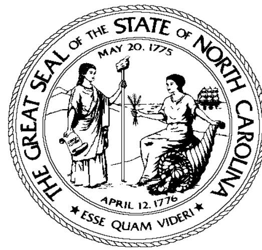

Report on

Market Conduct Examination

of

Union Security Insurance Company
(PPO)
Lenexa, Kansas

by Representatives of the

North Carolina Department of Insurance

as of

March 2, 2015

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Raleigh, North Carolina
March 2, 2015

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Department of Insurance
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Honorable Ken Selzer
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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, a target examination has been made of the market conduct activities of the Preferred Provider Organization (PPO) line of business of

Union Security Insurance Company
(NAIC # 70408)
NAIC Exam Tracking System Exam Number: NC170-M84
Lenexa, Kansas

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.

SCOPE OF EXAMINATION

The North Carolina Department of Insurance conducted a limited scope examination of the Company. This examination commenced on September 20, 2010, and covered the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Company being conducted through March 2, 2015. This action was taken due to market analysis on PPO operations. All comments made in this report reflect conditions observed during the period of the examination.

The 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 was not comprehensive, but included a limited review of the Company's practices and procedures in the areas of general administration, provider relations and delivery system, utilization management, provider credentialing, claims practices, policyholder treatment, marketing, delegated oversight, and underwriting.

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 utilization review determinations, grievances (including quality of care), consumer complaints, 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.

EXECUTIVE SUMMARY

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

> *Claims Practices* – Denied Claims - Failure to provide an accurate Explanation of Benefits (EOB) to the claimant regarding member liability on denied claims; failure to reprocess a claim following retroactive reinstatement of member's policy; and Claims Processing Standards - Failure to include statutorily compliant claims processing standards in written policies and procedures.

Policyholder Treatment – Member Grievances - Failure to include all statutory requirements in the member grievance policies and procedures; failure to include all statutory requirements in the grievance acknowledgment letter and/or determination letter; failure to send an acknowledgment letter after receipt of a grievance; failure to provide the member with a 15-day notification prior to the grievance review meeting date; failure to send an acknowledgment letter within three business days of receipt of a grievance; failure to complete a grievance review within 30 days; and failure to send a grievance determination letter.

Delegated Oversight – Intermediary Organizations - Failure to receive prior approval from the Department after significantly modifying a form which was subsequently executed with two intermediaries; failure to receive approval from the Department prior to executing a pharmacy benefit manager agreement; failure to submit timely the initial certification for two intermediaries; Intermediary Provider Contracts - Failure to demonstrate ongoing oversight of the provider contracts utilized by all four of its intermediaries; Network Availability and Accessibility Standards - Failure of one intermediary to sufficiently monitor its provider appointment wait time standards during the examination period; failure to provide documentation to demonstrate that one intermediary monitored its established hospital provider availability standards during the examination period; failure to provide a comprehensive explanation of the PPO benefit plan to all enrollees during the examination period; failure to provide a copy of the 2008 provider directory for two of the Company's intermediaries; failure of one intermediary to include all statutory requirements in its 2007 provider directory; failure to produce documentation to demonstrate one intermediary had monitored provider wait time standards during the examination period; Utilization Management - Failure to conduct proper oversight of the delegated entity's utilization management activities; failure to require ongoing oversight in delegated utilization management policies and procedures regardless of the entity's URAC accreditation or any other accreditation status; Utilization Management Policies and Procedures - Failure to include all noncertification notice requirements, including external review rights and/or availability of Managed Care Patient Assistance Program in the Company's utilization management policies and procedures; Medical Necessity Reviews - Failure to communicate prospective and concurrent review determinations within three business days after receiving all necessary information; failure to have a medical doctor licensed to practice medicine in North Carolina evaluate the clinical appropriateness of prospective and retrospective review noncertifications; failure to maintain a copy of the noncertification in the prospective review file; failure to include the member's right to an external review in retrospective review noncertification notifications; failure to send the retrospective review noncertification notification to the covered person and the covered person's provider; failure to send an acknowledgment letter within three business days of receipt of appeal requests; Provider Credentialing - Failure to demonstrate to the Department that the Company had conducted required oversight of the credentialing functions delegated to three intermediaries; and failure to maintain quarterly provider updates from one intermediary.

Special Concerns – Failure to process 142 out-of-network emergency or inpatient ancillary claims in accordance with statutory requirements and failure to reprocess all 142 claims correctly after two separate requests 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 statutory violations, 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 statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company's practices and provide consumer protection.

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 adverse trends or unfair trade practices were observed 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 the provision of its provider network to MedCost, LLC, Private Healthcare Systems (now MultiPlan), and WellPath Select, Inc. Medco Health Solutions, 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

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 WellPath Select, Inc. Please refer to the Delegated Oversight section of this report for discussion of the Company's monitoring activities.

PROVIDER CREDENTIALING

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 MedCost, LLC, Private Healthcare Systems (now MultiPlan), and WellPath Select, Inc. 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.

<u>Paid Claims Sample Review</u>

A random sample of 100 paid claim lines was reviewed from a total population of 31,042 paid claim lines. The review revealed that two claims (2.0 percent error ratio) were processed beyond 30 days from receipt. The Company paid the applicable interest for these claims at the time of adjudication in accordance with the provisions of NCGS 58-3-225(e). These interest payments totaled $2.55.

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

Service Days	Number of Files	Percentage of Total
1 - 7	19	19.0
8 - 14	5	5.0
15 - 21	71	71.0
22 - 30	2	2.0
31 - 60*	1	1.0
Over 60*	2	2.0
Total	**100**	**100.0**

* One claim processed over 30 days was properly pended by the Company, as additional information was required for adjudication. Two claims exceeding the 30 day processing timeframe were not pended.

Denied Claims Sample Review

A random sample of 100 denied claim lines was reviewed from a total population of 7,539 denied claim lines. The review revealed processing issues with 15 claims (15.0 percent error ratio). Therefore, the Company did not adhere to the provisions of NCGS 58-3-225. The issues identified as a result of the review are detailed as follows:

- Fourteen claims (14.0 percent error ratio) contained lines denied due to provider coding issues for which the Explanation of Benefits (EOB) erroneously indicated member responsibility/liability. The EOBs lacked appropriate remark code narratives to reflect no responsibility on behalf of the member for these types of denials. It was noted that the Company has subsequently initiated the steps necessary to apply these statements to EOBs when applicable.
- One claim (1.0 percent error ratio) was originally denied for member termination due to nonpayment of premium. The member was subsequently reinstated retroactively, however the claim was not reprocessed. Upon the Department's instruction, the Company reprocessed the claim, resulting in a benefit payment of $83.99 to the provider. In addition, the Company paid the applicable interest, which totaled $52.44.

The average service time to process a claim denial was 13 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	50	50.0
8 - 14	18	18.0
15 - 21	25	25.0
22 - 30	2	2.0
31 - 60*	3	3.0
Over 60*	2	2.0
Total	**100**	**100.0**

* Four claims processed over 30 days were properly pended by the Company as additional information was required for adjudication. One claim exceeding the 30-day processing timeframe was not pended.

Claims Processing Standards

The Company's standards for claims processing accuracy and timeliness, as well as actual performance during the examination period, are outlined in the following chart:

Performance Measure*	2007		2008	
	Standard (%)	**Actual (%)**	**Standard (%)**	**Actual (%)**
Processing accuracy	97.0	99.15	97.0	99.22
Timeliness: 30 days	95.0	97.33	95.0	97.08

* Standards and results are not North Carolina specific.

The Company has established a standard for claims processing timeliness of 95 percent for claims within 30 days. The standard does not meet the requirements of NCGS 58-3-225 (Prompt Pay Law), which state that within 30 days of receiving a claim, an insurer must perform an action, including sending either payment, notice of denial, or notice that the claim is officially pended requiring additional information, or pended based on nonpayment of fees or premiums. Therefore, the Company did not adhere to the provisions of NCGS 58-3-225, as its current standard does not comply with the statutory requirements.

Policy Rescissions Sample Review

The Company has policies and procedures in place which specify guidelines for policy rescission and modification. The Company conducted no policy rescissions during the examination period.

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.

The Company's policy entitled "Grievance Process - North Carolina" effective throughout the examination period failed to state specifically that its first level grievance acknowledgement letter must contain the name of the coordinator who would be responsible for handling the grievance. Therefore, the Company did not adhere to the provisions of

NCGS 58-50-62(e)(1). The Company's second level acknowledgment letter did not state the ten business day timeframe to make known to its members the name, address, and telephone number of the person designated to coordinate the grievance review. Additionally, the Company's second level process did not outline all of the required second level procedures, including that the review panel shall hold and schedule a meeting within 45 days after receiving the second level grievance request; notifying the covered person in writing 15 days before the review meeting date; and advising the member that his/her right to a full review is not conditioned on his/her appearance at the hearing. Therefore, the Company did not adhere to the provisions of NCGS 58-50-62(f)(1)(a) and (g)(1)(2) and(3).

In addition, the Company's policy for its second level decision letter did not contain a statement that the decision is the insurer's final determination, nor did it provide information regarding the insured's right to request an external review. Therefore, the Company did not adhere to the provisions of NCGS 58-50-62(h)(7).

Telephone Access

The Company operates a call center which accepts member and provider telephone calls through a toll-free telephone line. The Client Services Department is available five days a week from 9:00 AM to 6:00 PM, Eastern Standard 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 Client Services Department so they can call back during that time. Providers are given the option of using the self-service phone service to check member eligibility and/or the status of a claim.

The Client Services Department has established telephone service standards and monitors actual performance. Review of the telephone reports revealed that the Client Services Department did not meet the established average speed to answer standard of 30 seconds in 2008 as it exceeded it by 13 seconds, resulting in an actual performance of 43 seconds.

Member Grievances

The Company received a total of 18 member grievances during the examination period. Four files were deemed invalid. Therefore, the valid total population was reduced to 14 member grievances, which were reviewed. This review revealed one or more of the following instances in which the Company did not adhere to the provisions of NCGS 58-50-62 and/or Company policies and procedures:

- In 11 files (78.6 percent error ratio), the acknowledgement letter did not contain all of the required provisions such as the name, telephone number, and address of the coordinator and information on how to submit additional written material.
- In eight files (57.1 percent error ratio), the determination letter did not contain all of the required provisions, including the notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.
- In seven files (50.0 percent error ratio), the acknowledgement letter was not sent.
- In four files (28.6 percent error ratio), the member did not receive a 15 day notification prior to the review meeting date.
- In one file (7.1 percent error ratio), the acknowledgement letter was not sent within three business days of receipt of the grievance.
- In one file (7.1 percent error ratio), the review was not completed within 30 days.
- In one file (7.1 percent error ratio), the determination letter was not sent.

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

Service Days	Number of Files	Percentage of Total
1 - 7	6	42.9
15 - 21	2	14.3
22 - 30	3	21.4
31 - 60	3	21.4
Total	**14**	**100.0**

DELEGATED OVERSIGHT

Intermediary Organizations

The Company delegates the provisions of its intermediary provider network to MedCost, LLC (MedCost), Private Healthcare Systems (PHCS (now MultiPlan)), and WellPath Select, Inc. (WellPath). Medco Health Solutions, Inc. (Medco) serves as the pharmacy benefits manager (PBM). The Company did not adhere to the provisions of 11 NCAC 20.0202, 20.0203, and 20.0204 as it significantly modified an approved form (PPO 25893 Rev. 3/00), which no longer meets all of the provisions of 11 NCAC 20.0202, and subsequently executed the form as intermediary agreements with MedCost and WellPath without receiving prior approval from the Department. The Company also did not adhere to the provisions of 11 NCAC 20.0201, as it failed to receive approval from the Department prior to executing their PBM agreement with Medco.

The Company did not adhere to the provisions of 11 NCAC 20.0204 and Bulletin 97-B-3 as it failed to submit timely the initial intermediary certifications for MedCost and Medco. 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 did not adhere to the provisions of 11 NCAC 20.0204 as it failed to demonstrate to the Department that it had conducted ongoing oversight of the provider contracts utilized by all four of its intermediaries to determine compliance with the provisions of 11 NCAC 20.0202 and 20.0204.

Network Availability and Accessibility Standards

The Company did not adhere to the provisions of 11 NCAC 20.0304 as MedCost did not sufficiently monitor its provider appointment wait time standards during the examination period. The Company stated MedCost relied solely on member complaints and grievances to determine if there were any concerns regarding appointment wait times, and none were

reported during the examination period. This methodology does not yield results which demonstrate if the established appointment wait time standards were met. MedCost has established the following provider availability standards:

- Primary care – 100 percent of total PCPs (Family Practice, Pediatrics, Internal Medicine) statewide and in each county. The panel is never closed.
- Specialists (certain specialties excluded*) – 70 percent coverage in each specialty.
- Podiatry, Physical Therapy, Mental Health Providers and Optometry* - 30 percent coverage in each of these specialties.
- Hospital – at least one primary care hospital per county (if available).

It was noted that the Company did not consistently meet its established provider availability standards across all counties during the examination period. It was also noted that MedCost failed to provide a Coverage and Evaluation report for the third and fourth quarters of 2007, as required by its own policies and procedures. The Company did not adhere to its own policies and procedures.

The Company did not adhere to the provisions of 11 NCAC 20.0304 as it did not provide documentation to demonstrate that MedCost monitored the established hospital provider availability standards during the examination period.

The Company is responsible for establishing policies and procedures which address driving distance standards. The Company's driving distance standards did not account for local variations in the supply of providers and geographic considerations as required by 11 NCAC 20.0302(1).

A. Annual Filings

The Company's data year 2008 annual filing submissions (MedCost delegated data grids) included driving distance standards which were not consistent with the driving distance standards set forth in the Company policy entitled "Methodology for Determining

Provider Availability Targets: Driving Distance" which were submitted during this examination. The submitted policy outlined the following statewide standards:

- Two PCPs within 30 miles.
- One specialist within 30 miles.
- One hospital within 30 miles.

Item D12 of the annual filing submission provided the following driving distance standards for all provider types:

- Urban – within 15 miles.
- Suburban – within 25 miles.
- Rural – within 50 miles.

B. Provider Directories

The Company could not provide a copy of the 2008 provider directory for MedCost and PHCS. Therefore, the Company did not adhere to the provisions of 11 NCAC 19.0102 and 19.0106. In addition, the March 2007 PHCS provider directory did not indicate if the provider was or was not accepting new patients and did not indicate if there were any other restrictions that would limit access to particular providers. Therefore, the Company did not adhere to the provisions of NCGS 58-3-245(b)(3).

PHCS/MultiPlan has established the following appointment wait time standards in accordance with the provisions of 11 NCAC 20.0302(4):

- Routine appointment – Six weeks.
- Specialist appointment – Four weeks.
- Urgent appointment – One week.

The Department noted that the urgent care standard was outside the industry norm which typically ranges from 24-48 hours (with 72 hours as the outer limit).

The Company did not adhere to the provisions of 11 NCAC 20.0304 as it could not produce documentation to demonstrate that PHCS/MultiPlan had monitored provider appointment wait time standards during 2007 and 2008. The Company stated that PHCS/MultiPlan annually gathers information from sample populations via email and/or telephone and that the information is then reviewed to ensure that appointment wait time standards are met. However, the Company did not provide any documentation to demonstrate that monitoring occurred during the examination period.

Utilization Management

The Company delegated its utilization management activities to WellPath Select, Inc. The Company did not adhere to the provisions of NCGS 58-50-61(b) as it failed to conduct proper oversight of the delegated entity's utilization management activities. Instead of conducting their own annual oversight to determine compliance with the provisions of NCGS 58-50-61, the Company solely relied on the delegated entity's American Accreditation Health Care Commission (URAC) accreditation, which is not sufficient oversight to meet the statutory requirements.

In addition, the Company's "Delegated Management Functions: Evaluation and Oversight" policy did not adhere to the provisions of NCGS 58-50-61(b) as it stated that only organizations which are not URAC accredited will require the annual completion of the evaluation/oversight form. In North Carolina, accreditation or certification by an accrediting body does not supplant the requirements of the insurer to conduct its own monitoring to ensure statutory compliance.

Utilization Management Policies and Procedures

The Company's "Utilization Management Process – North Carolina" policy and procedures (versions 3 and 4) failed to state specifically that a noncertification notice for prospective, concurrent, and retrospective reviews must include notice of external review rights and the availability of the Managed Care Patient Assistance Program (MCPAP),

including the telephone number and address of the Program. Therefore, the Company did not adhere to the provisions of NCGS 58-50-77(a) and 58-50-61(h) respectively. In addition, the Company's "Utilization Management Process – North Carolina" policy and procedures (version 3) failed to state specifically that a noncertification notice for an expedited appeal must include notice of external review rights. The Company did not adhere to the provisions of NCGS 58-50-77(a).

Telephone Access

The Utilization Management department is available to providers and members 40 hours per week, through a toll-free telephone line in accordance with the provisions of NCGS 58-50-61. After normal business hours, a departmental voice mail service is used to accept calls. Calls are returned within one business day by the appropriate utilization management staff.

Standards for telephone accessibility have been established in accordance with the provisions of NCGS 58-50-61. The department monitors actual performance for calls abandoned and average speed to answer. Review of the telephone reports revealed that the Company failed to meet their established service level standards in 2007 and 2008, with the exception of the call abandonment standard which was met throughout the examination period.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning.

The Company appears to handle emergency notification in accordance with the provisions of NCGS 58-3-190, which require that the health plan not condition coverage of emergency care upon the member's notification of the receipt of such services.

A. Prospective Records Review

Since the Company did not conduct any monitoring of the delegated precertification review process, the Department assessed the Company's precertification review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. The total population of 43 precertification request files was reviewed. The sample was found to contain two invalid records. Therefore, the valid sample size was reduced to 41 precertification review files and all calculations reflect the smaller, valid sample. This review revealed that in one case (2.4 percent error ratio), the determination was not communicated within three business days after receiving all necessary information. The Company did not adhere to the provisions of NCGS 58-50-61(f).

The average service time to review and send notification of a prospective decision was one business day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	41	100.0
Total	**41**	**100.0**

B. Concurrent Records Review

Since the Company did not conduct any monitoring of the delegated concurrent review process, the Department assessed the Company's concurrent review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. The total population of 37 concurrent review request files was reviewed. A review of concurrent review requests revealed the following:

- In two cases (5.4 percent error ratio), the determination was not communicated within three business days after receiving all necessary information. The Company did not adhere to the provisions of NCGS 58-50-61(f).

In addition, the Company did not adhere to its own policies and procedures in the following instances:

- In two cases (5.4 percent error ratio), the Company failed to demonstrate that it had verbally and/or in writing communicated the certification to the insured.
- In one case (2.7 percent error ratio), the Company failed to follow its own "Lack of Information Policy" as a second attempt to obtain necessary clinical information via telephone call or fax was not placed/documented within two calendar days after making the initial contact.

The average service time to review and send notification of a concurrent decision was one business day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	37	100.0
Total	**37**	**100.0**

C. Retrospective Records Review

Since the Company did not conduct any monitoring of the delegated retrospective review process, the Department assessed the Company's retrospective review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review and other review procedures. A random sample of 50 retrospective review files from a population of 52 was reviewed. A review of the retrospective review files revealed the following:

- In two cases (4.0 percent error ratio), written noncertification notification to the member did not include the member's right to an external review, and the Company did not adhere to the provisions of NCGS 58-50-61 and 58-50-77(a)(1).
- In two cases (4.0 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 did not adhere to the provisions of NCGS 58-50-61(d).

In addition, the Company did not adhere to its own policies and procedures, as in 22 cases (44.0 percent error ratio), the Company failed to communicate the certification to the insured and/or the provider within one business day of the determination.

The average service time to review and send notification of a retrospective review decision was seven business days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	24	48.0
8 - 14	25	50.0
15 - 21	1	2.0
Total	**50**	**100.0**

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his/her appeal if a delay in the rendering of health care would be detrimental to his/her health.

Appeal Records Review

Since the Company did not conduct any monitoring of the delegated appeal process, the Department assessed the Company's appeal process for compliance with regulatory requirements as to member notification of the results of the review. The Company received one member appeal during the examination period. The review revealed no violations of statute.

Provider Credentialing

During the examination period, the Company did not establish a formal delegated credentialing oversight process, and therefore did not adhere to the provisions of 11 NCAC 20.0410(1) and (3), as it failed to demonstrate to the Department that it had conducted the required oversight of the credentialing functions delegated to the following entities:

- MedCost
- PHCS/MultiPlan
- WellPath Select, Inc.

In addition, the Company did not adhere to the provisions of 11 NCAC 19.0102(a) and 19.0106(d) as it failed to maintain quarterly provider updates from PHCS/MultiPlan as required by the provisions of 11 NCAC 20.0410(2).

SPECIAL CONCERNS

Based on the Department's findings in the Company's PPO marketing materials, which incorrectly stated that a covered person who seeks non-network emergency services is responsible for paying the provider any balance in excess of the negotiated rate, and the Company's subsequent disagreement with the Department's findings, the Department along with its legal counsel met with the Company's legal counsel and Vice President Regulatory Compliance and Compliance Officer to discuss the issue further. During the August 21, 2012, meeting, the Department explained to the Company representatives that NCGS 58-3-200(d) does not allow an insured to be penalized or subjected to out-of-network benefit levels unless in-network providers able to meet the health needs of the insured are reasonably available to the insured without unreasonable delay. Therefore, in these circumstances, the Company cannot hold the insured liable for any balance (after any applicable co-pay/co-insurance) in excess of the in-network rate. On the same date of the meeting, the Company was instructed to conduct a review on all out-of-network emergency claims adjudicated from January 1, 2007, through August 31, 2012, as well as inpatient ancillary claims which included services rendered by a non-participating provider. The Company was further instructed to reprocess the claims in accordance with the statutory provisions as detailed by the Department's counsel during the August 21, 2012, meeting. In the Company's response dated September 25, 2012, the Company declined to take any action to reprocess the claims.

The requested claims data was received from the Company in batches to the Department from December 2012, through March 2013. The number of claims processed by the Company is provided in the following chart:

Assurant, Inc. Company Name	Claim Files
Union Security Insurance Company	142
Total	**142**

The Department's review of USIC's 142 claims revealed the claims were not processed in accordance with the provisions of NCGS 58-3-200(d) and/or 58-3-300(d) and revealed one or more of the following issues:

- Incorrect application of reasonable and customary (R&C) rates while holding member liable for the difference between R&C and the billed charges (after application of co-pay/co-insurance);
- Incorrect application of incurred claim amounts to the member's out-of-network deductible instead of the in-network deductible (and only up to the R&C amount);
- Incorrect processing of claims yielded incorrect accumulators/deductibles for the benefit period, which could potentially affect other claims processed during the same benefit period for the insured and/or any dependents.

On April 11, 2013, the Department instructed the Company to review and reprocess each claim in question in accordance with the provisions of NCGS 58-3-190(d) and/or 58-3-200(d). The Company was instructed to record remedial action and to submit supporting documentation, including but not limited to refunds with applicable interest, to the Department no later than May 31, 2013. The Company submitted its response to the Department on May 31, 2013, stating the following:

> "*Thank you for meeting with Bonni Fredrick, Senior Counsel II and Julia Hix, Vice President Regulatory Compliance and Compliance Officer from Assurant Health on August 21, 2012 to discuss the provisions of NCGS 58-3-190(d) and NCGS 58-3-200(d). It was noted during this meeting that the Companies have the option to either agree to the Department's request or decline the Department's request and await the draft examination report and review the final examination issues in total.*
> *The Companies respectfully maintain the position that NCGS 58-3-190(d) and NCGS 58-3-200(d), as written, do not prohibit the utilization of reasonable and customary reductions of billed charges for out-of-network services and therefore, declines to reprocess the claims. The Companies request that once it has had an opportunity to review the examination findings in total, that discussions resume with the Department regarding this issue as well as additional examination findings."*

Therefore, the Company did not adhere to the provisions of NCGS 5-3-190(d) and/or 58-3-200(d) as it failed to process 142 claims in accordance with statutory requirements and

subsequently declined to reprocess the claims after two separate requests by the Department on August 21, 2012, and again on April 11, 2013.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

Claims Practices

The Company must provide an accurate EOB to claimants to adequately address member liability, reprocess claims following retroactive reinstatements of member policies, and include statutorily compliant claims processing standards in its written policies and procedures.

Policyholder Treatment (PPO)

The Company must include all statutory requirements in member grievance policies and procedures, in grievance acknowledgment and determination letters, and comply with all applicable statutory timeframes and requirements for processing member grievances, including but not limited to, sending the appropriate acknowledgement, notice of hearing and determination letters.

Delegated Oversight (PPO)

The Company, with regards to network activities, must file intermediary agreements and contract forms with the Department and receive approval prior to executing the agreements; submit timely initial certifications for intermediary organizations; demonstrate ongoing oversight of provider contracts utilized by intermediary organizations; monitor accessibility and availability standards for intermediary organizations; and provide all enrollees a comprehensive explanation of the PPO benefit plan. With regards to utilization management activities, the Company must conduct proper oversight of the delegated entity's utilization management activities; maintain ongoing oversight of delegated utilization management policies and procedures regardless of the accreditation status of the delegated entity; maintain appropriate policies and procedures that contain all statutory requirements for processing utilization management prospective, concurrent, and retrospective reviews,

as well as utilization management appeals; and have a medical doctor licensed to practice medicine in North Carolina evaluate the clinical appropriateness of noncertifications. The Company, with regards to provider credentialing activities, must be able to demonstrate that it has conducted the required oversight of credentialing functions delegated to intermediary organizations and maintain quarterly updates received from intermediary organizations.

Special Concerns (PPO)

The Company must amend its policies to accurately process out-of-network emergency and inpatient ancillary claims in accordance with statutory requirements.

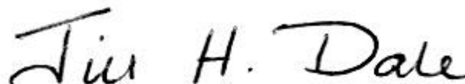
CONCLUSION

A target examination has been conducted on the market conduct affairs of Union Security Insurance Company for the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Company being conducted through March 2, 2015.

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

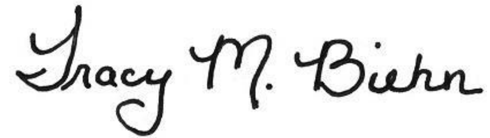
In addition to the undersigned, Tanyelle Byrd, MBA, MHA and Scott Grindstaff, MHP, HIA, North Carolina Market Conduct Examiners, participated in this examination and in the preparation of this report.

Respectfully submitted,



Jill H. Dale, PAHM, MHP, HIA
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.



Tracy Miller Biehn, LPCS, MBA
Deputy Commissioner
Market Regulation Division
State of North Carolina