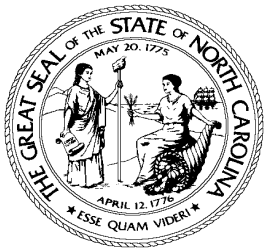

REPORT ON

MARKET CONDUCT EXAMINATION

of

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida

BY REPRESENTATIVES OF THE

NORTH CAROLINA DEPARTMENT OF INSURANCE

as of

June 30, 2011

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Raleigh, North Carolina
June 30, 2011

Honorable Wayne Goodwin
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Department of Insurance
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Commissioner of Insurance
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Honorable Commissioners:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a target examination has been made of the market conduct activities of the Preferred Provider Organization (PPO)

AMERICAN HERITAGE LIFE INSURANCE COMPANY
(NAIC #60534)
NAIC Exam Tracking System Exam Number: NC170-M90
Jacksonville, Florida

hereinafter generally referred to as the Company, at the North Carolina Department of Insurance (Department) office located at 11 South Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

FOREWORD

This examination reflects the North Carolina insurance activities of American Heritage Life Insurance Company (PPO). The examination is, in general, a report by exception. Therefore, much of the material reviewed will not be contained in this written report, as reference to any practices, procedures, or files that manifested no improprieties were omitted.

SCOPE OF EXAMINATION

This examination commenced on August 3, 2010 and covered the period of January 1, 2007 through December 31, 2008, with analyses of certain operations of the Company being conducted through June 30, 2011. All comments made in this report reflect conditions observed during the period of the examination.

The examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners (NAIC) Market Regulation Handbook procedures, including analyses of Company operations and accordingly included tests of provider relations and delivery system, claims practices, policyholder treatment and delegated oversight.

It is the Department's practice to cite companies in apparent violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for utilization review determinations, grievances (including quality of care), sales and advertising, producers who were not appointed and/or licensed, the use of contract forms that were neither filed with nor approved by the Department, the listing of a provider/facility in the provider/facility directory prior to being fully credentialed and use of unapproved underwriting methodology and factors; 7.0 percent for claims practices, provider and facility credentialing, and the content of quality management and utilization management review notification letters; and 10.0 percent for all other areas reviewed. When errors are detected in a sample, but the error rate is below the applicable threshold for citing an apparent violation, the Department issues a reminder to the Company.

EXECUTIVE SUMMARY

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

Claims Practices – failure to execute a policy and procedure which reflects the provisions of the Prompt Pay statute; failure to process paid and denied claims correctly and/or failure to provide a good faith reason narrative to the claimant regarding the adjudication.

Policyholder Treatment – failure to maintain telephone records which demonstrate the monitoring results of the call abandonment rate standard established for telephone customer service.

Delegated Oversight – failure to establish an internal audit mechanism for reviewing an intermediary organization's provider contracts and failure to conduct a review of said contracts on an on-going annual basis to ensure compliance with regulations.

Specific violations related to each area of concern 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 www.ncdoi.com by clicking "NCDOI DIVISIONS" then "Legislative Services".

In the course of an examination, various non-compliant practices may be identified, some of which may extend to other jurisdictions. In such cases, 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. When applicable, corrective action for other jurisdictions should be addressed.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify or criticize improper or non-compliant business practices in North Carolina or in other jurisdictions does not constitute acceptance of such practices. Examination report findings that do not reference specific insurance laws, regulations or bulletins are presented to improve the Company's practices and ensure consumer protection.

COMPANY OVERVIEW

History and Profile

American Heritage Life Insurance Company (the Company) was incorporated in Florida on September 11, 1956 and commenced business on December 27, 1956. The Company is wholly owned by American Heritage Life Investment Corporation, which in 1999 was acquired by and became wholly-owned by the Allstate Corporation. In North Carolina, the Company operates a mini-medical line of business, which is a large group only product. The Company is licensed in 49 states and the District of Columbia. The Department approved the Company's mini-medical plan in April 1999 and the PPO operations filing on April 25, 2006.

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. No irregularities, adverse trends or unfair trade practices were perceived in this section of the examination.

PROVIDER RELATIONS AND DELIVERY SYSTEM

The Company's provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. The Company delegates its provider network to its intermediary, Private Health Care Systems (PHCS). Please refer to the Delegated Oversight section of this report for discussion of the Company's monitoring activities.

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. During the examination period, the Company did not have a formally executed policy and procedure which reflects the provisions of NCGS 58-3-225 (Prompt Pay Law), nor a methodology for how interest

payments on health claims subject to prompt pay requirements are initiated, calculated and processed.

Paid Claims Sample Review

A random sample of 100 paid claim lines was reviewed from a total population of 65,722 paid claim lines processed by the Company during the examination period. The review revealed that 21 claims (21.0 percent error ratio) were processed either in error or beyond 30 days from receipt and the Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225. The issues revealed as a result of the review are detailed as follows:

- Ten claims (10.0 percent error ratio) were processed beyond 30 days from receipt without payment of the applicable interest. The Company was instructed to pay interest to the claimants for these claims, which totaled $4.54.

- Two claims payments (2.0 percent error ratio) contained a payment error resulting in an underpayment to the provider. The Company was instructed to re-adjudicate these claims, resulting in additional benefit payments totaling $98.60, plus interest payments to the claimants totaling $47.58.

- Six claims payments (6.0 percent error ratio) contained a payment error resulting in an overpayment to the provider as a result of failure to apply the negotiated savings given by the intermediary. These overpayments totaled $141.64.

- Three claims (3.0 percent error ratio) were processed in such a manner that it resulted in an explanation of benefits which did not contain an explanation of the member's copayment and/or deductible applicability.

As a result of the review of the random sample of 100 paid claims, the Department determined that the Company had not been paying applicable interest on claims payments exceeding 30 days as required by the provisions of NCGS 58-3-225(e). The Department requested the Company produce a report disclosing all claims which were due interest and remained unpaid during the period of January 1, 2005 through February 28, 2011. The report revealed a total of 13,145 claims which were due interest that remained unpaid. Therefore, the Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225(e). The Company was instructed to process and pay the applicable interest on all these claims. The Company paid this interest, which totaled $26,644.50 and the Company included an approved

letter with all interest payments explaining the details of each transaction. At the Department's request, the Company provided documentation to illustrate the proper adjudication of these interest payments.

The average service time to process a claim payment was 12 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	46	46.0
8 - 14	21	21.0
15 - 21	14	14.0
22 - 30	9	9.0
31 - 60	9	9.0
Over 60	1	1.0
Total	**100**	**100.0**

Denied Claims Sample Review

A random sample of 100 denied claim lines was reviewed from a total population of 28,509 denied claim lines processed by the Company during the examination period. The review revealed that 20 claims (20.0 percent error ratio) were processed either in error or beyond 30 days from receipt and the Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225. The issues revealed as a result of the review are detailed as follows:

- Nine claims (9.0 percent error ratio) were processed (denied) beyond 30 days from receipt.

- Four claims (4.0 percent error ratio) were improperly denied as a result of an adjudicator error. The Company was instructed to re-adjudicate these claims, resulting in benefit payments totaling $346.01, plus interest payments to the claimants totaling $200.08.

- Three claims (3.0 percent error ratio) were improperly denied as a result of an adjudicator error which the Company had identified during the examination period and re-adjudicated, resulting in benefit payments totaling $497.98. However, the Company did not pay the applicable interest at the time of the re-adjudication. The Department instructed the Company to pay the applicable interest to the claimants totaling $1.64.

- Three claims (3.0 percent error ratio) were processed in such a manner that resulted in an explanation of benefits which contained an inadequate/improper denial reason description.

- One claim (1.0 percent error ratio) was denied for lack of member creditable coverage, however upon receipt of the documentation, the claim was not re-adjudicated. The subsequent re-adjudication accurately resulted in zero payable benefit.

The Company provided the Department with documentation showing all additional benefit payments and interest payments resulting from the sample review findings.

As a result of the review of the random sample of 100 denied claims, the Department identified a claim for a mammogram screening which the Company denied in error based on the provisions of NCGS 58-65-92, which mandates coverage for mammograms. The Company was asked to conduct a self-audit of all claims received during the examination period for mammogram related services and issue a report to the Department detailing all claims which were denied in error. The Company identified 113 claims for mammogram screenings which were erroneously denied for "routine care not covered" during the examination period and therefore was deemed to be in apparent violation of the provisions of NCGS 58-65-92 and 58-3-225. These claims were reprocessed by the Company as follows:

- The audit revealed 24 claims erroneously denied for mammogram screenings which the Company had previously identified and reprocessed, resulting in a total of $1,412.45 in benefits paid. However, the Company did not pay the applicable interest for these claims and upon the Department's instruction the Company paid a total of $27.90 in interest payments to the applicable claimants.

- The audit revealed 89 claims erroneously denied for mammogram screenings which remained denied. The Company was instructed to reprocess these claims and pay the applicable interest, which resulted in a total of $4,157.27 in benefits paid and an additional total of $2,232.98 in interest payments to the applicable claimants.

At the Department's request, the Company provided documentation to illustrate the proper re-adjudication of these claims.

The average service time to process a claim denial was 10 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	55	55.0
8 - 14	17	17.0
15 - 21	13	13.0
22 - 30	6	6.0
31 - 60	9	9.0
Total	**100**	**100.0**

Claims Processing Standards and Monitoring

The Company's timeliness standard for processing claims is 15 days or less. The Company met this standard during most months of the examination period with the exception of October, November and December of 2008. The Company did not establish and monitor a standard for claims processing accuracy (quality) during the examination period.

Rescissions

The mini-medical product offered by the Company is a large group only product. Accordingly, as long as the insured enrolls for coverage when first offered, there are no health questions to answer and the Company neither rescinds nor reforms policies for members in this type of plan.

POLICYHOLDER TREATMENT

The Company's policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Telephone Access

The Company's customer service unit operates a toll-free telephone line which accepts member and provider telephone calls and provides policy, benefit and claims information. The hours of operation are Monday through Friday 7:00 AM through 8:00 PM. After hours, callers receive a message asking them to call back during normal business hours.

The Company's standard for average speed of answer in the customer service telephone area is 60 seconds or less. The Company met this standard during most months of

the examination period with the exception of all or part of July, August and September 2007, and July, October and November 2008. The Company was unable to provide telephone records which demonstrate the monitoring results of the call abandonment rate standard established for telephone customer service during the examination period because the telephone system only retains this information for the previous 13 months. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0102 and 19.0106.

Member Grievances

The Company had 8 member grievances/complaints during the examination period, all of which were handled in accordance with the provisions of NCGS 58-50-62.

The average service time to respond to a member complaint was 7 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	5	62.5
8 - 14	3	37.5
Total	**8**	**100.0**

DELEGATED OVERSIGHT

Intermediary Organizations

The Company contracts with Private Health Care Systems (PHCS) for the provision of its provider network and credentialing functions. The Company executed a contract with PHCS on July 1, 2005 and this form was approved by the Department prior to execution in accordance with the provisions of 11 NCAC 20.0204.

Intermediary Provider Contracts

The Company has not established an internal audit mechanism for reviewing its intermediary organization's (PHCS) provider contracts, nor has it conducted a formal review of the contracts on an on-going annual basis to ensure compliance with the provisions of 11 NCAC

20.0202. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0202 and 20.0204.

Provider Directories

The Company provided a copy of the PHCS 2007 and 2008 provider directories in accordance with the provisions of NCGS 58-3-245.

Network Availability and Accessibility Standards

The Company's monitoring of the provider availability and accessibility standards of its intermediary PHCS were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Performance targets for member accessibility to primary care and specialty care providers which address the distance a member must travel to obtain services and appointment availability have been developed by PHCS in accordance with the provisions of 11 NCAC 20.0302. As required by the provisions of 11 NCAC 20.0304, the Company has monitored PHCS's compliance with its provider accessibility standards annually. Geo-access software is used to measure access to healthcare providers and facilities in the PHCS Primary Network. The accessibility standards were not met consistently by PHCS throughout the examination period. The chart below illustrates the monitoring results for the standard of driving distance:

Type of Service	2007		2008	
	Standard (100%)	Actual (%)	Standard	Actual (%)
Primary care • High Urbanization	2 within 8 miles	99.8	2 within 8 miles	100
• Low Urbanization	2 within 15 miles	100	2 within 15 miles	100
Pediatrics • High Urbanization	2 within 8 miles	99.8	2 within 8 miles	100
• Low Urbanization	2 within 15 miles	98.5	2 within 15 miles	98.8
Ob/Gyn • High Urbanization	2 within 8 miles	99.8	2 within 8 miles	100
• Low Urbanization	2 within 15 miles	99.1	2 within 15 miles	99.7
Specialty care • High Urbanization	2 within 8 miles	99.8	2 within 8 miles	100
• Low Urbanization	2 within 15 miles	100	2 within 15 miles	100
Hospital • High Urbanization	1 within 8 miles	91.3	1 within 8 miles	100
• Low Urbanization	1 within 15 miles	95.4	1 within 15 miles	98.5

The standards established by PHCS for appointment wait times are as follows: Routine appointments for all provider types are handled within 30 days. Urgent appointments for all provider types are handled within 5 days. The Department notes that this is not within industry standard for urgent appointment accessibility. Emergent appointments are handled immediately, 24 hours per day, 7 days per week from the nearest emergency facility either within or outside the service area. An annual survey of a sample of practitioners in the PHCS Primary Network is conducted to determine actual appointment waiting times. These standards were met consistently by PHCS throughout the examination period.

SUMMARY

The target examination revealed the following:

1. Claims Practices

   a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as 21.0 percent of paid claims were processed in error or beyond 30 days from receipt and had to be reprocessed with applicable interest.

   b. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as 13,145 claims were identified dating back to January 1, 2005 which were due interest that remained unpaid.

   c. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as 20.0 percent of denied claims were processed in error or beyond 30 days from receipt and had to be reprocessed with applicable interest.

   d. The Company was deemed to be in apparent violation of the provisions of NCGS 58-65-92 and 58-3-225 as 113 claims for mammogram screenings were identified which had been denied in error and had to be reprocessed with applicable interest.

2. Policyholder Treatment

   a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0102 and 19.0106 for failure to maintain telephone records which demonstrated monitoring results of the call abandonment rate standard for telephone customer service.

3. Delegated Oversight

   a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0202 and 20.0204 as it had not established an internal audit mechanism for reviewing its intermediary organization's provider contracts and conducting a formal review of the contracts on an on-going annual basis to ensure compliance with the provisions of 11 NCAC 20.0202.

4. Additional Issues Noted During the Examination

   a. The Company did not have a formally executed policy and procedure which reflects the provisions of NCGS 58-3-225 (Prompt Pay Law), nor a methodology for how interest payments on claims are initiated, calculated and processed.

   b. The Company did not meet its timeliness standard for processing claims during October, November and December 2008, nor did it establish and monitor a standard for claims processing accuracy (quality) during the examination period.

   c. The Company did not meet its standard for average speed of answer in the customer service telephone area during July, August and September 2007, and July, October and November 2008.

d. The Company's intermediary (PHCS) failed to consistently meet the provider accessibility standards for driving distance throughout the examination period. In addition, the standard for urgent appointment wait times (handled within 5 days), is not within industry standard.

TABLE OF STATUTES AND RULES

Statute/Rule	Title
NCGS 58-2-131	Examinations to be made; authority, scope, scheduling, and conduct of examinations.
NCGS 58-2-132	Examination reports.
NCGS 58-2-133	Conflict of interest; cost of examinations; immunity from liability.
NCGS 58-2-134	Cost of certain examinations.
NCGS 58-3-225	Prompt claim payments under health benefit plans.
NCGS 58-3-245	Provider directories.
NCGS 58-50-62	Insurer grievance procedures.
NCGS 58-65-92	Coverage for mammograms and cervical cancer screening.
NCGS 58-67-100	Examinations.
11 NCAC 19.0102	Maintenance of Records.
11 NCAC 19.0106	Records Required for Examination.
11 NCAC 20.0202	Contract Provisions.
11 NCAC 20.0204	Carrier and Intermediary Contracts.
11 NCAC 20.0302	Provider Accessibility Standards.
11 NCAC 20.0304	Monitoring Activities.

CONCLUSION

A target examination has been conducted on the market conduct affairs of American Heritage Life Insurance Company (PPO) for the period of January 1, 2007 through December 31, 2008 with analysis of certain operations of the Company being conducted through June 30, 2011. The Company's response to this report, if any, is available upon request.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of general administration, provider relations and delivery system, claims practices, policyholder treatment and delegated oversight.

Respectfully submitted,

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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.

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