

REPORT OF MARKET CONDUCT EXAMINATION

**KANSAS HEALTH INSURANCE ASSOCIATION
TOPEKA, KS**

AS OF

DECEMBER 30, 2006

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:

Kansas Health Insurance Association
Topeka, KS

Hereafter referred to as KHIA or the “Plan”, and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of the Kansas Health Insurance Plan (KHIA) operations and management, complaint handling, grievance procedures, TPA contracts, utilization review and claims processing from January 1, 2005 – December 31, 2006, to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas.

The examination was conducted utilizing the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook). The exam team selected 343 claim files and 35 complaint files to verify the Plan's procedures and practices. An acceptable tolerance standard as stated in the Handbook of 7% was used for claims and 10% was used for complaints. The report is written by test rather than by exception which means all standard tests are described and all results are reported.

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

- KHIA Operations and Management
- TPA Contracts
- Complaint Handling
- Claims
- Grievance Procedures
- Utilization Review

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a targeted market conduct examination of the Kansas Health Insurance Association (KHIA) claims and complaints from January 1, 2005 – December 31, 2006. The report is written by test and violations are listed within each category.

Although Kansas statutes do not require such an examination, KHIA requested this review as a means to determine its performance in serving its members. KID agrees with KHIA that a periodic review of the claims handled by this high-risk pool is in the best interests of Kansas citizens and policyholders. The examination was conducted utilizing the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook) and K.S.A. 40-222. This examination differed from financial audits conducted in past years by the Kansas Insurance Department Financial Surveillance Division. While those audits reviewed the financial stability and accounting standards employed by the Association, the Market Conduct Exam reviewed the Association's claims processing, complaint handling, appeals and grievance processing and contracting for administrative duties.

KHIA employs a third party administrator (TPA) to perform typical services including: determine eligibility of applicants; process claims and appeals; maintain a billing procedure for premiums; maintain records covering claims and payments disbursed; provide customer service on claims and appeals; and report performance standards to the Board. An actuary is employed to assist with the development of premiums and plan benefits.

The Association 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 TPA staff and the KHIA Board and staff. However, the exam team made recommendations on the following issue:

MARKET CONDUCT RECOMMENDATIONS

TPA Performance Standards

The examiners recommend that all the criteria be spelled out in detail in this document or in the “KHIA Performance Standards Rule Sets” and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

Complaint Handling

Develop a more formalized procedure to track complaint files and to keep the claim information with the complaint file. While the examiners were on-site, a change in personnel created new supervisory and management duties within the complaint and claims areas. It appears these new supervisors recognize the need and such revisions are underway.

The specific areas the examiners recommend are:

- a. Provide a system to record all KID and direct complaints in one central register as soon as they are received;
- b. Maintain a central location for complaint files or develop a system that keeps the claim information with the complaint file;

Claim Handling

1. Conduct a current analysis to assure that claims processing timelines have improved during 2007.
2. Conduct a file review to assure that recent changes in claims processing have occurred, especially:
 - a. letters acknowledging acceptance or denial of a claim is sent within 15 working days after receipt of properly executed proof of loss; (if not paid)
 - b. claim investigations are completed within 30 days; and
 - c. letters notifying claimants with reasons why more time is needed to conduct an investigation are sent within 15 working days after receiving properly executed proof of loss and every 45 days thereafter until the investigation is complete.

DESK EXAMINATION/ON-SITE EXAMINATION

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OPERATIONS/MANAGEMENT

Tests for Operations Management

GENERAL EXAMINATION STANDARDS

Standard 1. Claim records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Claim records were available during the examination and are kept electronically both onsite and offsite. All records requested were available and provided.

The Association passed Standard 1.

Standard 2. TPA is licensed as a TPA in Kansas for the time under review.

The third party administrator has met the requirements to conduct TPA duties within the state of Kansas.

The Association passed Standard 2.

Standard 3. The TPA cooperates on a timely basis with examiners performing the examinations.

Generally, responses were timely but access to electronic files was delayed for a few days due to a claim system failure. New hardware and software installations delayed the exam timelines. Disaster recovery procedures were implemented and consumer representatives informed callers of potential delays and answered questions per normal procedures.

The Association passed Standard 3.

CONTRACTS AND WRITTEN AGREEMENTS

Tests for Contracts and Written Agreements

TPA EXAMINATION STANDARDS

Standard 1. Verify written agreement(s) are executed between the TPA and KHIA pertinent to the claim handling of KHIA.

A written Administrative Agreement with Exhibits and a Schedule of Fees was entered into on January 1, 2006 and will end as of midnight December 31, 2008.

The Association passed Standard 1.

Standard 2. The written agreement includes a statement of duties the TPA is expected to perform on behalf of the insurer or regulated, risk-bearing entity subject to the jurisdiction of the Department of Insurance and the lines, classes or types of insurance for which the TPA is authorized to administer.

The general administrative duties of the TPA regarding claims administration and payment of claims are stated in the Agreement. One exhibit enumerates the details required to handle claims, applications, premiums, internal audits, quarterly and annual reports, document storage and plan booklets and other consumer materials. The TPA is expected to implement the Action Plan for the Pool as detailed in another exhibit.

These duties also involve meeting with the Executive Director of the Pool, maintaining a payment fund, reviewing requests and appeals for denied claims and communicating with the Kansas Insurance Department on inquiries and complaints.

The measurement of performance standards is reported quarterly to the Board by the TPA and further documentation can be requested. Although the performance standards are clearly stated, it appears that the measurement criteria are left to the discretion of the TPA.

The examiners recommend that all the criteria be spelled out in detail in this document or in the "KHIA Performance Standards Rule Sets" and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

Other NAIC standards were contained within the TPA agreement, schedules and exhibits. Fees paid to the TPA are based upon services provided, not savings from claims settlements.

The Association passed Standard 2.

Standard 3. The TPA provides required written notices (approved by the client, applicable insurer or other related entity) to covered individuals in accordance with applicable statutes, rules and regulations pertinent to the claim handling process.

All written notices reviewed by the examiners for billing premiums, benefit updates, application requirements and pertinent periodic communications to participants were sent within required timelines and with the approval of the Association.

The Association passed Standard 3.

Standard 4. The TPA delivers materials and written communications pertinent to the claim handling process in a timely manner.

Individual requests for benefit schedules, cards, network information, etc. appeared to be met on a timely basis as well as distribution of notices requested by the Association.

The Association passed Standard 4.

Standard 5. Claim transactions are processed accurately and completely by the TPA.

Documentation to support claim payments, claim denials, medical record requests, participant requests and provider records were maintained in a consistent manner and were processed within privacy and confidentiality standards. Claim handling was based on the documentation received and occasionally required repeated requests for this information.

The Association passed Standard 5.

Recommendation:

The examiners recommend that all the criteria be spelled out in detail in this document or in the “KHIA Performance Standards Rule Sets” and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

COMPLAINT HANDLING

Complaint Handling Procedures

Complaints are divided into the categories of Claims Department Complaints, Premium Billing & Enrollment Department Complaints and Complaint, Appeals and Grievances for Medical Necessity or Experimental or Investigational Denials. Complaint procedures are carried out by claims processing personnel and management or the premium billing and enrollment personnel and supervisor.

Claims Complaints, Premium Billing & Enrollment Complaints

An examiner determines if claim should be reprocessed or if it was processed correctly according to the Plan Document. All complaint determinations and communications are documented into the Chronolog system. There is an expectation that complaints will be resolved within ten (10) days of receipt of the request and if more time is needed, the complainant shall receive an explanation for the delay.

If a processing error occurred in the original claim, it will be reprocessed and a corrected EOB will serve as the notification to the complainant that the decision was in his/her favor. For Billing Complaints, notification to the complainant will be either verbally or in writing. If the original processing did not contain an error and the original resolution is upheld, a letter is sent to the complainant explaining the reasons(s) for denial and instructions on appeal rights.

The complainant may file an appeal for an upheld denial within sixty (60) days after receiving denial notice.

Tests for Complaint Handling

GENERAL EXAMINATION STANDARDS

Standard 1. All complaints are recorded in the required format on the Association complaint register. K.S.A. 40-2404 (10).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
KID	35	2	96%

The Association passed Standard 1.

Standard 2. The Association has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, Sections 5(a) & 6.

The examiners received the complaint handling procedures manual used by the customer service representatives. This document details the procedures to follow in handling various types of complaints and those procedures were followed by the TPA.

Comment: While the complaint log revealed details about the various complaints, it was not always possible to locate the actual files. The complaint files were kept by the last person who worked the file. Therefore, complaint files were not maintained in one central location.

The Association passed Standard 2.

Standard 3. The Association takes 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, 4 and 6; K.S.A. 40-2442(a)(b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
KID	35	4	89%

- Three files did not have sufficient documentation to follow the sequence of events to resolve the complaints per K.A.R. 40-1-34,4.
- One complaint occurred because the original claim was not paid within 30 days per K.S.A. 40-2442(a)

The Association failed Standard 3.

Standard 4. The time frame within which the Association responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6 & 8(a)&(c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
KID	35	1	97%

- One file did not have a response back to KID within 15 working days per K.A.R. 40-34, 6(b).

The Association passed Standard 4.

Recommendation:

The examination team recommends that procedures be written to ensure that all KID and direct complaint files are recorded in one central register as soon as they are received and a system be developed to keep the claim information with the complaint file in one designated area.

UTILIZATION REVIEW

Standard 1. The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

The Association follows URAC and NCQA standards in all utilization procedures and the Quality Assessment Committee reviews these procedures annually. Detailed procedures are in place for prospective, concurrent and retrospective reviews as well as adverse decision and case management programs. These reviews include pre-authorization for hospital admissions, medical necessity for surgical procedures, case management of mental health, chemical dependency, substance abuse and psychiatric care treatment and education for the maintenance of a healthy lifestyle and the prevention of illnesses and diseases.

Duties and timelines of the Medical Director (2nd Level Reviewer) and clinical peers (3rd Level Reviewer) are detailed when certification cannot be determined by the Medical Review Specialist or the Utilization Nurse Reviewer.

Letters sent to insureds in each of the programs listed above were provided to the examiners. Instructions to proceed with a program, denials for not medically necessary procedures, requests for medical records and appeal processes with deadlines are provided as appropriate.

The Association passed Standard 1.

Standard 3. The health carrier provides information about its utilization review program to members in a timely manner and in compliance with applicable statutes, rules and regulations.

The policy issued to insureds contains the process, definitions and timelines for all utilization review and appeal procedures. Also, specific procedures are outlined in an individual letter sent to each insured whenever they inquire about an issue or file a complaint about a claim.

The Association passed Standard 3.

GRIEVANCE PROCEDURES

Standard 1. The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

The Association complies with the definitions of complaint and grievance.

The Association passed Standard 1.

Standard 2. The entity develops written grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Part P. of the KHIA policy spells out the benefits, procedures and timelines to file a complaint, grievance and external review procedures. Additionally, letters are provided to insureds who request the procedures to file a complaint or grievance or who receive claim denial letters and include instructions on contacting the Kansas Insurance Department.

An addendum to the KHIA Plan of Action included the mission and function of the Grievance Committee became effective on January 2, 2007. The Chairman and two Directors appointed by the KHIA Board comprise this Grievance Committee. While this Committee has always existed and continues to review grievances, the Plan of Action now is in alignment with the procedures set for the in the Policy.

The Association passed Standard 2.

Standard 4. The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the department of insurance, if applicable.

The policy issued to insureds provides a step-by-step grievance procedure. Additionally, as complaints are received, individual letters are sent outlining the steps to follow for that specific issue.

The Association passed Standard 4.

Standard 5. The company reports its grievance procedures to the insurance commissioner on an annual basis.

The Association developed its grievance procedure with input from the Commissioner and is not required to report those procedures on an annual basis.

The Association passed Standard 5.

CLAIMS PROCESSING

Claims Testing Procedures

During the first three months of the 2006 examination period for claims, the TPA converted from one claims processing software system to another and experienced some delays as reflected in the No Pay and Paid claims listed below.

In an effort to obtain a more accurate picture of the normal claims payment processing time, the examiners sampled an additional 50 claims paid and denied outside the 30 days required by the Kansas health care Prompt Payment Act after July 1, 2006. The number of claims paid and denied beyond 30 days remained high and the examiners decided to sample paid and denied claims from January 1-June 30, 2005, to test the normal payment processing time prior to the conversion to the new claims processing system.

The error rates on claims paid and denied in the first half of 2005 were well within the tolerance levels recommended by the NAIC Market Regulation Handbook and adopted by the Kansas Insurance Department.

Tests for Claims

GENERAL EXAMINATION STANDARDS

Standard 1. The initial contact by the Association 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	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 1.

Standard 2. Investigations are conducted in a timely manner. K.A.R. 40-1-34 Sections 7 & 8(a)(c), K.S.A. 2442 (a)(b)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	18	82%
Paid	100	14	86%
Over 30 after July 1	50	35	34%
2005 Claims	58	1	99%

- 18 No Pay files were not processed within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 14 Paid files were not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 35 After July 1 files were not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 1 2005 Claims file was not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.

The Association failed Standard 2 in three categories.

Standard 3. Claims are resolved in a timely manner. K.A.R. 401-34 Section 8 (a) & (c), K.S.A. 40-2442(a)(b)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 3.

Standard 4. The regulated entity responds to claim correspondence in a timely manner. K.A.R. 40-1-34 Section 6 (a)(b)(c)(d), K.S.A. 40-2442(a)(b)

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 4.

Standard 5. Claim files are adequately documented. K.A.R.40-1-34 Section 4, K.A.R. 40-1-34 Section 8(f).

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	0	100%
Paid	100	8	92%
Over 30 after July 1	50	0	100%
2005 Claims	58	2	97%

- Eight Paid files did not contain sufficient notes and work papers to adequately reconstruct the events of the claim file as required by K.A.R. 40-1-34, Section 4.
- Two 2005 Claims files did not contain sufficient notes and work papers to adequately reconstruct the events of the claim file as required by K.A.R. 40-1-34, Section 4.

The Association failed Standard 5 in one category.

Standard 6. Claims are properly handled in accordance with policy provisions and applicable statutes, (including HIPAA), rules and regulations. K.A.R. 40-1-34 Sections 5(a-f), 6(a-d), 7, 8(c,f,g,i), K.S.A. 40-2442(a)(b).

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 6.

Standard 7. Regulated entity claim forms are appropriate for the type of product.

The claim forms provided by the Association are appropriate for health plans.

The Association passed Standard 7.

Standard 8. Claims are reserved in accordance with the Association’s established procedures.

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

The Association passed Standard 8.

Standard 9. Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. KAR. 40-1-34 Section 8(a)

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

The Association passed Standard 9.

Standard 11. Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under policy.

<u>Type</u>	<u>Sample</u>	<u>Violations</u>	<u>%Pass</u>
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 11.

HEALTH EXAM STANDARDS

Standard 1. Claim files are handled in accordance with policy provisions, HIPAA and state law.

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

The Association passed Standard 1.

Standard 2. The Association complies with the requirement of the federal NewBorns' and Mothers' Health Protection Act of 1996. K.S.A. 40-2,102 (a)(b)

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

The Association passed Standard 2.

Standard 3. The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA). K.S.A. 40-2,105 (a)

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

The Association passed Standard 3.

Standard 4. The Association complies with the requirements of applicable statutes, rules and regulations for group coverage replacements.

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

The Association passed Standard 4.

Comment: During the review of claim files, the examiners discovered that notifications were not sent to claimants under K.A.R. 40-1-34, Sections 6(a)(c), 7 and 8(a)(c). After discussing this issue with the TPA staff, changes were made in the claims processing manual and their staff implemented immediate changes to comply with this regulation while the examiners were still onsite.

Recommendation:

- 1. Conduct a current analysis to assure that claims processing timelines have improved during 2007.**
- 2. Conduct a file review to assure that recent changes in claims processing have occurred, especially:**
 - a. letters acknowledging acceptance or denial of a claim is sent within 15 working days after receipt of properly executed proof of loss; (if not paid)**
 - b. claim investigations are completed within 30 days; and**
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Develop a more formalized procedure to track complaint files and to keep the claim information with the complaint file. While the examiners were on-site, a change in personnel created new supervisory and management duties within the complaint and claims areas. It appears these new supervisors recognize the need and such revisions are underway.

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Conclusion

The MC Exam Team acknowledges the cooperation and courtesy extended to the examination team by KHIA Director Ed Fonner and the TPA staff, especially Debbie McCormick, Sharon Manning and Chad Somers.

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

Market Conduct Division

Mary Lou Maritt
Examiner-In-Charge

Tate Flott
Market Conduct Examiner

Respectfully submitted,

A rectangular box containing a handwritten signature in cursive script that reads "Mary Lou Maritt".

Mary Lou Maritt
Examiner-In-Charge