REPORT ON

MARKET CONDUCT EXAMINATION

of the

AMERICAN REPUBLIC INSURANCE COMPANY
(PPO)
(Life & Health)
Des Moines, Iowa

BY REPRESENTATIVES OF THE

NORTH CAROLINA DEPARTMENT OF INSURANCE

as of

February 18, 2013

TABLE OF CONTENTS

Raleigh, North Carolina
February 18, 2013

Honorable Wayne Goodwin
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Department of Insurance
State of North Carolina
Dobbs Building
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Raleigh, North Carolina 27603

Honorable Susan E. Voss
Commissioner of Insurance
Iowa Insurance Division
330 Maple Street
Des Moines, Iowa 50319-0065

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, a compliance and target examination has been made of the market conduct activities of the Life and Health and the Preferred Provider Organization (PPO) lines of business of

AMERICAN REPUBLIC INSURANCE COMPANY
(NAIC # 60836)
NAIC Exam Tracking System Exam Number: NC170-M101
Des Moines, Iowa

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

FOREWORD

This examination reflects the North Carolina insurance activities of American Republic Insurance Company. 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

The compliance examination of the Life and Health line of business commenced on March 7, 2011 and covered the period of January 1, 2008 through December 31, 2009 with analyses of certain operations of the Company being conducted through December 28, 2011. The target examination of the PPO line of business commenced on January 31, 2011 and covered the period of January 1, 2008 through December 31, 2011, with analyses of certain operations of the Company being conducted through February 7, 2013. This action was taken due to previous examination findings referenced in the Market Conduct Report of June 28, 2006 and the Department's market surveillance activities. All comments made in this report reflect conditions observed during the periods of the examinations.

The examinations were 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 in the areas of general administration, provider relations and delivery system, utilization management, provider credentialing, claims practices, policyholder treatment, delegated oversight, and underwriting practices.

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/noncompliance at or above the following levels: 0 percent for utilization review determinations, grievances (including quality of care),

consumer complaints, sales and advertising, producers who were not appointed and/or licensed, and the use of forms and rates/rules that were neither filed with nor approved by the Department; 7 percent for claims and the content of utilization management review notification letters; 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 an apparent violation, the Department issues a reminder to the company.

Previous Examination Findings

A target examination of the Life and Health line of business covering the period January 1, 2002 through December 31, 2004 was performed on the Company and a report dated June 28, 2006 was issued. The target examination report identified concerns in the areas of underwriting and claims practices. Specific previous violations relating to these areas are listed within the appropriate sections of the report. Deficiencies noted in the previous examination report that did not exceed the Department's error tolerance thresholds were cited as reminders and may not appear as specific violations in this examination report. Any reminders which have not been sufficiently addressed by the Company, may be cited again in this examination report and thus may not appear in the "previous findings" as related to that particular section, but were an overall concern in the previous examination.

EXECUTIVE SUMMARY

The market conduct examinations revealed concerns with Company procedures and practices in the following areas:

Claims Practices (PPO) – failure to process paid and denied claims correctly and/or failure to provide an accurate Explanation of Benefits (EOB) to the claimant regarding the adjudication.

Claims Practices (Life and Health) – Individual other health claims denied: failure to include an EOB to the insured and EOBs did not contain a reason for the denial.

Policyholder Treatment (PPO) – failure to send an acknowledgment letter within 3 business days of receipt of a grievance; failure to include all statutory requirements in the grievance determination letter; failure to complete a grievance review within 30 days; failure to send an acknowledgment letter; failure to provide the member with a

15-day notification prior to the grievance review meeting date; and failure to convene a review panel within 45 days of receipt of the second level grievance.

Delegated Oversight (PPO) – failure to receive approval from the Department prior to executing 4 intermediary agreements; failure to submit timely the initial certifications for 4 intermediaries; failure to establish an internal audit mechanism for reviewing intermediary organizations' provider contracts; failure to provide documentation to demonstrate the Company conducted a formal review of intermediary provider contracts in 2008; failure to provide adequate documentation to ascertain which intermediary contracts had been reviewed by the Company in 2009; failure to develop a formal methodology to determine the specific number of providers necessary to serve its members with regard to 2 intermediaries; failure to provide a methodology for arranging or providing health care services outside of the service area when providers are not available in the service area; failure to conduct annual monitoring of provider availability and accessibility standards throughout the examination for all 4 intermediaries; failure of 1 intermediary to establish provider availability standards for primary care providers and pediatricians; failure of 2 intermediaries to meet the established standards for average or expected wait time for urgent, routine, and specialist appointments; failure to include an effective date and/or documentation of formal approval in its written provider accessibility policy and procedures; failure of 1 delegated entity to provide correct utilization management information regarding concurrent reviews in the 2008 and 2009 data year filings; failure to include all statutory requirements in noncertification notifications of retrospective review files; failure to ensure noncertifications were evaluated by a medical doctor licensed to practice medicine in the state of North Carolina; failure to maintain adequate documentation to determine which individual made the noncertification determination; failure to include full details of the certification in the certification letter; and failure to include all of the regulatory provisions in the written credentialing policies and procedures.

Underwriting Practices (Life and Health) – individual life declined; individual major medical issued substandard; individual major medical declined; individual supplemental health declined; and individual other health declined: failure to send an Adverse Underwriting Decision (AUD) notice to the applicant or sending an AUD notice that was neither filed nor approved by the Department.

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 "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various non-compliant practices, some of which may extend to other jurisdictions. 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 Republic Insurance Company, based in Des Moines, Iowa, is a stock company licensed in 49 states and the District of Columbia. The Company markets primarily Medicare supplement and individual major medical products. The Company was issued its license to do business from the North Carolina Department of Insurance (Certificate of Authority) on July 1, 1962. The Company issued the 180-day notice to the Commissioner during the fourth quarter of 2011 of the intent to discontinue and withdraw from the health insurance market in North Carolina.

GENERAL ADMINISTRATION (PPO)

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 (PPO)

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 the provision of its provider network to

First Health Group Corp., Great-West Life & Annuity Company, MedCost, LLC, and Private Healthcare Systems. Express Scripts, Inc. serves as the pharmacy benefits manager. Please refer to the Delegated Oversight section of this report for discussion of the Company's monitoring activities.

UTILIZATION MANAGEMENT (PPO)

The Company's utilization management activities were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules. The Company delegates utilization management to Great-West Life & Annuity Company, Encompass Health Management System, and Medical Review Institute of America. Please refer to the Delegated Oversight section of this report for discussion of the Company's monitoring activities.

PROVIDER CREDENTIALING (PPO)

The Company's provider credentialing policies and procedures were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules. The Company delegates provider credentialing to Great-West Life & Annuity Company, MedCost, LLC, and Private Healthcare Systems. Please refer to the Delegated Oversight section of this report for discussion of the Company's monitoring activities.

CLAIMS PRACTICES (PPO)

The Company's claims practices were reviewed to determine adherence to Company guidelines, and compliance with applicable North Carolina statutes and rules.

Paid Claims

A random sample of 100 paid claim lines was reviewed from a total population of 27,275 paid claim lines. The review revealed that 7 claims (7.0 percent error ratio) were 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:

- One claim (1.0 percent error ratio) was processed beyond 30 days from receipt without payment of the applicable interest. The Company was instructed to pay interest to the claimant for this claim, which totaled $479.51.

- One claim (1.0 percent error ratio) contained a payment error resulting in an underpayment to the provider. The Company was instructed to re-adjudicate this claim, resulting in an additional benefit payment totaling $885.54, plus an interest payment to the claimant totaling $758.47.

- One claim (1.0 percent error ratio) contained a processing error resulting in the misapplication of the member's deductible. The Company was instructed to re-adjudicate this claim, and the member's deductible was corrected.

- Four claims (4.0 percent error ratio) were processed resulting in an explanation of benefits which reflected a discrepancy in the member's total responsibility based on denied lab charges which are subject to lab code bundling protocol.

The Company was also reminded of the provisions of NCGS 58-3-225 as 2 claims (2.0 percent error ratio) were processed beyond 30 days from receipt. The Company processed and paid the applicable interest due for these claims, which totaled $1.15 in accordance with the provisions of NCGS 58-3-225.

It is also noted that the Company provided the Department with adequate documentation showing all additional benefit and interest payments resulting from the sample review findings.

Denied Claims

A random sample of 100 denied claim lines was reviewed from a total population of 16,507 denied claim lines. The issues revealed as a result of the review are detailed as follows:

- One claim (1.0 percent error ratio) for emergency services was denied in error based on nonparticipating provider status and was deemed to be in apparent violation of the provisions of NCGS 58-3-190. The Company was instructed to re-adjudicate this claim, resulting in an additional benefit payment totaling $774.00, plus an interest payment to the claimant totaling $1,973.70.

- One claim (1.0 percent error ratio) for a mammogram was denied in error and was deemed to be in apparent violation of the provisions of NCGS 58-51-57 which mandates coverage for screening mammograms. The Company was

instructed to re-adjudicate this claim, resulting in the benefit being applied to the member's in-network deductible.

- Eighteen claims (18.0 percent error ratio) contained denials resulting in an EOB which reflected a discrepancy in the member's total responsibility based on either denied lab charges which are subject to lab code bundling protocol, or the provider's incorrect use of a procedure code modifier. These claims were deemed to be in apparent violation of the provisions of NCGS 58-3-225.

Policy Rescissions

The Company's total population of 16 policy rescission files was reviewed to determine adherence to Company guidelines and assess complete file documentation. This review revealed that all rescissions were processed in accordance with the Company's policies and procedures and contained adequate file documentation. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

CLAIMS PRACTICES (LIFE AND HEALTH)

Individual Medicare Supplement Claims Paid

As a result of the Department's market surveillance activities, a random sample of 100 claim files from a population of 325,637 was 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.

The average service time to process a claim payment was 2 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	96	96.0
8 - 14	4	4.0
Total	**100**	**100.0**

Individual Medicare Supplement Claims Denied

As a result of the Department's market surveillance activities, a random sample of 100 claim files from a population of 10,689 was 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.

The average service time to process a claim denial was 4 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	92	92.0
8 - 14	7	7.0
15 - 21	1	1.0
Total	**100**	**100.0**

Individual Supplement Health Claims Paid

As a result of the Department's market surveillance activities, a random sample of 50 claim files from a population of 184 was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Two claims (4.0 percent error ratio) were not processed within 30 days and did not contain evidence that the Company acknowledged receipt of the claim. The Company was reminded of the provisions of NCGS 58-3-100(c). All other claims that were processed in excess of 30 days contained timely acknowledgments and status reports.

The average service time to process a claim payment was 29 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	2	4.0
8 - 14	16	32.0
15 - 21	8	16.0
22 - 30	4	8.0
31 - 60	15	30.0
Over 60	5	10.0
Total	**50**	**100.0**

Individual Supplement Health Claims Denied

As a result of the Department's market surveillance activities, a random sample of 50 files from a population of 214 was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

One claim (2.0 percent error ratio) was not processed within 30 days and did not contain evidence that the Company acknowledged receipt of the claim. The Company was reminded of the provisions of NCGS 58-3-100(c).

One claim (2.0 percent error ratio) was not processed within 45 days and the file did not contain evidence that claim status reports were sent every 45 days until the claim was settled. The Company was reminded of the provisions of NCGS 58-3-100(c) and 11 NCAC 4.0319(5).

All other claims that were processed in excess of 30 days contained timely acknowledgments and status reports.

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

Service Days	Number of Files	Percentage of Total
1 - 7	12	24.0
8 - 14	20	40.0
15 - 21	6	12.0
31 - 60	10	20.0
Over 60	2	4.0
Total	**50**	**100.0**

Individual Other Health Claims Paid

As a result of the Department's market surveillance activities, a random sample of 50 claims from a population of 620 was 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.

The claim that was processed in excess of 30 days contained timely acknowledgements and status reports.

The average service time to process a claim payment was 11 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	17	34.0
8 - 14	23	46.0
15 - 21	6	12.0
22 - 30	3	6.0
31 - 60	1	2.0
Total	**50**	**100.0**

Individual Other Health Claims Denied

As a result of the Department's market surveillance activities, a random sample of 50 files from a population of 385 was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0105 as:

- Two claim files (4.0 percent error ratio) did not contain an EOB to the insured.
- Two claim files (4.0 percent error ratio) had EOBs that did not contain a reason code for the denial.

All claims that were processed in excess of 30 days contained timely acknowledgments and status reports.

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

Service Days	Number of Files	Percentage of Total
1 - 7	23	46.0
8 - 14	20	40.0
15 - 21	3	6.0
22 - 30	1	2.0
31 - 60	1	2.0
Over 60	2	4.0
Total	**50**	**100.0**

POLICYHOLDER TREATMENT (PPO)

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 operates a call center which accepts member and provider telephone calls through a toll-free telephone line. The Member Services Department is available 5 days a week from 7:30 AM to 5:00 PM, Central Time. After normal business hours and during holidays, a recorded message informs callers that the office is closed and provides them with the hours of operation for the Member Services Department so they can call back during business hours or they can leave a message for a return phone call. Providers are given a website address to check member eligibility and/or the status of a claim.

The Member Services Department has established telephone service standards and monitors actual performance. Review of the telephone reports revealed that the Member Services Department met its average speed to answer standard of 60 seconds or less throughout 2008 with the exception of December. The Member Services Department failed to meet the average speed to answer standard in 2009 for the months of September through December. The Company's abandonment rate standard of 5 percent or less was met

throughout the examination period with the exceptions of December 2008 and September, October and December of 2009.

Member Grievances

The Company received a total of 38 member grievances during the examination period. A review of all 38 member grievance files revealed the following deemed apparent violations of the provisions of NCGS 58-50-62:

- In 5 files (13.2 percent error ratio), the acknowledgment letter was not sent within 3 business days of receipt of the grievance.
- In 1 file (2.6 percent error ratio), the determination letter did not contain all of the required statutory provisions, including notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.
- In 1 file (2.6 percent error ratio), the review was not completed within 30 days.
- In 1 file (2.6 percent error ratio), the acknowledgement letter was not sent.
- In 1 file (2.6 percent error ratio), the member did not receive a 15-day notification prior to the review meeting date.
- In 1 file (2.6 percent error ratio), the Company failed to convene a review panel within 45 days of receipt of the second level grievance.

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

Service Days	Number of Files	Percentage of Total
1 - 7	12	31.6
8 - 14	2	5.3
15 - 21	8	21.1
22 - 30	15	39.4
31 - 60	1	2.6
Total	**38**	**100.0**

POLICYHOLDER TREATMENT (LIFE AND HEALTH)

Privacy of Financial and Health Information

The Company provided privacy of financial and health information documentation for the examiners' review. The Company exhibited policies and procedures in place that ensure that nonpublic personal financial or health information is not disclosed unless the customer or consumer has authorized the disclosure. The Company was found to be in compliance with the provisions of NCGS 58-39-25, 58-39-26, and 58-39-27.

DELEGATED OVERSIGHT (PPO)

Intermediary Organizations

The Company delegates the provision of its intermediary provider network to First Health Group Corp. (First Health), Great-West Life & Annuity Company (Great-West), MedCost, LLC (MedCost) and Private Healthcare Systems (PHCS). Express Scripts, Inc. serves as the pharmacy benefits manager. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0201(b) and 20.0204(a) as it failed to receive approval from the Department prior to executing intermediary agreements with the following entities:

- Great-West Life & Annuity Company
- MedCost, LLC
- Private Healthcare Systems
- Express Scripts, Inc.

The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0204 and Bulletin 97-B-3 as it failed to submit timely the initial intermediary certifications for the following entities:

- First Health Group Corp.
- Great-West Life & Annuity Company

- MedCost, LLC
- Express Scripts, Inc.

The regulatory provisions require the Company to submit the initial certification at the same time the Company enters into a relationship with an intermediary.

Intermediary Provider Contracts

During the examination period, the Company had not established an internal audit mechanism for reviewing its intermediary organizations' provider contracts and was unable to provide documentation to demonstrate that it had conducted a formal review of the contracts in 2008 to ensure compliance with the provisions of 11 NCAC 20.0202. For 2009, the Company provided documentation of a review, but the Department could not ascertain which contracts were monitored. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0202 and 20.0204.

As of December 2010, the Company implemented a written policy and procedure for monitoring provider contracts and documenting the results.

Network Availability and Accessibility Standards

Neither the Company nor 2 of its intermediaries (First Health and PHCS) has developed a formal methodology to determine the specific numbers of providers necessary to serve its members as required by regulation, a deemed apparent violation of the provisions of 11 NCAC 20.0301(1) and (2). In addition, the Company failed to provide a methodology for arranging or providing health care services outside of the service area when providers are not available in the area for all of its intermediaries, a deemed apparent violation of the provisions of 11 NCAC 20.0301(3). The Company did not conduct annual monitoring of its intermediaries' established provider availability and accessibility standards (First Health, Great West, MedCost, and PHCS) throughout the examination period, a deemed apparent violation of the provisions of 11 NCAC 20.0304.

The Company has developed performance targets for member accessibility to primary and specialty care physician services, hospital-based services, and non-physician providers. Written policies and performance targets address the distance a member must travel to obtain services as well as appointment availability in accordance with the provisions of 11 NCAC 20.0302. However, during 2008, the Company's intermediary, First Health, did not establish standards for its primary care providers and pediatricians in a suburban area, a deemed apparent violation of the provisions of 11 NCAC 20.0301(1).

The Company's intermediaries, First Health and Great West, failed to meet all of the established standards for average or expected wait time for urgent, routine, and specialist appointments. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0301(1).

The Company has developed a policy entitled "Adequate Access to PPO Providers". However, there is no effective date or formal approval of the policy to determine when, or if, it was utilized during the examination period. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0106.

The First Health policy entitled "Network Availability and Accessibility" dated January 20, 2004 (revised January 1, 2011) does not include detail information as to how the Company arranges or provides health care services outside of the service area when providers are not reasonably available in network without unreasonable delay. Therefore, the Company was reminded of the provisions of NCGS 58-3-200(d) and 11 NCAC 20.0301(3). In addition, the policy stated that the Company's review of performance standards consisted of 4 components; however, only 3 components were listed.

Utilization Management

The Company delegates utilization management to Great-West, Encompass Health Management System (Encompass) and Medical Review Institute of America (MRIoA). The

Company does not conduct preauthorization on any North Carolina state issued policies. Neither insureds nor providers are required to call in to preauthorize service.

A. Annual Filings

The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-191 as its delegated entity, MRIoA, provided incorrect utilization management information regarding concurrent reviews in the 2008 and 2009 data year filings.

B. Retrospective Reviews

The Company was unable to provide documentation to demonstrate monitoring of the retrospective review process delegated to Great-West, Encompass, and MRIoA for the examination period. Therefore, the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(b).

During the examination period, Great-West conducted 10 retrospective review determinations on the Company's behalf. Since the Company did not conduct any monitoring of the delegated retrospective review process, the Department reviewed the entire population of retrospective review files for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. A review of the retrospective review files revealed the following:

- In 3 files (30.0 percent error ratio), written noncertification notification to the member did not inform the insured about the availability of the Managed Care Patient Assistance Program, including the telephone number and address of the Program and did not adequately outline the member's right to appeal, including external review rights regarding an initial noncertification. Therefore, the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(h) and 58-50-77(a)(1).

- In 3 files (30.0 percent error ratio), the noncertification review was not evaluated by a medical doctor licensed to practice medicine in the state of North Carolina, and the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(d).

- In 1 file (10.0 percent error ratio), the retrospective review was not completed within 30 days of receiving all necessary information, and the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(g).

- In 1 file (10.0 percent error ratio), the noncertification notification was not sent to the covered person and the covered person's provider within 5 business days of making the determination, and the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(g).

- In 1 file (10.0 percent error ratio), there was insufficient documentation to ascertain which individual made the noncertification determination, and the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(d) and 11 NCAC 19.0102.

- In 1 file (10.0 percent error ratio), the certification letter did not include the full details of the certification, including the last day of the certification and total number of days authorized, and the Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(g).

Provider Credentialing

The Company delegates provider credentialing to Great-West, MedCost, and PHCS. During this examination, the Department reviewed the Company's delegated credentialing policies and procedures as indicated in the Department's April 14, 2011 letter to the Company regarding its 2009 annual filing data submission. A review of these policies and procedures revealed the following:

- Failure to specify that a 15-day notification of an incomplete application must be in writing and failure to include all of the required regulatory provisions necessary for the written notification, a deemed apparent violation of the provisions of 11 NCAC 20.0405(c)(1).

- Failure to specify that the applicant must be notified of the decision within 60 days of receiving a complete application, a deemed apparent violation of the provisions of 11 NCAC 20.0405(b).

- Failure to specify all of the regulatory requirements for a written notification when the application is missing information or documents have not been received within 60 days after initial receipt of the application, a deemed apparent violation of the provisions of 11 NCAC 20.0405(b) and (c)(3).

UNDERWRITING PRACTICES (LIFE AND HEALTH)

Individual Life Issued Substandard

The Company's underwriting practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous examination revealed the following:

- The Company was deemed to be in apparent violation of the provisions of 11 NCAC 4.0507 as 44.0 percent of the policy files contained an illustration that was not labeled “Revised Illustration.”

- The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 52.0 percent of the policy files contained an AUD notice that was neither filed with nor approved by the Department.

The current examination revealed the following: The Company advised that there were no life policies issued substandard during the examination period.

Individual Life Declined

The Company’s underwriting practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous examination revealed the following:

- The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as:

  a) 82.0 percent of the application files contained an AUD notice that was neither filed with nor approved by the Department.

  b) 4.0 percent of the application files did not contain an AUD notice.

The entire population of 4 application files was reviewed. **The current examination revealed the following:** Three application files (75.0 percent error ratio) did not contain an AUD notice. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 6 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	3	75.0
8 - 14	1	25.0
Total	**4**	**100.0**

Individual Major Medical Issued Substandard

The Company's underwriting practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous examination revealed the following:

- The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as:

  a) 40.9 percent of the files contained an AUD notice that was neither filed with nor approved by the Department.

  b) 9.1 percent of the files did not contain an AUD notice to the insured.

A random sample of 50 policy files from a population of 601 was reviewed. **The current examination revealed the following:** Thirty-three policy files (66.0 percent error ratio) did not contain evidence that an AUD notice was sent to the insured. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and issue a policy was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	4	8.0
8 - 14	10	20.0
15 - 21	11	22.0
22 - 30	14	28.0
31 - 60	8	16.0
Over 60	3	6.0
Total	**50**	**100.0**

Individual Major Medical Declined

The Company's underwriting procedures were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous examination revealed the following:

- The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 18.0 percent of application files did not contain an AUD notice or the AUD notice was neither filed with nor approved by the Department.

A random sample of 50 application files from a population of 360 was reviewed. **The current examination revealed the following:** Thirty-one application files (62.0 percent error ratio) contained an AUD notice that was neither filed with nor approved by the Department. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 20 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	7	14.0
8 - 14	14	28.0
15 - 21	11	22.0
22 - 30	10	20.0
31 - 60	7	14.0
Over 60	1	2.0
Total	**50**	**100.0**

Individual Medicare Supplement Issued

As a result of the Department's market surveillance activities, a random sample of 50 policy files from a population of 1,666 was 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.

The average service time to underwrite and issue a policy was 5 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	42	84.0
8 - 14	6	12.0
15 - 21	1	2.0
31 - 60	1	2.0
Total	**50**	**100.0**

Individual Medicare Supplement Replacements

As a result of the Department's market surveillance activities, a random sample of 50 policy files from a population of 282 was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

One policy file (2.0 percent error ratio) did not contain a copy of the Notice to Applicant Regarding Replacement. The Company was reminded of the provisions of 11 NCAC 12.0843.

The average service time from the date the application was received to the date on the notification letter to the replaced insurer could not be calculated as the replaced insurer is not required to be notified.

Individual Medicare Supplement Declined

As a result of the Department's market surveillance activities, a random sample of 50 application files from a population of 107 was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Twenty application files (40.0 percent error ratio) contained an AUD notice that was neither filed with nor approved by the Department. The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 1 calendar day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	46	92.0
8 - 14	3	6.0
15 - 21	1	2.0
Total	**50**	**100.0**

Individual Supplement Health Issued

As a result of the Department's market surveillance activities, all files from a population of 35 policy files 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.

The average service time to underwrite and issue a policy was 9 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	18	51.4
8 - 14	11	31.4
15 - 21	3	8.6
22 - 30	2	5.7
31 - 60	1	2.9
Total	**35**	**100.0**

Individual Supplement Health Declined

The Company's underwriting practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous examination revealed the following:

- The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 10.0 percent of the application files contained an AUD notice that was neither filed with nor approved by the Department.

The entire population of 3 application files was reviewed. **The current examination revealed the following:** Two application files (66.7 percent error ratio) did not contain evidence that an AUD notice was sent to the applicant. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 9 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	33.3
8 - 14	2	66.7
Total	**3**	**100.0**

Individual Other Health Issued

As a result of the Department's market surveillance activities, a random sample of 50 files from a population of 183 was 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.

The average service time to underwrite and issue a policy was 7 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	37	74.0
8 - 14	8	16.0
15 - 21	2	4.0
22 - 30	2	4.0
31 - 60	1	2.0
Total	**50**	**100.0**

Individual Other Health Declined

As a result of the Department's market surveillance activities, all files from a population of 9 application files were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Three application files (33.3 percent error ratio) indicated that the applicant was not provided an AUD notice. The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 3 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	9	100.0
Total	**9**	**100.0**

SUMMARY

The compliance and target examinations were undertaken to review and update the status of issues referenced in the Market Conduct Report of June 28, 2006 and to determine the Company's level of adherence to North Carolina statutes and regulations in response to the Department's market surveillance activities. The current examinations revealed the following:

1. Claims Practices (PPO)

   a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as 7.0 percent of paid claims were processed beyond 30 days from receipt without payment of the applicable interest, contained a processing error, or resulted in an inaccurate EOB.

   b. The Company was reminded of the provisions of NCGS 58-3-225 as 2.0 percent of paid claims were processed beyond 30 days from receipt with the applicable interest.

   c. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-190, 58-51-57, and/or 58-3-225 as 20.0 percent of denied claims were either denied in error or resulted in an inaccurate EOB.

2. Claims Practices - Individual Supplemental Health Claims Paid (Life and Health)

   a. The Company was reminded of the provisions of NCGS 58-3-100(c) as 4.0 percent of the claims were not processed within 30 days and the files did not contain evidence that the Company acknowledged receipt of the claim.

3. Claims Practices - Individual Supplemental Health Claims Denied (Life and Health)

a. The Company was reminded of the provisions of NCGS 58-3-100(c) as 2.0 percent of the claims were not processed within 30 days and the files did not contain evidence that the Company acknowledged receipt of the claim.

b. The Company was reminded of the provisions of NCGS 58-3-100(c) and 11 NCAC 4.0319 as 2.0 percent of the claims were not processed within 45 days and the files did not contain evidence that the claim status reports were sent every 45 days until the claims were settled.

4. Claims Practices - Individual Other Health Claims Denied (Life and Health)

a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0105 as:

- 4.0 percent of the claims did not contain an EOB; and
- 4.0 percent of the claim files contained an EOB that did not contain a reason code for the denial.

5. Policyholder Treatment (PPO)

a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-50-62 as in 13.2 percent of member grievance files, the acknowledgment letter was not sent within 3 business days of receipt of the grievance; in 2.6 percent of files, the determination letter did not contain all of the required statutory provisions, including notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program; in 2.6 percent of files, the review was not completed within 30 days; in 2.6 percent of files, the acknowledgement letter was not sent; in 2.6 percent of files, the member did not receive a 15-day notification prior to the review meeting date; and in 2.6 percent of files, the Company failed to convene a review panel within 45 days of receipt of the second level grievance.

6. Delegated Oversight (PPO)

a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0201(b) and 20.0204(a) as it failed to receive approval from the Department prior to executing 4 intermediary agreements.

b. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0204 and Bulletin 97-B-3 as it failed to submit timely the initial intermediary certifications for 4 intermediaries.

c. 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 organizations' provider contracts and was unable to provide documentation to demonstrate that it had conducted a formal review of the contracts in 2008. For 2009, the Company provided documentation of a review, but the Department could not ascertain which contracts were monitored.

d. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0301(1) and (2) as neither the Company nor 2 of its intermediaries developed a formal methodology to determine the specific numbers of providers necessary to serve its members.

e. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0301(3) as it failed to provide a methodology for arranging or providing health care services outside of the service area when providers are not available in the service area.

f. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0304 as it failed to conduct annual monitoring of provider availability and accessibility standards throughout the examination period for all 4 of its intermediaries.

g. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0302 as 1 intermediary failed to establish provider availability standards for primary care providers and pediatricians.

h. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0301(1) as 2 of its intermediaries failed to meet the established standards for average or expected wait time for urgent, routine, and specialist appointments.

i. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0106 as its "Adequate Access to PPO Providers" policy did not include an effective date or documentation of formal approval.

j. The Company was reminded of the provisions of NCGS 58-3-200(d) and 11 NCAC 20.0301(3) as First Health's "Network Availability and Accessibility" policy dated January 20, 2004 (revised January 1, 2011) did not include detail information as to how the Company arranges or provides health care services outside of the service area when providers are not reasonably available in network without unreasonable delay.

k. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-191 as its delegated entity, MRIoA, provided incorrect utilization management information regarding concurrent reviews in the 2008 and 2009 data year filings.

l. The Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61(b) as it was unable to provide documentation to demonstrate monitoring of the delegated retrospective review process during the examination period.

m. The Company was deemed to be in apparent violation of the provisions of NCGS 58-50-61, 58-50-77, and/or 11 NCAC 19.0102 as in 30.0 percent of retrospective files, written noncertification notification to the member did not inform the insured about the availability of the Managed Care Patient Assistance Program, including the telephone number and address of the Program and did not adequately outline the member's right to appeal, including external review rights regarding an initial noncertification; in 30.0 percent of files, the noncertification review was not evaluated by a medical doctor licensed to practice medicine in the state of North Carolina; in 10.0 percent of the files, the review was not completed within 30 days of receiving all necessary information; in 10.0 percent of the files, the noncertification notification was not sent to the covered person and the covered person's provider within 5 business days of making the determination; in 10.0 percent of files, there was insufficient documentation to ascertain which individual made the noncertification determination; and in 10.0 percent of files, the certification letter did not include the full details of the certification, including the last day of the certification and total number of days authorized.

n. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0405 as its credentialing policies and procedures failed to specify that a 15-day notification of an incomplete application must be in writing and failed to include all of the required regulatory provisions necessary for the written notification; failed to specify that the applicant must be notified of the decision within 60 days of receiving a complete application; and failed to specify all of the regulatory requirements for a written notification when the application is missing information or documents have not been received within 60 days after initial receipt of the application.

7. Underwriting Practices – Individual Life Declined (Life and Health)

a. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 75.0 percent of the application files did not contain an AUD notice.

8. Underwriting Practices – Individual Major Medical Issued Substandard (Life and Health)

a. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 66.0 percent of the policy files did not contain evidence that an AUD notice was sent to the insured.

9. Underwriting Practices – Individual Major Medical Declined (Life and Health)

a. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 62.0 percent of the application files contained an AUD notice that was not filed with nor approved by the Department.

10. Underwriting Practices – Individual Medicare Supplement Replacements (Life and Health)

a. The Company was reminded of the provisions of 11 NCAC 12.0843 as 2.0 percent of the policy files did not contain a copy of the Notice to Applicant Regarding Replacement.

11. Underwriting Practices – Individual Medicare Supplement Declined (Life and Health)

a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 40.0 percent of the application files contained an AUD notice that was not filed with nor approved by the Department.

12. Underwriting Practices – Individual Supplement Health Declined (Life and Health)

a. The Company was again deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 66.7 percent of the application files did not contain an AUD notice.

13. Underwriting Practices – Individual Other Health Declined (Life and Health)

a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-39-55 as 33.3 percent of the application files did not contain an AUD notice.

14. Additional Issues Noted During the Examination (PPO)

a. The Company's Member Services Department failed to meet its average speed to answer standard in December 2008 and September through December 2009.

b. The Company's Member Services Department failed to meet its telephone abandonment rate standard in December 2008 and September, October and December 2009.

c. First Health's "Network Availability and Accessibility" policy states performance standards are based on 4 components but only 3 components were listed in the policy.

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 58-3-100	Insurance company licensing provisions.
NCGS 58-3-190	Coverage required for emergency care.
NCGS 58-3-191	Managed care reporting and disclosure requirements.
NCGS 58-3-200	Miscellaneous insurance and managed care coverage and network provisions.
NCGS 58-3-225	Prompt claim payments under health benefit plans.
NCGS 58-39-25	Notice of insurance information practices.
NCGS 58-39-26	Federal privacy disclosure notice requirements.
NCGS 58-39-27	Privacy notice and disclosure requirement exceptions.
NCGS 58-39-55	Reasons for adverse underwriting decisions.
NCGS 58-50-61	Utilization review.
NCGS 58-50-62	Insurer grievance procedures.
NCGS 58-50-77	Notice of right to external review.

NCGS 58-51-57	Coverage for mammogram and cervical cancer screening.
11 NCAC 4.0319	Claims Practices: Life: Accident and Health Insurance.
11 NCAC 4.0507	Delivery of Illustration and Record Retention.
11 NCAC 12.0843	NAIC Medicare Supplement Insurance Minimum Standards Model Act.
11 NCAC 19.0102	Maintenance of records.
11 NCAC 19.0105	Claim Records.
11 NCAC 19.0106	Records required for examination.
11 NCAC 20.0201	Written Contracts.
11 NCAC 20.0202	Contract Provisions.
11 NCAC 20.0204	Carrier and Intermediary Contracts.
11 NCAC 20.0301	Provider Availability Standards.
11 NCAC 20.0302	Provider Accessibility Standards.
11 NCAC 20.0304	Monitoring Activities.
11 NCAC 20.0405	Verification of Credentials.

CONCLUSION

Compliance and target examinations have been conducted on the market conduct affairs of American Republic Insurance Company for the period of January 1, 2008 through December 31, 2009 with analyses of certain operations of the Company being conducted through December 28, 2011 for the Life and Health line of business, and January 1, 2008 through December 31, 2009 with analyses of certain operations of the Company being conducted through February 7, 2013 for the PPO line of business.

The examinations were 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, utilization management, provider credentialing, claims practices, policyholder treatment, delegated oversight and underwriting practices.

In addition to the undersigned, Tanyelle Byrd, MBA, MHA, Brian Dearden CLU, ChFC, FLMI, ALHC, ACS, AIRC, AIAA, RHU, REBC, Scott Grindstaff, MHP, HIA, and Marion Flemmings HIA, HIPAAP, HCSA, North Carolina Market Conduct Examiners participated in this examination and in the preparation of this report.

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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