Report on

Market Conduct Examination

of

Ambetter of North Carolina, Inc.

Charlotte, North Carolina

by Representatives of the

North Carolina Department of Insurance

as of

February 28, 2025

TABLE OF CONTENTS

SALUTATION 1

SCOPE OF EXAMINATION 1

EXECUTIVE SUMMARY 2

GENERAL ADMINISTRATION 3

Risk Management 3

Management Information System 4

Premium Collected and Total Member Months 4

DELIVERY SYSTEM AND PROVIDER RELATIONS 4

UTILIZATION MANAGEMENT 5

Utilization Review Requests 5

Standard and Expedited Noncertification Appeals 5

PROVIDER AND FACILITY CREDENTIALING 7

Provider Credentialing 7

Facility Credentialing 7

CLAIMS PRACTICES 8

Paid Claims 8

Denied Claims 9

POLICYHOLDER TREATMENT 9

Policyholder Grievances 10

MENTAL HEALTH PARITY REQUIREMENTS 11

DELEGATED OVERSIGHT 11

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES 11

CONCLUSION 12

Raleigh, North Carolina
February 28, 2025

Honorable Michael Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
3200 Beechleaf Court
Raleigh, North Carolina 27604

Honorable Commissioner:

In accordance with the provisions of North Carolina General Statutes 58-2-131 through 58-2-134, a general examination has been made of the market conduct activities of the following entity:

Ambetter of North Carolina, Inc.
(NAIC # 16395)
Charlotte, North Carolina
(herein generally referred to as "the Company")
NAIC Exam Tracking System Exam Number: NC-NC131-27

The examination was conducted at the North Carolina Department of Insurance (Department) office located at 3200 Beechleaf Court, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

This general examination commenced on September 7, 2022, and covered the period of January 1, 2019, through December 31, 2021. Analyses of certain operations of the Company were concluded during the wrap-up conference which was held on December 17, 2024. This action was taken as a routine requirement on domestic insurance companies. All comments made in this report reflect conditions observed during the period of examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination consisted of the Companies' practices

and procedures in General Administration, Delivery System and Provider Relations, Utilization Management, Provider and Facility Credentialing, Claims Practices, Policyholder Treatment, Mental Health Parity, and Delegated Oversight. The findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance at or above the following levels: 0 percent for timeliness of utilization review, member appeal and grievance acknowledgment and determination letters; 7 percent for claims and for noncertification letter content of utilization reviews, member appeals and grievances; and 10 percent for all other areas reviewed. When errors are detected in a sample, but the error rate is below the applicable threshold for citing a violation, the Department issues a reminder to the company.

EXECUTIVE SUMMARY

This general examination revealed concerns with Company procedures and practices in the following areas:

Utilization Management – Failure to provide timely determinations for utilization review requests; failure to provide compliant written acknowledgement and decision notification letters to covered persons for utilization reviews, member appeals, and expedited appeals; failure to provide timely acknowledgement letters and decision letters to covered persons for both standard and expedited member appeals. Noncertification notices and decision letters did not contain details regarding assistance from Health Insurance Smart NC.

Facility Credentialing – Failure to maintain adequate credentialing documentation within files.

Claims Practices – Failure to process denied claims within the required timeframe; and failure to allow 180 days after the provision of care for the claimant to submit a claim.

Policyholder Grievances – Failure to provide timely written acknowledgement and decision letters to covered persons; and failure to re-adjudicate claims which remained in error based on an upheld grievance decision (claims were identified as a result of the Department's review of grievance files).

Specific violations are noted in the appropriate section of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site https://www.ncdoi.gov/insurance-industry/market-regulation.

This examination identified various statutory violations. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina does not constitute acceptance of such violations.

GENERAL ADMINISTRATION

The Company's general administration activities were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules. The Board of Directors, which may exercise all powers of the Company, manages the business and affairs of the Company. The governing body of the Company appears active and involved and receives reports from the Board's standing and ad hoc committees, as evidenced in the Board of Directors' meeting minutes. It is noted that the Company is operating in conformity with its Articles of Incorporation and its Bylaws. The Company notified the Department of all elections, resignations and terminations of officers and/or board members within 15 days of each change in accordance with the provisions of 11 NCAC 20 .0602. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

Risk Management

The Company has established a risk management program which includes all employees being responsible for ensuring the success of the program. The risk management program is supported by a comprehensive set of policies and procedures. Risk is assessed, evaluated and handled according to the level of risk assigned.

Management Information System

The management information system supports all business functions of the Company. All software modules are integrated and provide the latest technology and hardware available for benefits management and claims processing activities. The Company protects its data and information system with safety features, backup storage of data, as well as physical protections such as fire and flood controls. A business continuation/disaster recovery plan has been developed in accordance with the provisions of 11 NCAC 19 .0107(e).

Premium Collected and Total Member Months

Premium collected and total member months for each calendar year of the examination period is reflected in the following chart:

	Member Type		
	Commercial Insured	**Medicare**	**Medicaid**
2019 Member Months Premium collected as of Dec. 31	79,064 $69,769,462	N/A	N/A
2020 Member Months Premium collected as of Dec. 31	185,759 $104,832,017	N/A	N/A
2021 Member Months Premium collected as of Dec. 31	239,572 $181,272,304	N/A	N/A

DELIVERY SYSTEM AND PROVIDER RELATIONS

The Company's delivery system and provider relations activities were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules. The Company has established standards and monitors results for provider availability and accessibility in accordance with the provisions of Title 11, Chapter 20, Section .0300 of the North Carolina Administrative Code. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules. The Company has developed a Utilization Management Program in accordance with NCGS 58-50-61 and evaluates the program's performance on an annual basis.

Utilization Review Requests

The Company received a total of 17,257 utilization review requests during the examination period, consisting of prospective, concurrent, and retrospective reviews. A random sample of 100 utilization review files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and other applicable statues, as well as the Company's internal policies and procedures. The review revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(f) within 19 (19.0% error ratio) utilization review files, as the determination was not communicated to the covered person's provider within three business days.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(f) within six (6.0% error ratio) utilization review files, as notification of the determination was not adequately documented within the file.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(h) within two utilization review files (2.0% error ratio), as the noncertification notice did not contain details regarding the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the program.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(g) within four retrospective utilization review files (4.0% error ratio), as notification of the determination was not adequately documented within the file.

Standard and Expedited Noncertification Appeals

The Company received a total of 275 standard utilization review appeals during the examination period. A random sample of 50 appeal files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61

and other applicable statues, as well as the Company's internal policies and procedures. The review revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(k) within six (12.0% error ratio) utilization review appeal files, as the acknowledgement letter was not sent within three business days after receiving the appeal in three files. Three additional files contained no acknowledgement letter.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(k) within three (6.0% error ratio) utilization review appeal files, as within two files, notification of the determination was not completed within 30 days after receiving the appeal. One additional file contained no determination letter.

The average service time to process a standard member appeal was 18 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	11	22.0
8 - 14	14	28.0
15 - 21	6	12.0
22 - 30	17	34.0
31 - 60	2	4.0
Total	**50**	**100.0**

The Company received a total of 60 expedited utilization review appeals during the examination period. A random sample of 50 expedited appeal files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and other applicable statutes, as well as the Company's internal policies and procedures. The review revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(l) within two (4.0% error ratio) expedited appeal files, as the review was not completed within four days after receiving the expedited appeal.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(l) within one (2.0% error ratio) expedited appeal files, as one file contained no decision letter, and within another file, the decision letter did not contain details regarding the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the program.

The average service time to process an expedited member appeal was 2 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 4	48	96.0
5 - 10	1	2.0
11 - 20	0	0.0
21 - 30	1	2.0
Total	**50**	**100.0**

PROVIDER AND FACILITY CREDENTIALING

The Company's Credentialing activities for both providers and facilities were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules.

Provider Credentialing

The Company performed a total of 4,593 provider credentialing functions during the examination period. A random sample of 50 provider credentialing files was selected from this population. These files were reviewed to assess the Company's compliance with the provisions of 11 NCAC 20 .0401-.0411 and other applicable statutes, as well as the Company's internal policies and procedures. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

Facility Credentialing

The Company credentialed a total of 794 facilities during the examination period. A random sample of 50 facility credentialing files was selected from this population. These files were reviewed to assess the Company's compliance with the provisions of 11 NCAC 20 .0401-.0411 and other applicable statues, as well as the Company's internal policies and procedures. The review revealed that the Company was deemed to be in violation of the provisions of 11 NCAC 20 .0404(2)(a) within six (12.0% error ratio) facility credentialing

files, as attestation certification from the applicable accrediting agency was not contained in the file.

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine adherence to Company policies and procedures, and compliance with applicable North Carolina statutes and rules. The Company has established, and monitors performance standards for claims processing in accordance with North Carolina's Prompt Pay Law, NCGS 58-3-225.

Paid Claims

The Company processed a total of 1,506,646 paid claims lines during the examination period. A random sample of 100 paid claim files was selected from this population of claim lines. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 and other applicable statues, as well as the Company's internal policies and procedures. The review revealed that within four (4.0% error ratio) paid claim files, the Company did not process the claim and issue payment within 30 days of receipt of the claim. Applicable interest was not paid at the time of processing, so the Department instructed the Company to process and remit interest payments on these claims. Interest for these four claims totaled $62.44. The Company was reminded of the provisions of NCGS 58-3-225.

The average service time to process a paid claim was 17 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	1	1.0
8 - 14	59	59.0
15 - 21	24	24.0
22 - 30	12	12.0
31 - 60	3	3.0
Over 60	1	1.0
Total	**100**	**100.0**

Denied Claims

The Company processed a total of 609,825 denied claims lines during the examination period. A random sample of 100 denied claim files was selected from this population of claim lines. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 and other applicable statues, as well as the Company's internal policies and procedures. The review revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-3-225(b) within six (6.0% error ratio) denied claim files, as these claims were not processed within 30 days of receipt, and notification of pended claim status was not sent to the claimant.
- The Company was deemed to be in violation of the provisions of NCGS 58-3-225(f) within three (3.0% error ratio) denied claim files, as these claims were improperly denied for not being submitted within the required timeframe. The insurer must allow a minimum of 180 days after the provision of care for the claimant to submit a claim.

The average service time to process a denied claim was 19 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	9	9.0
8 - 14	40	40.0
15 - 21	18	18.0
22 - 30	27	27.0
31 - 60	4	4.0
Over 60	2	2.0
Total	**100**	**100.0**

POLICYHOLDER TREATMENT

The Company's policyholder treatment practices were reviewed to determine adherence to Company policies and procedures, and compliance with applicable North Carolina statutes and rules.

The following chart shows the main complaint types received by the Company via telephone during the examination period:

Complaint Type (Company defined)	Number of Telephone Calls		
	2019	2020	2021
Access to care	29	50	48
Attitude/service	4	6	8
Billing/financial	51	100	174
Quality of care	1	0	0
Not Categorized	81	124	204
Total	166	280	434

Policyholder Grievances

The Company received a total of 856 member grievances during the examination period. A random sample of 50 grievance files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62 and other applicable statues, as well as the Company's internal policies and procedures. The review revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)2 within two (4.0% error ratio) grievance files, as the determination was not communicated to the covered person within 30 days after receiving the grievance within two files.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)1 within five (10.0% error ratio) grievance files, as the acknowledgement letter was not sent within three business days after receiving the grievance.

- The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d) within two (4.0% error ratio) files, as the member was subjected to out-of-network financial responsibility (balance billing) for radiology services which were provided at an in-network (participating) facility. These two grievances were wrongly upheld, as in-network radiology services were not available without unreasonable delay, and the member had no control over this. One of these grievances involved mammogram screening services.

The average service time to process a member grievance was 19 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	6	12.0
8 - 14	10	20.0
15 - 21	12	24.0
22 - 30	20	40.0
31 - 60	2	4.0
Total	**50**	**100.0**

MENTAL HEALTH PARITY REQUIREMENTS

The Company's adherence to mental health parity requirements was reviewed to determine adherence to Company policies and procedures, and compliance with requirements of the *'Mental Health Parity and Addiction Equity Act'* (MHPAEA). These requirements include (but are not limited to) adherence to strategies used in applying Nonquantitative Treatment Limitations (NQTL's). The Company produced a comprehensive set of documentation related to MHPAEA requirements. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

DELEGATED OVERSIGHT

The Company's delegated oversight practices were reviewed to determine adherence to Company policies and procedures, and compliance with applicable North Carolina statutes and rules. The Company maintains a very limited number of delegated activities. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must comply with the statutory requirements regarding timely written acknowledgement and decision letters for utilization review requests and member appeals, as well as required content of the letters. The Company must maintain adequate credentialing documentation within credentialing files per statutory requirements. The Company must adhere to the statutory requirements of the Prompt Pay Law to process claims within the required

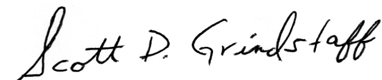
timeframe and allow 180 days for the claimant to submit a claim. The Company must comply with the statutory requirements regarding timely written acknowledgement and decision letters for policyholder grievances. Noncertification notices and decision letters must contain details regarding the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the program.

CONCLUSION

An examination has been conducted on the market conduct affairs for Ambetter of North Carolina, Inc. for the period January 1, 2019, through December 31, 2021.

This examination was conducted in accordance with the North Carolina Department of Insurance and the NAIC Market Regulation Handbook procedures, including analyses of Company operations in the areas of provider relations, utilization management, provider and facility credentialing, claims practices, policyholder treatment, mental health parity requirements and delegated oversight.

Respectfully submitted,



Scott D. Grindstaff, MHP, HIA, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report, and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Teresa Knowles, MCM, ACS
Deputy Commissioner
Market Regulation Division
State of North Carolina