BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF KANSAS

In the Matter of	)	
AF&L INSURANCE COMPANY	)	**Docket No. 79428**
NAIC# 35963	)	

SUMMARY ORDER
(Pursuant to K.S.A. 77-501 *et seq.* and K.S.A. 40-2,125)

Pursuant to the authority conferred upon the Commissioner of Insurance in KS.A. 40-2,125, Vicki Schmidt, the duly elected, qualified and serving Commissioner of Insurance ("Commissioner"), hereby finds, and Orders as follows against AF&L Insurance Company ("AFL" or "Company"). This Summary Order shall become effective as a Final Order, without further notice, upon the expiration of the fifteen (15) day period with no request for hearing.

Findings of Fact

The Commissioner finds the following facts:

1. AF&L is domiciled in Pennsylvania and has been authorized in Kansas since 1997.
2. Company issued a long term care insurance policy to a Kansas resident ("Consumer"). This policy form was filed and approved for sale by the Kansas Insurance Department ("Department").
3. Consumer began covered nursing home confinement in 2016. Company paid the full cost of care, including for "care" and "room and board" from November 2016 through December 2017.
4. Beginning in 2018, Company ceased paying benefits. In March 2018 Company began seeking to recoup prior paid benefits amounting to $37,800.00 for nursing home care.
5. In seeking to recoup benefits, Company purported to only owe benefits for "room and board" during covered confinement and not for "care" itself.

6. Consumer passed away on March 20, 2018, leaving three months of unpaid benefits. Company was still actively seeking to recoup prior-paid benefits.
7. On May 17, 2018, Consumer's family submitted a complaint to Department. Department requested full copies of claim file and policy documents from Company.
8. Company responded on June 27, 2018 with partial documentation. Company failed to provide full claim file documentation, including coverage provisions specific to Consumer's current daily benefit limit.
9. In its response, Company did agree to cease trying to collect prior-paid benefits but renewed its objection to paying those remaining due. Company renewed its opinion that it only owes "room and board."
10. Upon review, Department concluded that the approved policy covered both "room and board" as well as "care" during covered confinement.
11. Department sent a letter to Company on August 30, 2018, requesting that Company pay full daily benefits for all covered periods still owed after Company ceased payments. Company failed to respond to request.
12. Department sent another letter to Company on November 28, 2018 renewing its request and citing to the unanswered August 30, 2018 letter. The November letter was returned to Department as undeliverable. On December 7, 2018, Department resent letter to an alternate address listed on the return label.
13. Company responded on December 28, 2018 indicating it would not alter its decision and stating that coverage for "care" as well as "room and board" would be "financial unsustainable" but not addressing the required coverage provisions in the policy.

14. Department again responded to Company on February 25, 2019 with specific policy language citations requiring coverage for both "care" and "room and board."

15. On May 8, 2019, Company responded that it now believed it should have paid only for "care" and not "room and board" based on the policy's tax qualified status and not based upon approved policy language. It renewed its objection to paying additional benefits.

16. Department concludes that benefits for both "room and board" as well as "care" are covered in Consumer's policy and that tax qualified status was not relevant to this analysis. Relevant policy language includes the following:

LONG TERM CARE means Nursing Home Care, Assisted Living Facility Care, Home Health Care or Community Based Services. Long Term Care does not mean simple rest care, hotel or retirement home expense, Durable Medical Equipment expense, or any other expense which is related to Your Home.

NURSING HOME CARE means care regularly and customarily provided to Nursing Home patients on a twenty-four (24) hour-a-day basis. It must be: 1) care that can either improve or maintain Your condition; and 2) care that is supervised by licensed and qualified professional personnel.

QUALIFIED LONG TERM CARE means necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care Services that are required by a Chronically Ill Individual.

LONG TERM CARE BENEFITS FOR NURSING HOME AND ASSISTED LIVING FACILITY CARE

ALL BENEFITS listed under this Section, whether obtained individually or in combination with each other, will not exceed in total, the Daily Maximum Benefit amount for Nursing Home Care shown in the Policy Schedule.

NURSING HOME CARE: Subject to the Elimination Period, We will pay a benefit for each day You are Confined in a Nursing Home. We will pay the reasonable charges incurred for room and board, not to exceed the Daily Maximum Benefit amount for Nursing Home Care shown in the Policy Schedule.

ASSISTED LIVING FACILITY CARE: Subject to the Elimination Period, We will pay a benefit for each day You are confined in an Assisted Living Facility. We will pay the reasonable charges incurred for room and board, not to exceed the Daily Maximum Benefit amount for Assisted Living Facility Care shown in the Policy Schedule.

17. On August 2, 2019, the Legal Division at the Department wrote to Company detailing violations and requesting proper claim adjudication on or before August 16, 2019. Company has not acknowledged receipt or responded to that request as of the date of this Order.

Applicable Law

1. K.S.A. 40-2,125 provides, in part:

a) If the commissioner determines after notice and opportunity for a hearing that any person has engaged or is engaging in any act or practice constituting a violation of any provision of Kansas insurance statutes or any rule and regulation or order thereunder, the commissioner may in the exercise of discretion, order any one or more of the following:

(1) Payment of a monetary penalty of not more than $1,000 for each and every act or violation, unless the person knew or reasonably should have known such person was in violation of the Kansas insurance statutes or any rule and regulation or order thereunder, in which case the penalty shall be not more than $2,000 for each and every act or violation;

(2) suspension or revocation of the person's license or certificate if such person knew or reasonably should have known that such person was in violation of the Kansas insurance statutes or any rule and regulation or order thereunder; or

(3) that such person cease and desist from the unlawful act or practice and take such affirmative action as in the judgment of the commissioner will carry out the purposes of the violated or potentially violated provision.

2. K.S.A. 40-2228h, provides:

(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of long-term care 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 long-term care 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 30 days after receipt of all the requested additional information, an insurer issuing a policy of long-term care 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 long-term care 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) Any violation of this act by an insurer issuing a policy of long-term care 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.

(g) The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of the Kansas long-term care insurance prompt payment act.

3. K.S.A. 40-2404, provides, in part:

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

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

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

Conclusions of Law and Orders

Based on the Findings of Fact enumerated in Paragraphs #1 through #17 and the applicable law cited above, **THE COMMISSIONER OF INSURANCE MAKES THE FOLLOWING ORDERS:**

1. The Commissioner of Insurance has jurisdiction over this matter and shall retain jurisdiction to issue any further orders deemed necessary.
2. AF&L has refused to pay claims after becoming reasonably payable and without adequate justification, resulting in a failure to adjudicate claims in good faith.
3. AF&L did not respond to proper inquiries of the Department.
4. AF&L shall immediately remit full benefits still owed for the months of January, February, and March, 2018, plus statutory interest at a rate of 1% per month from January 1, 2018 until full payment is remitted to the estate of Consumer.
5. AF&L shall also immediately remit a penalty in the amount of $1,000.
6. AF&L shall also immediately **CEASE AND DESIST** from any actions that are unlawful under the insurance laws of the state of Kansas, including, but not limited to, the actions described herein.

IT IS SO ORDERED THIS 3rd DAY OF JANUARY, 2020, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

Vicki Schmidt
Commissioner of Insurance

BY:

Justin L. McFarland
General Counsel

NOTICE AND OPPORTUNITY FOR HEARING

AF&L Insurance Company, within fifteen (15) days of service of this Summary Order, may file with the Kansas Insurance Department a written request for hearing on this Summary Order, as provided by K.S.A. 77-542. In the event a hearing is requested, such request should be directed to:

Justin L. McFarland, General Counsel
Kansas Insurance Department
1300 SW Arrowhead Rd.
Topeka, Kansas 66604

Any costs incurred as a result of conducting any administrative hearing shall be assessed against the agent/agency who is the subject of the hearing as provided by K.S.A. 40-4909(f). Costs shall include witness fees, mileage allowances, any costs associated with reproduction of documents which become part of the hearing record, and the expense of making a record of the hearing.

If a hearing is not requested, this Summary Order shall become effective as a Final Order, without further notice, upon the expiration of the fifteen (15) day period for requesting a hearing. The Final Order will constitute final agency action in the matter.

In the event the Respondent files a petition for judicial review, the agency officer designated pursuant to K.S.A. 77-613(e) to receive service of a petition for judicial review on behalf of the Kansas Insurance Department is:

Justin L. McFarland, General Counsel
Kansas Insurance Department
1300 SW Arrowhead Rd.
Topeka, Kansas 66604

CERTIFICATE OF SERVICE

The undersigned hereby certifies that she served the above and foregoing Summary Order on this 3rd day of January 2020, by causing the same to be deposited in the United States Mail, first class postage prepaid, addressed to the following:

Samuel Heron
Director of Operations
AF&L Insurance Company
580 Virginia Drive, Suite 330
Fort Washington, PA 19034

Toni Garrard
Senior Administrative Assistant