 2004**

**BY**

**KANSAS INSURANCE DEPARTMENT**

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

Dear Commissioner Praeger:

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

Liberty Mutual Insurance Company  
NAIC# 23043 FEIN# 041543470  
ETS# KSO23-M25

Liberty Mutual Fire Insurance Company  
NAIC# 23035 FEIN# 041924000  
ETS# KS023-M26

175 Berkley St.  
Boston, MA 02116

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

Lyle Behrens, CPCU, CIE, ARM  
Market Conduct Supervisor

## EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a targeted market conduct examination of Liberty Mutual Insurance Company (LMIC) and Liberty Mutual Fire Insurance Company (LMFIC) from January 1, 2002 – December 31, 2004. The report is written by test and violations are listed within each category. The exam team reviewed general operations, underwriting, claims, and complaints in the St. Louis, MO, Claims Office. File samples were selected for review to verify the Company procedures and practices in claims, complaints and underwriting. Liberty Mutual staff from Boston and Portsmouth came to St. Louis to review their underwriting procedures and to train the examiners in the procedures used in these areas.

The exam team utilized the standards and tests recommended in the NAIC Market Conduct Examiners Handbook. A tolerance standard of 7% is used for claim procedures and 10% is used for all other procedures.

The company passed most tests, and in terms of delivering good service to its insureds, the examiners note an overall positive and professional performance exhibited by the LMIC and LMFIC staff and management to their policyholders. However, the exam team made recommendations on the following issues.

### **LIST OF RECOMMENDATIONS\***

#### **Complaint Handling**

Seven of the ten consumer complaints reviewed did not contain an acknowledgement within the 24-hour corporate guideline. The company should review their consumer complaint handling procedures to ensure that their guidelines are followed.

#### **Underwriting and Rating\***

1. The Auto Rating Manual must be updated within 30 days in Section B, page 03 to reflect a 36-month experience period for determining new business eligibility and a 40-month experience period for renewal eligibility. This is a violation of K.S.A. 40-955(a)(f).
2. The company charged an incorrect premium on all new business written from 1/19/04 – 3/14/05 due to the use of an incorrect tier developed from a matrix not filed and approved by KID. The Company must provide a list of policies and the amount of premium refunded within 30 days from the issuance of the Final Order for this exam. This is a violation of K.S.A. 40-955(a)(f).
3. Liberty Mutual did not include the rating matrix or an explanation of qualifications for Liberty Mutual's 1/20/03 Tier plan on the rule page of their filed rating manual. Liberty Mutual failed to show any different risk characteristics which distinguish different classes of business and which justify a different premium charged. The Company must file a matrix or explanation for the 1/03 – 3/04 rate period to comply with K.S.A. 40-953 and K.S.A. 40-955 within 30 days from the issuance of the Final Order for this exam.

4. The Company began using credit information in 2004. The Company filed its initial credit program including a provision to re-tier customers on variables other than credit. During the Market Conduct examination, the auditors determined that the renewal procedures did not comply with K.S.A. 40-5104(g)(1). The Company disagreed but in order to resolve the impasse will revise its procedures as requested by the auditors. The Company must submit their plan to implement procedures to obtain credit information and recalculate insurance scores at least every 36 months to comply with K.S.A. 40-5104 within 30 days from the issuance of the Final Order for this exam.

5. In the Kansas State Homeowners Rating Manual under “Tier Eligibility” the Company has indicated, “Then, we add 1 point if the customer has targeted animal(s) (I.E. vicious breed dog or non-domestic animal).” The term “targeted animal(s) (I.E. vicious breed dog or non-domestic animal)” is not defined or clarified anywhere in the homeowner’s rate manual.

LM must define “targeted animal” in their rating manual since this is an element that will affect the rating of a homeowner’s policy. LM has not distinguished between the types of animals that they feel reflect the differences in expected losses and expenses and other common household pets. The Company must file amendments to their homeowners rating manual within 30 days from the issuance of the Final Order for this exam to comply with K.S.A. 40-953.

6. The Company must amend its rejection procedures to include either notifying the applicant of the adverse underwriting reasons in a letter or verbally advising applicants on how to obtain these reasons in writing. Copies of these letters must be available to future market conduct examiners as well as sufficient information to document the person talked to, date and time of the conversation. This is a violation of K.S.A. 40-2, Sections 111 and 112.

7. The exam uncovered an inconsistency in the filed rating pages caused by a typographical error in a filing. This had been corrected by the Company before it was brought to the Company’s attention by the exam team, and it did not change the way the Company was rating their policies. However, the Company should review their filing procedures to ensure that all filings are accurate, and to ensure that they follow filed procedures.

8. During the migration of Prudential policies, the Company gave a credit in the tier placement of Prudential insureds if they had Prudential life insurance policies, though this procedure was not a filed migration procedure. The Company should review their filing procedures to ensure the appropriate procedures are filed as required by Kansas law, and to ensure that the Company follows filed procedures. This is a violation of K.S.A. 40-955(f).

**\*Examiner’s Notes--The Companies complied with all the above recommendations to the satisfaction of the Department and this exam report is now final.**

### **Claim Handling**

Nine homeowner claim files did not show that the initial call was returned to the claimant within 24 hours as specified in company guidelines. The company should review their claim handling procedures to ensure that their guidelines are followed.

## **PURPOSE AND SCOPE OF REVIEW**

A targeted market conduct examination of LMIC and LMFIC operations were completed per K.S.A. 40-222 to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas from January 1, 2002 – December 31, 2004. The exam focused on the Company's general operations, claims processing, complaint handling and underwriting practices. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

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

### **COMPANY OVERVIEW**

- History and Profile
- Prior Market Conduct Examination Reports
- Fines and/or Penalties
- Company Operations and Management
- Certificates of Authority
- Internal Audit Procedures
- Privacy Procedures

### **COMPLAINT HANDLING**

- Record Keeping
- Timely Response

### **UNDERWRITING AND RATING**

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

### **CLAIM HANDLING**

- Claim Processing
- Timeliness and Accuracy of Claim Payment
- Proper Maintenance of Claim Files

## **SUMMARY OF REVIEW**

The market conduct examination focused on LMIC and LMFIC from January 1, 2002 to December 31, 2004.

Interrogatories requesting information on complaints, underwriting and claims were submitted to the Company for written response. The responses received adequately addressed the issues presented. Random samples were selected for review to verify the Company procedures and practices in claims, complaints and underwriting. The exam team utilized the standards and tests recommended in the NAIC Market Conduct Examiners Handbook. A tolerance standard of 7% is used for claim procedures and 10% is used for all other procedures.

Violations of Kansas statutes and regulations are included within each category along with recommendations to improve Company operations and compliance with KID requirements.

## **DESK EXAMINATION/ON-SITE EXAMINATION**

### **COMPANY OVERVIEW**

#### **History and Profile**

LMIC:

The company was incorporated under the laws of Massachusetts January 1, 1912 and began business July 1, 1912. The sponsors were leading manufacturers interested in providing workers' compensation insurance at cost. The company was incorporated as a part of the Workmen's Compensation Act of Massachusetts, under the name "Massachusetts Employers Insurance Association." The present title was adopted August 15, 1917. On November 28, 2001, the company reorganized from a mutual insurance company to a stock insurance company as part of a mutual holding company structure.

LMFIC:

This company was incorporated October 31, 1908 under the laws of Massachusetts as "United Druggists Mutual Fire Insurance Company." The word "Druggists" was deleted from its title in 1918. The present name was adopted on December 15, 1949. All contracts have been on a non-assessable basis since 1942. On March 19, 2002, the company reorganized from a mutual insurance company to a stock insurance company as part of a mutual holding company structure.

#### **Operations**

Practically all lines of insurance, except title, are written by each company and its companion carriers, including The First Liberty Insurance Corporation, LM Insurance Corporation, Liberty Insurance Corporation and Liberty Life Assurance Company of Boston.

#### LMIC:

In addition to the workers' compensation coverage written by the company, available forms of insurance include automobile, general liability, burglary, robbery, fidelity, surety, forgery, personal and group accident, multiple peril policies, umbrella excess liability and personal catastrophe.

#### LMFIC:

In addition to fire, extended coverage, inland marine and homeowner's policies, available insurance includes allied fire lines, casualty coverages (including automobile and workers' compensation) and commercial multiple peril contracts.

Relations with policyholders are through full-time employees as business is solicited and serviced on a direct dealing basis. The operational organization is divided into fifteen geographical divisions with over 300 branch offices coast to coast, including Alaska and Hawaii. Broad local authority is delegated to the division office. The company is also staffed to offer, on a nationwide basis, a complete claim service to policyholders.

Each company and its companion carriers share in one another's business under an inter-company reinsurance arrangement. LMIC participates at 66.5% and LMFIC participates at 10%.

#### Company Agreements

There were not any company agreements with outside entities as the Company does not subcontract its claims, complaints or management operations. MGA services are not utilized.

#### Internal Audits

##### Subsidiary Audits:

Corporate Internal Auditing (CIA) recommends to management the type of audit functions needed and conducts unannounced subsidiary audits on a regular basis. Quarterly reports are provided to the Vice President of CIA. CIA annually reviews and discusses these subsidiary internal audit plans and their findings.

CIA completes a Quality Assurance Review of each subsidiary audit function on an annual basis and issues a written report to the subsidiary's CEO and Audit Director at the conclusion of the Quality Assurance Review.

##### Claims Audits:

Monthly audits are conducted by claims supervisors from random claim files. Some are sent to the next level supervisor for further investigation and 100% of all bodily injury (BI) claims are reviewed. Each supervisor reviews a specific number of files for each person and the BI Team Manager reviews a specific number of BI files for each person. The Claims Manager also conducts one secondary review per Supervisor and Team Manager. There is extensive detail recorded on each file reviewed to provide further training and clarification with claims



representatives. Statistical detail is maintained from month-to-month to compare individual improvement in file handling and to identify specific problems in the processing steps in general.

#### Complaint Audits:

The President's Service Team handles complaints and the manager reviews every complaint and response.

#### Underwriting Audits:

These reps handle multiple states and review their work both for policy standards and state laws. Regional centers conduct quarterly audits and the Home Office conducts annual or biannual audits throughout the company.

#### Prior Market Conduct Examination Report(s)

The Company provided the examiners with market conduct examination reports from 1999 through 2003 for review. There were no recommendations in these previous exams that required a follow-up by this market conduct unit.

#### Fines and/or Penalties

The NAIC I-Site database was reviewed and the company provided a summary of all fines and penalties taken against it in the past five (5) years. There was nothing noted that warranted follow-up by this exam team.

### **Tests for Company Operations/Management**

#### **Standard 1**

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

Monthly and quarterly audit reports prepared by the Auto Claims Manager and his staff were reviewed and discussed. These audits were thorough and instructive for both the service center staff, supervisors and team managers.

The company passed Standard 1.

#### **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.

The company passed Standard 7.

**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 the company was in compliance.

The company passed Standard 8.

**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.

The company passed Standard 9.

**Standard 10**

The company has procedures for the collection, use, and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders. K.A.R. 40-1-46

Business units enter into contractual service agreements with vendors when either the receipt or dissemination of nonpublic personal information is involved and seeks to include the right to audit the vendor's business operations for compliance. Only employees with a need to know are given access to personal nonpublic information.

The company passed Standard 10.

**Standard 11**

The company had developed and implemented written policies, standards and procedures for the management of insurance information.

The Company maintains an intranet site as its baseline educational resource for its employees. Individual business units maintain their own privacy intranet sites and training programs for employees. Procedures to access, maintain and secure insurance information are detailed in the *Liberty Mutual Group Statement of Principles on Personal Information Privacy*, the *Employee Handbook*, and the *Liberty Mutual Business Ethics and Compliance Handbook* and cover topics such as: personal conduct, privacy, confidentiality, physical and data security, fraud and dishonesty, progressive discipline and termination, media inquiries, personal medical records, business trade secrets, financial data, employment practices, fair business practices and compliance, claims investigation, litigation and settlement information, physical security and network and data security.

The company passed Standard 11.

**Standard 12**

The company has policies and procedures to protect the privacy of nonpublic information relating to its customers, former customers and consumers that are not customers.

K.A.R. 40-1-46

Consumers who are not customers are included in the internet privacy policy and the privacy policies governing the everyday handling of nonpublic information. There were not any complaints filed with the Company or the Department concerning privacy issues.

The company passed Standard 12.

**Standard 13**

The company provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

K.A.R. 40-1-46

Privacy notices are sent to new policyholders with the policy and to renewals with billings. This notice details the type of information collected, the type of information disclosed, the entities allowed by law who may receive the information and a statement of safeguards used to protect nonpublic personal information. The website privacy policy link is located on every screen and is different from the privacy notice sent to policyholders. The website policy protects customers and consumers who are not customers.

The company passed Standard 13.

**Standard 15**

The company's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations. K.A.R. 40-1-46

The company developed a privacy policy by using current Kansas laws which adopted by reference the NAIC "Privacy of Consumer Financial and Health Information Regulation."

The company passed Standard 15.

**Standard 17**

Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Liberty Mutual Holding Company, Inc. (LMHC) adopted a Non-Public Personal Information Security Plan in 2002 which outlines the criteria, purpose and use of its privacy and security procedures. A three-tiered management and accountability structure is in place to ensure compliance within both the common enterprise-wide and business unit-specific procedures. Participants include representatives from legal, operating

personnel, business units and front-line managers who report to the Corporate Privacy Committee and ultimately to the chairman and CEO of LMHC. The Company does not sell personal information to mass marketers or telemarketers.

The company passed Standard 17.

## **COMPLAINT HANDLING**

### **Company Complaint Handling Procedures**

Complaint Handling Procedures for the Company's Personal Market begins with a definition of a complaint as "*a complaint shall mean a written communication primarily expressing a grievance.*" The procedures further expand this definition to include electronic complaints received through the Liberty Mutual Internet site or employee email, and telephone or in-person complaints made directly to an office other than the local office (i.e. Underwriting/ Production, Region, Home Office) or elevated from the local office internally. It is also noted that customer complaints are construed to include those brought by third parties such as insurance departments, claimants, etc. All Personal Market complaints, as defined above, are entered into the corporate complaint database, eStarBase. All materials concerning the complaint are forwarded to the Regional eStarBase Administrator and/ or Presidential Service Team (PST) for data entry and storage. All complaints that do not pertain to the Personal Market Strategic Business Unit, regardless of where received are forwarded to the PST for processing. This includes complaints received from a State Department of Insurance (DOI). The PST will follow the appropriate SBU's complaint handling procedures and assume administrative responsibility for the complaint.

### State Insurance Department Complaint Guidelines

When a complaint is received from a State DOI, the Home Office PST or Regional Vice President is designated as the contact person and serves as an internal liaison in the direction and resolution of the complaint. It is the responsibility of the contact person to ensure all DOI complaints are entered into eStarBase and monitored for timely resolution and compliance with state requirements. The contact person will also direct complaint correspondence to the appropriate department for handling. The original correspondence, the eStarBase cover sheet, all closing materials and any follow-up materials are maintained. Complaint correspondence is filed in one central location by year, state, and eStarBase number and maintained for five years unless otherwise specified by the State.

### Personal Market Customer Complaint Handling

The Company Complaint Handling Procedures describes the steps in the handling of personal market consumer complaints. When the complaint is first received, information is gathered and the complaint is forwarded to the appropriate manager for handling. The manager enters the complaint into the eStarBase and the due date is established. If the complaint is not immediately

resolvable, the manager will acknowledge the complaint with a personalized letter or telephone call within 24 hours of receipt. This acknowledgement is documented in the eStarBase system. (This initial acknowledgement does not apply to DOI complaints unless specifically requested.) The manager or a delegate then investigates the complaint. This should be completed within five working days and documented in the eStarBase system.

The manager should contact the complainant within ten working days of receipt of the complaint with the resolution. Telephone complaints may be resolved verbally. Written complaints may be initially resolved verbally, but a final resolution must be confirmed in writing. The resolution of the complaint should be documented by the manager through the eStarBase Administrator within fifteen working days. The complaint is closed in eStarBase by the eStarBase administrator. If a complaint has not been resolved by the due date, the eStarBase administrator who initially entered the complaint will follow up with the manager to whom the complaint was assigned for the status and resolution of the complaint. Complaints are monitored quarterly by Regional Vice Presidents. SBU Management and the PST monitor the corporate complaint handling process and performance for adherence to Company policies and standards. Detailed quarterly reports are run for each region and distributed by HO personal sales to HO and region management. Regional and SBU management then develop a course of action to correct the root cause of consumer problems where appropriate.

### **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 company passed Standard 1.

#### **Standard 2**

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34 Sections 5(a) and 6

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

The company 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. K.A.R. 40-1-34,6

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
KID Complaints	40	0	100%

Consumer Complaints	10	0	100%
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The company passed Standard 3.

**Standard 4**

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

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
KID Complaints	40	1	98%
Consumer Complaints	10	0	100%

On one complaint the company failed to respond to a DOI complaint within the fifteen working days allowed by K.A.R. 40-1-34,6(b).

The company passed Standard 4.

**Recommendation:**

1. Seven of the ten consumer complaints reviewed did not contain an acknowledgement within the 24 hour corporate guidelines. The company should review their consumer complaint handling to ensure that they are following their own guidelines.

**UNDERWRITING AND RATING**

Underwriting Procedures

Auto and Homeowner New Business

New business applications are quoted and bound utilizing systems designed to automate most of the underwriting decisions and to generate the correct tier placement based on the applicable criteria. The applications are reviewed individually by the Production staff to verify the accuracy of the information then the policy is produced.

Auto New Business

As indicated above, the majority of the Auto New Business is quoted and produced utilizing a system application. This application is designed to automate the majority of the underwriting decisions and allow for consistent application of underwriting rules. This system was in place during the entire exam period.

Homeowner New Business

Since January 20, 2004, Homeowner New Business has been quoted utilizing a system application. This tool generates an application for the Sales Force to submit to the Underwriting and Production Centers. The Underwriting and Production Centers then manually underwrite and produce the policies. Prior to January 20, 2004, all Homeowner new business policies were manually quoted, underwritten and produced.

### Auto and Homeowner Renewal Business

The majority of the renewal business is produced automatically prior to the renewal date and the applicable tiers are assigned based on the Renewal Tier criteria. Policies which have had losses, excluding Auto policies with single Not At Fault Losses or other conditions, generate a review. These policies are reviewed individually by the Production staff and assigned the proper tier based on those criteria.

All renewal policies are initially underwritten by the policy writing system. Renewal policies with no prior losses or other adverse conditions renew automatically. Renewal policies with prior losses or adverse conditions are individually reviewed by the Production staff.

### **Tests for Underwriting & Rating**

#### **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.A.R. 40-955

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Auto	50	5	90%
New Business	25	3	
Renewals	25	2	
Home	50	7	*86%
New Business	25	3	
Renewals	25	4	

The company failed Standard 1. \*

Four auto policies were placed in incorrect tiers and one policy was rated with an incorrect trailer factor which violates K.S.A. 40-955.

Three homeowner policies were issued with the wrong territory code, one policy misapplied the protective device classification, one policy misapplied the multiple policy discount and two policies were placed in incorrect tiers, all of which violate K.S.A. 40-955.

#### **Standard 2: Rating Practices**

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

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Auto	50	0	100%
Home	50	0	100%

The company passed Standard 2.

**Standard 4: Rating Practices**

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

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
New Business	50	0	100%
Renewals	50	0	100%

The company passed Standard 4.

**Standard 11: 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

See the section “General Rating Manual Violations” following Standard 26 for more detail.

**Standard 12: 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>Violations</u>	<u>%Pass</u>
New Business	50	0	100%
Renewals	50	0	100%

The company passed Standard 12.

**Standard 14: 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

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
New Business	50	0	100%
Renewals	50	0	100%
Cancellations	75	0	100%

The company passed Standard 14.

**Standard 15: Underwriting Practices**

File documentation adequately supports decisions made. K.S.A. 40-953, K.S.A. 40-954

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
New Business	50	0	100%
Renewals	50	0	100%
Cancellations	75	0	100%
Non-Renewals	50	0	100%



The company passed Standard 15.

**Standard 16: 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>Violations</u>	<u>%Pass</u>
New Business	50	0	100%
Renewals	50	0	100%

The company passed Standard 16.

**Standard 18: 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

This was not specifically tested. In the course of reviewing the sample, the procedures for verifying the VIN number were discussed with the Company and any deviations from the electronic procedure would have been noticed by the examiner.

**Standard: 20 Underwriting Practices – Mass Market auto**

The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations in application of mass marketing plans.

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

**Standard 22: Termination Practices**

Rejections/Declinations. Rejections and declinations are not unfairly discriminatory. K.S.A. 40-954(c), K.A.R. 40-3-40

A letter is sent if a new business applicant is rejected in part due to an insurance score. Applicants are informed verbally if the rejection was based on other underwriting guidelines and are provided instructions on how to acquire the reasons in writing. The exam team did not receive any such letters.

Out of a sample of 50 auto and home rejections, the company provided the exam team with thirty (30) auto applications which were captured electronically during the application process. Homeowner applications are not captured electronically. However with only an application and no other documents that pertain to the underwriting of the account, the exam team could not determine if the files were handled in accordance with Kansas laws.

The Company failed Standard 22.

**Standard 23: Termination Practices**

Cancellation/Non-renewal and Declination notices comply with policy provisions and state laws and company guidelines. K.S.A. 40-276(a), K.S.A. 40-277, K.S.A. 40-278, K.S.A. 40-2,111, K.S.A. 40-2,120 – 122, K.A.R. 40-3-23, K.A.R. 40-3-28, K.A.R. 40-3-31

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Cancellations	72*	0	100%
Non-Renewals	50	1	98%
Rejections/Declinations	50	50	0%

\*3 files in the sample were removed; not Kansas residents

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

Fifty declinations were verbal but there are no records to indicate person talked to, date, time or whether instructions were given on how to acquire reasons in writing. This is a violation of K.S.A. 40-2, Sections 111 and 112.

The company failed Standard 23.

**Recommendation:**

The Company must amend its rejection procedures to include either notifying the applicant of the adverse underwriting reasons in a letter or verbally advising applicants on how to obtain these reasons in writing. Copies of these letters must be available to future market conduct examiners as well as sufficient information to document the person talked to, date and time of the conversation. This is a violation of K.S.A. 40-2, Sections 111 and 112.

**Standard 24: 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

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Cancellations	72*	0	100%
Non-Renewals	50	0	100%

\*3 files in the sample were removed; not Kansas residents

The company passed Standard 24.

**Standard 25: 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)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Cancellations	72*	0	100%

\*3 files in the sample were removed; not Kansas residents

The company passed Standard 25.

**Standard 26: Terminations**

Rescissions are not made for non-material misrepresentation.

This standard was not specifically tested. Rescissions were not found in the samples reviewed.

**General Rating Manual Violations**

The following violations were based on a review of the rating manuals.

1. The Auto Rating Manual does not explain that different experience periods are used to determine eligibility for new and renewal business.
2. In the Kansas State Homeowners Rating Manual under “Tier Eligibility” the Company has indicated, “Then, we add 1 point if the customer has targeted animal(s) (I.E. vicious breed dog or non-domestic animal).” The term “targeted animal(s) (I.E. vicious breed dog or non-domestic animal)” is not defined or clarified anywhere in the homeowner’s rate manual.

LM must define “targeted animal” in their rating manual since this is an element that will affect the rating of a homeowner’s policy. LM has not distinguished between the types of animals that they feel reflect the differences in expected losses and expenses and other common household pets. The Company must file amendments to their homeowners rating manual within 30 days from the issuance of the Final Order for this exam to comply with K.S.A. 40-953.

3. Liberty Mutual did not include the rating matrix or an explanation of qualifications for Liberty Mutual’s 1/20/03 Tier plan on the rule page of their filed rating manual. Liberty Mutual failed to show any different risk characteristics which distinguish different classes of business and which justify a different premium charged. The Company must file a matrix or explanation for the 1/03 – 3/04 rate period to comply with K.S.A. 40-953 and K.S.A. 40-955 within 30 days from the issuance of the Final Order for this exam.\*

**\*Editor’s Note: The Company subsequently has filed a new plan for 2004.**

4. At the time of this examination, the company did not have any procedures or systems in place to obtain current credit information to review insurance scores at least every 36 months and has indicated that it does not plan to implement such a program. The exam team recommends that renewal procedures be developed before 2007 to comply with Kansas laws. This is a violation of K.S.A. 40-5104.\*

**\*Editor's Note: The Company subsequently has filed new procedures.**

### **General Underwriting and Rating Recommendations:**

1. The exam uncovered an inconsistency in the filed rating pages caused by a typographical error in a filing. This had been corrected by the Company before it was brought to the Company's attention by the exam team, and it did not change the way the Company was rating their policies. However, the Company should review their filing procedures to ensure that all filings are accurate, and to ensure that they follow filed procedures.
2. During the migration of Prudential policies, the Company gave a credit in the tier placement of Prudential insureds if they had Prudential life insurance policies, though this procedure was not a filed migration procedure. The Company should review their filing procedures to ensure the appropriate procedures are filed as required by Kansas law, and to ensure that the Company follows filed procedures. This is a violation of K.S.A. 40-955 (f).

## **CLAIM HANDLING**

### **Company Claim Handling Procedures**

Incoming claims are generally reported through the company call service center (CSC) via a toll free number or the internet. At this point, the initial report is obtained and the matter is assigned a claim number. The claim is assigned by the CSC to the proper claim office for further handling. This information is conveyed to the person filing the initial report. The assignment to the local claims office is completed electronically and referred no later than the next business day.

The local claims office will initiate an evaluation of the coverage, gather the facts of the loss, contact the involved persons/organizations, and gather all necessary facts to complete an investigation of the claim. The claim is acknowledged to both the policyholder and any other claimants. Any required forms, documentation, or other items are requested at the time of acknowledgement by the local claims office (or as soon as they become necessary, thereafter). Company procedures indicate a first call should be made to the customer within twenty-four hours of the initial report of the claim. Any appraisals of property damage are also arranged at this point. In the event a claim involves injury, proper authorizations are requested for the purpose of obtaining relevant medical or wage loss information. The claims office will continue to monitor the claim from the point where the investigation has been completed through to the point of ultimate disposition. The company does specify three levels of claim investigation

depending on the severity of the claim, with more stringent time frames and claim handling criteria with the more severe claims. In the event the company is advised of the service of a 3<sup>rd</sup> party suit, the local claims office promptly takes steps to hire counsel for the policyholder and properly answer the suit.

Homeowner claims for Kansas policyholders are routed to the Naperville Homeowner claims unit. First party auto damage claims are assigned to a dedicated unit located in the Naperville, IL office. The Naperville auto unit will review the coverage, arrange for the appropriate appraisals, and complete the investigation and resolution of the claim. Total loss vehicle claims are forwarded to the St. Louis Total Loss and Salvage unit for handling and disposition of the total loss vehicle. The Company uses ADP Autosource to determine the fair market value for total loss vehicles.

**Tests for Claims**

**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>Violations</u>	<u>%Pass</u>
No Pay	50	1	98%
Paid	50	0	100%

One claim did not contain an acknowledgement within ten working days as required by K.A.R. 40-1-34, 6(a).

The company passed Standard 1.

**Standard 2**

Timely investigations are conducted. K.A.R. 40-1-34 Sections 7 and 8(c)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	50	0	100%

The company passed Standard 2.

**Standard 3**

Claims are resolved in a timely manner. K.A.R. 401-34 Section 8 (a)(c)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	1	98%
Paid	50	0	100%

One claim was not accepted or denied within fifteen working days after receiving proof of loss as required by K.A.R. 40-1-34, 8(a). This claim remained open after forty-five days, without notifying the insured that additional time was needed as required by K.A.R. 40-1-34, 8(c).

The company passed Standard 3.

**Standard 4**

The company responds to claim correspondence in a timely manner. K.A.R. 40-1-34, 6(a)(d)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	50	0	100%

The company passed Standard 4.

**Standard 5**

Claim files are adequately documented.

K.A.R.40-1-34 Sections 4 and 6(a), K.A.R. 40-1-34, 8 (b)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	50	0	100%

The company 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 5(a), 8 and 9, K.S.A. 40-3110, K.S.A. 40-2,126.

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	50	0	100%

The company passed Standard 6.

**Standard 7**

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

The exam team did not specifically test for this standard. In the normal review of the sample claims files, any reservation of rights and excess of loss letter activity would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

The company 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, 9(d)

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

The company passed Standard 8.

**Standard 9**

Company claim forms are appropriate for the type of product.

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	0	100%
Paid	50	0	100%

The company passed Standard 9.

**Standard 10**

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

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

The company passed Standard 10.

**Standard 11**

Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. K.A.R. 40- 1-34,8 (a), (b) (c)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	50	1	98%

One claim file did not contain a copy of the denial letter as required by K.A.R. 40-1-34,8(a).

The company passed Standard 11.

**Standard 12**

Cancelled benefit checks and drafts reflect appropriate claim handling practices. Checks were coded for proper payment and were cashed in a timely manner by the claimant.

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
Cancelled Checks	25	0	100%

The company 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)(f)(g)

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

The company passed Standard 13.

### **Recommendation:**

1. Nine homeowner claim files did not show that the initial call was returned to the claimant within 24 hours as specified in company guidelines. The company should review their claim handling to ensure that they are following their own guidelines.

## **GENERAL COMMENTS**

### **LIST OF RECOMMENDATIONS**

#### **Complaint Handling**

Seven of the ten consumer complaints reviewed did not contain an acknowledgement within the 24 hour corporate guidelines. The company should review their consumer complaint handling to ensure that they are following their own guidelines.

#### **Underwriting and Rating**

1. The Auto Rating Manual must be updated within 30 days in Section B, page 03 to reflect a 36-month experience period for determining new business eligibility and a 40-month experience period for renewal eligibility. This is a violation of K.S.A. 40-955 (a)(f).
2. The company charged an incorrect premium on all new business written from 1/19/04 – 3/14/05 due to the use of an incorrect tier developed from a matrix not filed and approved by KID. The Company must provide a list of policies and the amount of premium refunded within 30 days from the issuance of the Final Order for this exam. This is a violation of K.S.A. 40-955 (a)(f).
3. Liberty Mutual did not include the rating matrix or an explanation of qualifications for Liberty Mutual's 1/20/03 Tier plan on the rule page of their filed rating manual. LMG failed to show any different risk characteristics which distinguish different classes of business and which justify a different premium charged. The Company must file a matrix or explanation for the



1/03 – 3/04 rate period to comply with K.S.A. 40-953 and K.S.A. 40-955 within 30 days from the issuance of the Final Order for this exam.

4. The Company began using credit information in 2004. The Company filed its initial credit program including a provision to re-tier customer on variables other than credit. During the Market Conduct examination, the auditors determined that the renewal procedures did not comply with K.S.A. 40-5104(g)(1). The Company disagreed but to resolve the impasse will revise its procedures as requested by the auditors. The Company must submit their plan to implement procedures to obtain credit information and recalculate insurance scores at least every 36 months to comply with K.S.A. 40-5104 within 30 days from the issuance of the Final Order for this exam

5. In the Kansas State Homeowners Rating Manual under “Tier Eligibility” the Company has indicated, “Then, we add 1 point if the customer has targeted animal(s) (I.E. vicious breed dog or non-domestic animal).” The term “targeted animal(s) (I.E. vicious breed dog or non-domestic animal)” is not defined or clarified anywhere in the homeowner’s rate manual.

LM must define “targeted animal” in their rating manual since this is an element that will affect the rating of a homeowner’s policy. LM has not distinguished between the types of animals that they feel reflect the differences in expected losses and expenses and other common household pets. The Company must file amendments to their homeowners rating manual within 30 days from the issuance of the Final Order for this exam to comply with K.S.A. 40-953.

6. The Company must amend its rejection procedures to include either notifying the applicant of the adverse underwriting reasons in a letter or verbally advising applicants on how to obtain these reasons in writing. Copies of these letters must be available to future market conduct examiners as well as sufficient information to document the person talked to, date and time of the conversation. This is a violation of K.S.A. 40-2, Sections 111 and 112.

7. The exam uncovered an inconsistency in the filed rating pages caused by a typographical error in a filing. This had been corrected by the Company before it was brought to the Company’s attention by the exam team, and it did not change the way the Company was rating their policies. However, the Company should review their filing procedures to ensure that all filings are accurate, and to ensure that they follow filed procedures.

8. During the migration of Prudential policies, the Company gave a credit in the tier placement of Prudential insureds if they had Prudential life insurance policies, though this procedure was not a filed migration procedure. The Company should review their filing procedures to ensure the appropriate procedures are filed as required by Kansas law, and to ensure that the Company follows filed procedures. This is a violation of K.S.A. 40-955(f).

### **Claim Handling**

Nine homeowner claim files did not show that the initial call was returned to the claimant within 24 hours as specified in company guidelines. The company should review their claim handling to ensure that they are following their own guidelines.

## **CONCLUSION**

The exam team acknowledges the cooperation and courtesy extended by Mark Plesha, Director of Regulatory Affairs; Nick Marrangoni, Director of Regulatory Affairs; Michael Grove, Portfolio Underwriter Midwest Region; Bob Passmore, Claims Manager-Personal Market; Bob Popielewski, and all other staff who were responsible for providing Liberty Mutual Insurance Company and Liberty Mutual Fire Insurance Company information and research.

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

### **Market Conduct Division**

Lyle Behrens  
Supervisor

Mary Lou Maritt  
Examiner-In-Charge

Stacy Rinehart  
Market Conduct Examiner

Respectfully submitted,

\_\_\_\_\_  
Mary Lou Maritt  
Examiner-In-Charge

## APPENDIX I

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

#### Table of Contents

Section 1.	Authority
Section 2.	Scope
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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.

**B. K.S.A. 40-222 (c) Examinations**

(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.

**C. K.S.A. 40-276a Automobile insurance; denial of renewal; conditions and exceptions**

(a) Any insurance company that denies renewal of an automobile liability insurance policy in this state shall give at least 30 days written notice to the named insured, at his last known address, or cause such notice to be given by a licensed agent of its intention not to renew such policy. No insurance company shall deny the renewal of an automobile liability insurance policy except in one or more of the following circumstances or as permitted in subsection (b):

(6) when any of the reasons specified as reasons for cancellation in K.S.A. 40-277 are existent, except that (A) when failure to renew is based upon termination of agency contract, obligation to renew will be satisfied if the insurer has manifested its willingness to renew, and (B) obligation to renew is terminated on the effective date of any other automobile liability insurance procured by the named insured with respect to any automobile designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal. Nothing in this section shall require an insurance company to renew an automobile liability insurance policy if such renewal would be contrary to restrictions of membership in the company which are contained in the articles of incorporation or the bylaws of such company.

**D. K.S.A. 40-953 Excessive, inadequate rates, or unfairly discriminatory rates; competitive and noncompetitive markets**

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 relation 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 relation 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 relation to the riskiness of the class of business, or if expenses are unreasonably high in relation 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 relation 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.

#### **E. K.S.A. 40-955 Rate filings; disapproval of filings**

(a) Every insurer shall file with the commissioner, except as to inland marine risks where general custom of the industry is not to use manual rates or rating plans, every manual of classifications, rules and rates, every rating plan, policy form and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the proposed effective date and the character and extent of the coverage contemplated and shall be accompanied by the information upon which the insurer supports the filings. A filing and any supporting information shall be open to public inspection after it is filed with the commissioner. An insurer may satisfy its obligations to make such filings by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer. Nothing contained in this act shall be construed to require any insurer to become a member or subscriber of any rating organization.

(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.

#### **F. KSA 40-3110 - Payment of PIP benefits**

(a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of

expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of the injury.

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

#### **G. 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:

- (a) Use an insurance score that is calculated using income, address, zip code, race, religion, color, sex, disability, national origin, ancestry or marital status of the consumer as a factor.
- (b) Without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subsection (a), refuse to quote, deny, cancel or refuse to renew any policy of personal insurance solely on the basis of credit information.
- (c) Without consideration of any other applicable factor independent of credit information, base an insured's renewal rates for personal insurance solely upon credit information.
- (d) Without consideration of any other applicable factor independent of credit information, take an adverse action against a consumer solely because such consumer does not have a credit card account.
- (e) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(1) Treat the consumer as if the applicant or insured had neutral credit information, as defined by the insurer; or

(2) exclude the use of credit information as a factor and use only other underwriting criteria.

f) Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the personal insurance policy is first written or notice of renewal is issued.

(g)(1) Except as provided in paragraphs (2) and (3), 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.

(2) The insurer shall:

(A) Re-underwrite and re-rate the consumer's personal insurance policy, at the annual renewal of such policy, based upon a current credit report or insurance score for such consumer, if requested by the consumer. Such consumer's current credit report or insurance score shall be used if the result of the re-underwrite and re-rate reduces the consumer's rate. Such consumer's current credit report or insurance score shall not be used to increase the consumer's rate. The insurer shall not be found to be in violation of rate filings by adjusting an insured's rate in accordance with this subparagraph. Nothing in this subparagraph shall require an insurer to recalculate a consumer's insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

(B) Have the discretion to obtain current credit information upon any renewal before the 36 months, if consistent with such insurer's underwriting guidelines.

(3) No insurer shall be required to obtain current credit information for an insured, if:

(A) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report, if consistent with such insurer's underwriting guidelines;

(B) credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with such insurer's underwriting guidelines; or

(C) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(h) Use any of the following as a negative factor against a consumer in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

- (1) Any credit inquiry not initiated by the consumer or any inquiry requested by the consumer for such consumer's own credit information;
- (2) any inquiry relating to insurance coverage, if so identified on a consumer's credit report;
- (3) any collection account with a medical industry code, if so identified on the consumer's credit report; or
- (4) any additional lender inquiry beyond the first such inquiry related to the same loan purpose, if coded by the consumer reporting agency on the consumer's credit report as being from the given loan industry and made within 30 days of one another.

#### **G. K.S.A. 40 – 2,111 Definitions**

As used in K.S.A. 40-2,111 through 40-2,113, and amendments thereto: (a) "Adverse underwriting decision" means: Any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:

- (1) A declination of insurance coverage;
  - (2) a termination of insurance coverage;
  - (3) an offer to insure at higher than standard rates, with respect to life, health or disability insurance coverage; or
  - (4) the charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished, with respect to property or casualty insurance coverage.
- (b) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance company or agent of requested insurance coverage.
- (c) "Health care institution" means any medical care facility, adult care home, drug abuse and alcoholic treatment facility, home-health agency certified for federal reimbursement, mental health center or mental health clinic licensed by the secretary of social and rehabilitation services, kidney disease treatment center, county, city-county or multicounty health departments and health-maintenance organization.
- (d) "Health care provider" means any person licensed to practice any branch of the healing arts, licensed dentist, licensed professional nurse, licensed practical nurse, advanced registered nurse practitioner, licensed optometrist, licensed physical therapist, licensed social worker, licensed physician assistant, licensed podiatrist or licensed psychologist.
- (e) "Institutional source" means any natural person, corporation, association, partnership or governmental or other legal entity that provides information about an individual to an agent or insurance company, other than:

- (1) An agent;
- (2) the individual who is the subject of the information; or
- (3) a natural person acting in a personal capacity rather than a business or professional capacity.

(f) "Insurance transaction" means any transaction involving insurance, but not including group insurance coverage, primarily for personal, family or household needs rather than business or professional needs.

(g) "Medical-record information" means personal information which:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment; and

(2) is obtained from a health care provider or health care institution, from the individual, or from the individual's spouse, parent or legal guardian.

(h) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation, nonrenewal or lapse of an insurance policy, in whole or in part, for any reason other than:

(1) The failure to pay a premium as required by the policy; or

(2) at the request or direction of the insured.

#### **H. K.S.A. 40-2,112 Adverse underwriting decisions; furnishing reasons**

(a) In the event of an adverse underwriting decision the insurance company, health maintenance organization or agent responsible for the decision shall either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such persons that upon written request they may receive the specific reason or reasons in writing.

(b) Upon receipt of a written request within 60 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance company, health maintenance organization or agent shall furnish to such person within 21 business days of the receipt of such written request:

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subsection (a); or

(2) if specific items of medical-record information are supplied by a health care institution or health care provider it shall be disclosed either directly to the individual about whom the information relates or to a health care provider designated by the individual and licensed to

provide health care with respect to the condition to which the information relates, whichever the insurance company, health maintenance organization or agent prefers; and

(3) the names and addresses of the institutional sources that supplied the specific items of information given pursuant to subsection (b)(2) if the identity of any health care provider or health care institution is disclosed either directly to the individual or to the designated health care provider, whichever the insurance company, health maintenance organization or agent prefers.

(c) The obligations imposed by this section upon an insurance company, health maintenance organization or agent may be satisfied by another insurance company, health maintenance organization or agent authorized to act on its behalf.

(d) The company, health maintenance organization or the agent, whichever is in possession of the money, shall refund to the applicant or individual proposed for coverage, the difference between the payment and the earned premium, if any, in the event of a declination of insurance coverage, termination of insurance coverage, or any other adverse underwriting decision.

(1) If coverage is in effect, such refund shall accompany the notice of the adverse underwriting decision, except such refund obligation shall not apply if:

(A) Material underwriting information requested by the application for coverage is clearly misstated or omitted and the company or health maintenance organization attempts to provide coverage based on the proper underwriting information; or

(B) the company or health maintenance organization includes with the notice of the adverse underwriting decision an offer of coverage to an applicant for life insurance under a different policy or at an increased premium. If such a counter-offer is made by the insurer, the insured or the insured's legal representative shall have 10 business days after receipt thereof in which to notify the company or health maintenance organization of acceptance of the counter-offer, during which time coverage will be deemed to be in effect under the terms of the policy for which application has been made, but such coverage shall not extend beyond 30 calendar days following the date of issuance of the counter-offer by the insurance company or health maintenance organization. The insurance company or health maintenance organization shall promptly refund the premium upon notice of the insured's refusal to accept the counter-offer or upon expiration of such 30 calendar day period, whichever occurs first.

(2) If coverage is not in effect and payment therefore is in the possession of the company, health maintenance organization or the agent, the underwriting decision shall be made within 20 business days from receipt of the application by the agent unless the underwriting decision is dependent upon substantive information available only from an independent source. In such cases, the underwriting decision shall be made within 10 business days from receipt of the external information by the party that makes the decision. The refund shall accompany the notice of an adverse underwriting decision.

**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.