

STATE OF NORTH DAKOTA

# **MARKET CONDUCT EXAMINATION REPORT**

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NORIDIAN MUTUAL INSURANCE COMPANY

FARGO, ND 58121

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As of June 1, 2006

By Representatives of the  
North Dakota Insurance Department

STATE OF NORTH DAKOTA  
DEPARTMENT OF INSURANCE

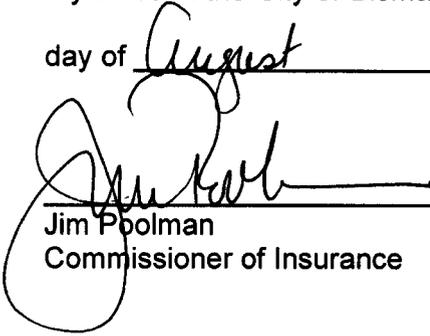
I, the undersigned, Commissioner of Insurance of the State of North Dakota, do hereby certify that I have compared the annexed copy of the Market Conduct Examination Report of the

**Noridian Mutual Insurance Company  
Fargo, North Dakota**

as of August 29, 2007, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this 31<sup>st</sup> day of August, 2007.

  
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Jim Poolman  
Commissioner of Insurance

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Fargo, North Dakota  
August 29, 2007

Honorable Jim Poolman  
Commissioner  
North Dakota Insurance Department  
600 East Boulevard Avenue  
Bismarck, ND 58505

Dear Commissioner Poolman:

Pursuant to your authority delegated under the provisions of N.D.C.C. Chapter 26.1-03 and in accordance with your instructions, a market conduct examination of the business practices and affairs has been conducted on:

**Noridian Mutual Insurance Company**  
**dba Blue Cross Blue Shield of North Dakota**  
4510 13<sup>th</sup> Avenue SW  
Fargo, ND 58121

herein after referred to as the Company, at its home office at 4510 13<sup>th</sup> Avenue SW, Fargo, ND 58121. The report of examination is herewith respectfully submitted.

## **SCOPE OF EXAMINATION**

This market conduct examination commenced on April 17, 2006, and covered the period beginning January 1, 2004, and ending December 31, 2005. The exam was later extended to review certain activities through June 1, 2006. It was conducted by representatives from Huff Thomas & Company as Examination Consultants for the North Dakota Insurance Department.

This examination was conducted pursuant to the provisions of N.D.C.C. Chapter 26.1-03 and in accordance with procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners (NAIC).

The purpose of this market conduct examination was to determine the Company's ability to fulfill and the manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders and its compliance with specified sections of N.D.C.C. Title 26.1.

This market conduct examination included a review of the applicable records and files pertaining to the phases listed below. This examination was comprised of the following nine phases:

Operations and Management  
Complaint Handling  
Grievance Handling  
Marketing and Sales  
Producer Licensing  
Policyholder Service  
Underwriting and Rating  
Claim Handling  
Utilization Review

A signed letter of representation was received from the Company's General Counsel in which he stated that to the best of his knowledge and belief, the Company has not intentionally withheld any books, records, accounts, papers, documents or computer or other recordings in its possession, relating to its transactions and affairs with its policyholders as pertains to matters relating to the period under examination and as requested by the Examiners.

## **FORWARD**

This report of examination is confined to comments on exceptions that involve departures from laws, regulations or bulletins and questionable business practices or patterns that are determined to be contrary or detrimental to the best interests of the insurance buying public and require special explanation or description. Standards as prescribed by the 2006 NAIC Market Regulation Handbook are only described in detail where the Examiners concluded the Company was not meeting a specific standard. The failure to identify or criticize certain practices does not constitute acceptance by the Examiners.

## **OPERATIONS AND MANAGEMENT**

### **History**

The Company was incorporated March 20, 1940, as the North Dakota Hospital Services Association. The Company amended the Articles of Incorporation on February 28, 1964, changing the name to Blue Cross of North Dakota. The North Dakota Physicians Service was incorporated on December 7, 1945. The Company amended its Articles of Incorporation on March 27, 1971, changing the name to Blue Shield of North Dakota. On July 1, 1986, the two companies were merged becoming Blue Cross and Blue Shield of North Dakota.

The Company converted from a not-for-profit health services corporation to a nonprofit mutual insurance company on January 30, 1998. The Company's name was changed from Blue Cross and Blue Shield of North Dakota to Noridian Mutual Insurance Company. The conversion passed ownership to the policyholders. The Company is incorporated as a nonprofit mutual insurance company and is governed by N.D.C.C. Chapters 10-33 and 26.1-12 and Section 26.1-17-33.1.

## Operations

**Backup Procedures.** The Company was requested to provide copies of their central recovery and back up procedures for their computer information to determine if appropriate controls, safeguards and procedures for protecting the integrity of computer information were in place. The Company provided a 600 page document titled Business Contingency and Continuity Plan and these procedures were contained in this document.

The Company has a facility in Grand Forks, North Dakota, that serves as the backup storage site. The Company backs up all systems to tape each night. The Tape Librarian is responsible for coordinating the transporting of back-ups and inventory reports to the off-site backup storage facility each day with the carrier.

The Company backs up all electronic files, including claim files from the servers and stores them in a secured room at Critical Systems Operation Center (CSOC) which is located in a building adjacent to the Home Office.

**Antifraud Plan.** The Company's antifraud plan was reviewed to determine if it was reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts. The plan designates the Fraud Committee to develop corporate policy and procedures in relation to antifraud initiatives and to investigate potential fraudulent activity.

The Fraud Committee is composed of the following members: legal counsel, a medical director, a manager from claims, a manager from medical review, assistant vice president of reimbursement, assistant vice president of finance, assistant vice president of member services, the compliance officer and two compliance specialists.

The Company employs several methods from which to generate information on fraudulent activity including the following:

- Fraud Hotline - Available 24 hours
- Compliance Hotline - Available 24 hours
- Dedicated Post Office Box
- Customer Service Staff
- SIU Alerts - Alerts from other plans.

The Company has an adequate and up-to-date antifraud plan in place. All information on fraudulent activity is recorded in a fraud log book. The plan establishes the authority of the fraud committee. The plan provides methods of detecting, investigating and resolving fraudulent activity.

**Disaster Recovery Plan.** The Company has a detailed disaster recovery plan contained in their Business Contingency and Continuity Plan. The objective of the plan is to identify the resources and processes needed to resume information technology and telecommunication systems for critical business functions.

The disaster recovery plan identifies the function for the following areas: employee call list, locations, customers, vendors, equipment, software, supplies, vital records report and recovery priorities.

The Company has an up to date disaster recovery plan. The plan provides a written description of predetermined actions to be used during recovery operations and ensures resumption of vital functions.

**Record Retention.** The Company was requested to provide a copy of their record retention policy. The Company indicated they do not have a record retention policy. The Company provided the proposed draft of their record retention policy dated May 1999. The record retention practices currently employed by the Company do not ensure complete files are maintained for an adequate period of time.

*It is recommended the Company implement written record retention policies to ensure compliance with N.D.C.C. § 26.1-03-19.2(1) which requires financial examinations at least every five years.*

**Information Practices.** The Company procedures for the collection, use and disclosure of information gathered in connection with insurance transactions were reviewed. The Company's privacy policy and their "notice of privacy practices" provide the member with adequate information about the use of their personal information. The notification also advises the member about their rights regarding the use of personal health information.

The Company provided a copy of their corporate confidentiality policy. The policy classifies the following information confidential: protected health information, proprietary information and Medicare related information. No exceptions were noted.

### **Management**

The Company is managed by a Board of 13 Directors. The present composition of the Board of Directors is eight Consumer Directors and five Provider Directors. The Board meets six times a year. Committees meet three to five times a year. Each Director serves on two of the following five committees: Audit and Compliance, Governance and Nominating, Human Resources and Compensation, Finance and Investment and the Quality Committee.

As of December 31, 2005, the Board consisted of the following 13 members:

<b>Name &amp; Address</b>	<b>Year Elected</b>	<b>Business Affiliation</b>
Jane M. Bissel Provider	2000	Mercy Hospital, Valley City, North Dakota
Julia A. Blehm Provider	2003	MeritCare Hospital Fargo, North Dakota
Laura D. Carley Consumer	2000	Industrial Builders Fargo, North Dakota
John D. Coughlin Consumer	2002	Coughlin Construction Co. Minot, North Dakota
Dr. Dennis J Elbert Consumer	2000	University of North Dakota Grand Forks, North Dakota
Robert E. Grossman Provider	1997	Hettinger Clinic Hettinger, North Dakota
Robert M. Johnsen Consumer	1996	Johnsen Trailer Sales Bismarck, North Dakota
Roger A. Kenner Consumer	2001	Kenner Seed & Simmental Ranch Leeds North Dakota
Frank Patrick Keough Consumer	1996	American State Bank and Trust Williston, North Dakota
Robert L. Lamp Consumer	2001	Association Services, Inc. Fargo, North Dakota
Gary P. Miller Provider	2004	St. Alexius Medical Center Bismarck, North Dakota
Mark S. Sanford Consumer	1997	Grand Forks Public Schools Grand Forks, North Dakota
Mary K. Wakefield Provider	2002	Center for Rural Health Grand Forks, North Dakota

**Compliance With Market Conduct Examination Report – Chiropractic Benefits.** The Company was requested to provide evidence of changes made in policies or procedures as the result of the Order from the Commissioner regarding the Market Conduct Examination Report – Chiropractic Benefits.

In response to the Order, the Company hired a Director of Chiropractic Services which replaced the Chiropractic Consultant position. The Director is a half-time employee rather than a part-time outside consultant. The Company also created a Chiropractic Claims Review and Advisory

Committee (CCRAC) which consists of 12 chiropractors. CCRAC advises the Director relating to chiropractic policy, unusual or disputed claims, provider profiling and provides opinions regarding standards of practice for reimbursement. Three members of CCRAC comprise the Peer Review Committee.

The Company complied with the Order by implementing changes to policies and procedures. Following is a listing of some of the changes the Company made:

- Electronic signatures are acceptable.
- Procedures to satisfy the 30-day turnaround time for appeals.
- Procedures state committee members must be willing to exercise judgment independent of the Chiropractic Consultant.
- Procedures to not allow maintenance care for patients where it is not contractually obligated.
- Procedures to notify patients by mail within two days of placing the patient on schedule of care.
- The Company also implemented written policies and procedures regarding:
  - Procedures regarding the role of the Director of Chiropractic Services
  - Procedures regarding the role of the Chiropractic Peer Review Committee
  - Rights of patients regarding independent reviews
  - Selection and term for members of the Chiropractic Peer Review Committee members
  - Conflict of interest policy for the members

**Denied Chiropractic Claims Testing.** To determine if the Company was properly handling chiropractic claims a sample of 25 denied claims were tested. The claims were denied timely and the files were properly documented. The review of the 25 denied chiropractic claims did not indicate any problematic claim handling practices.

**Chiropractic Appeals Testing.** To further determine if the Company was in compliance with the Order, a sample of 25 chiropractic appeals was selected for testing. The appeals were handled by the Director of Chiropractic Services, the Peer Review Committee or both.

In the appeal process the Company reviewed any additional information provided. The Company reversed or partially reversed 12 of the 25 appeals reviewed. The chiropractic appeals reviewed were properly documented and handled timely. The Company has an adequate chiropractic appeals process in place that complies with Company procedures and the Order from the Commissioner regarding the Market Conduct Examination Report regarding chiropractic benefits.

No exceptions were noted in this review.

## PREVIOUS EXAMINATION FINDINGS

*The Company should adopt a formal written antifraud plan. The plan should include standards to address the resolution of all reports of potential fraud and establish the authority of the Fraud Committee.* In the Operations and Management section the Company's antifraud plan was reviewed and it was determined the Company has an adequate and up-to-date antifraud plan in place.

*The Company should update and maintain the database of appointed agents and agencies to correspond to the proper licensure and appointment requirements and periodically check the database for accuracy.* In the Producer Licensing section, the Company's agent listing was reconciled with the Insurance Department's listing without exception. The Company has an accurate database of appointed agents.

## PERTINENT FACTUAL FINDINGS

### Complaint Handling

The Company provided complaint listings for 2004 and 2005 which included complaints made directly to the Insurance Department and direct complaints. The majority of the complaints involved disputed claims. According to the Company, if a complaint involving a disputed claim is filed with the Insurance Department, then it is considered a complaint rather than an appeal or a grievance. The Company complaint listing was reconciled with the Insurance Department listing without exception.

**Complaint Register.** The Company complaint register was reviewed to determine if the Company was recording sufficient information for the Company to recognize and conduct an analysis in areas developing complaints. The complaint listing provided by the Company included the name of the complainant, receipt date, benefit plan number and the complaint number assigned by the Company. The information included in the Complaint Register is derived from the Company's correspondence control system. The Complaint Register provided by the Company did not contain sufficient information. The 2006 NAIC Market Regulation Handbook recommends that the Complaint Register include:

- The line of business;
- Function; and
- Reason for the complaint.

The above noted information provides pertinent information for the Company to recognize and conduct analysis in areas developing complaints.

*It is recommended the Company implement internal procedures to ensure that sufficient information is included in the Complaint Register to enable analysis in areas developing complaints. (Exception 1)*

**Complaint Reports.** The Company was requested to provide complaint reports provided to management which could be used to analyze areas developing complaints. The report identified by the Company was the "Customer Service Written Grievances" report, which includes only those complaints involving "the fashion in which care is provided" and "not to the

terms of insurance or coverage.” This report includes two fields, which could be used to analyze complaint data, “Topic” and “Description” but the generic entries in these fields do not provide information for analysis of trends developing complaints.

*It is recommended the Company implement internal procedures for the preparation of reports to analyze and identify areas developing complaints.*

**Complaint Handling Procedures.** The Company’s complaint handling procedures were reviewed to determine compliance with N.D.C.C. § 26.1-04-03(10) which requires insurance companies to adopt and implement reasonable standards for the prompt handling of written communications received from insureds or claimants, primarily expressing a grievance (complaint).

After the service representative has determined a communication is a complaint, the complaint is routed to the appropriate area for review and response. Consumer complaints from the Insurance Department are routed through the Member Services Department for research and response.

The Company’s complaint handling procedures comply with the requirements of the North Dakota Century Code and provide for a method for distributing and responding to complaints within required timeframes.

**Insurance Department Contact Information.** The complaint response to insureds was reviewed to determine if the Company provided the Insurance Department’s telephone number as recommended in the 2006 NAIC Market Regulation Handbook. The Company failed to advise the insureds of their right to contact the Insurance Department, including the Department’s address or telephone number, in its responses to complaints.

*It is recommended the Company advise insureds of their right to contact the Insurance Department, and include the address or telephone number in correspondence involving complaints.*

**Complaint File Documentation and Timely Resolution.** The Insurance Department complaints and internal complaints were reviewed to determine whether the Company maintained adequate documentation to support the timely resolution of complaints received by the Company. The Company did not date-stamp 19 of the 35 complaints reviewed. In addition to the complaints, the Company did not date stamp most of the other communications received in conjunction with these complaints, such as medical records.

Because the complaints and other communications were not date-stamped, the Examiners were unable to determine whether the Company responded to complaints and other pertinent communications in a timely manner. Because it failed to date stamp written communications and other related documents primarily expressing grievances, the Company cannot confirm the timely handling of complaints, appeals, and grievances. N.D.C.C. § 26.1-04-03(10) provides:

Unfair handling of communications by insurance company. Failing to adopt and implement reasonable standards for the prompt handling of written communications, primarily expressing grievances, received by the insurance company from insureds or claimants.

*It is recommended the Company implement procedures to ensure that all communications involving complaints, appeals and grievances are date-stamped the day they are received to ensure timely handling.*

**Complaint Response.** The Company's responses to insured's complaints were reviewed to determine whether the response addressed the issues raised and whether the explanations were sufficient. The Examiner noted the Company included nonspecific explanations to insureds and providers, including the following:

Any rule, guideline, protocol or relevant documentation used to make this determination can be provided free of charge upon request.

The practice of providing nonspecific, generic responses to complaints makes it difficult for the insureds and the providers to further respond to disputed claims and oftentimes causes multiple complaints or appeals to settle the issue.

*It is recommended the Company implement procedures to ensure responses to complaints are specific and clearly identify the reason for the denial or limitation of benefits.*

**Underlying Issue of Complaint.** Complaints were reviewed to determine if the underlying issue of the complaint is in compliance with applicable statutes, rules and regulations. The following exceptions were noted:

1. Complaint No. ND0417702224: The Company agreed to reprocess the complainant's 2004 diabetes supply claims purchased out of state at the in-network level because they were not available in-network. Furthermore, the Company revised its reimbursement guidelines for diabetic supplies to ensure these claims are processed as in-network going forward.

Although the Company reprocessed the diabetes supply claims for this insured, it made no attempt to identify and reprocess other diabetic supply claims, which were processed as out of network. Through its inconsistent handling of claims for diabetes supplies, in this instance the Company inconsistently administered the benefits provided. Therefore, in this instance involving diabetic supplies the Company did not fully comply with N.D.C.C. § 26.1-04-03(7)(b).

*It is recommended the Company implement procedures to ensure all insureds are treated consistently. Furthermore, when guidelines are changed, it is recommended the Company take the appropriate steps to ensure all insureds, not just those filing complaints or appeals, are treated equally and the benefits provided are consistent with policy provisions.*

2. Complaint No. ND0423602182: In responding to an appeal of a denial of therapy and skilled nursing facility care, the Company used the term "significant progress" but did not define the term nor did the term appear in either the benefit plan or the summary description. That is, the Company did not disclose the limitation in this plan or in any other of its plans that benefits are not available for therapy and skilled nursing facility care when "significant progress" is not achieved with regard to the therapy provided, as determined by the Company. It should be noted that this term was not used in the Company's plan description.

The Company does not define what it considers to be "significant progress" in the therapy provided in any of the Benefit Plans or Summary Plan Descriptions. Therefore, the Company is not in full compliance with N.D.C.C. § 26.1-04-03(9)(c) because in this instance the Company did not define the term "significant progress".

*For terms used in documents other than its benefit plans and summary plan descriptions, it is recommended the Company define terms such as the term "significant progress" that may be used to settle claims so claimants and providers have the opportunity to intelligently appeal claims.*

Also, the Company received an appeal from the insured's Power of Attorney. The Company provided the appealing party an Explanation of Benefits that stated a review of this claim had been made and referred the complainant to the original Explanation of Benefits. The Company failed to provide an adequate explanation of the reason(s) for the denial of benefits and failed to explain the procedures for filing further appeals/grievances. In this instance the Company did not fully comply with N.D.C.C. § 26.1-04-03(10).

*It is recommended the Company implement procedures to ensure it provides responses to all complaints which are sufficiently specific and clear rather than referring complainants/appellants to previous EOBs for an explanation.*

3. Complaint Nos. ND0500500966 and ND0502500169: The Company revised its guidelines regarding gastric bypass surgery effective November 2, 2004, but failed to communicate these guidelines to the providers until it mailed its monthly newsletter, BCBSND Healthcare News, on December 8, 2004. The provider involved in these two cases was provided a copy of updated guidelines with the denials for preapproval in late November and/or early December of 2004.

Upon appeal, the Company agreed to reprocess these requests for prior approval using the guidelines in effect prior to November 2, 2004, because the provider was not made aware of the changes in its gastric bypass surgery guidelines.

The Company, by implementing revised claims/preapproval guidelines that adversely affect insureds before they have been communicated to the insureds and the providers is not in compliance with N.D.C.C. § 26.1-04-03(9)(c) which provides:

Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

*It is recommended the Company implement procedures to ensure new and revised policies that adversely affect insureds are communicated to insureds and providers at the time of or prior to their implementation.*

Furthermore, the Company did not reprocess all requests for prior approval that were adversely affected by this change in policy. The Company only reprocessed those prior approvals that were appealed.

*It is recommended the Company implement procedures to reprocess claims and prior approvals when necessary and to ensure unfair discrimination in the benefits provided does not exist between insureds who file complaints or appeals and those who do not.*

4. Complaint No. ND0504900471: The Company advised the insured to make a claim to the Workers Compensation Insurer because the insured believed the injury to be work related. The insured filed a claim for workers compensation benefits that was denied for untimely filing.

The terms of the claimant's plan provide the Company with a basis for denying claims because of the insured's failure to timely file a claim with the Workers Compensation Insurance Carrier prejudiced the right to those benefits.

Subsequently, the Workers Compensation Insurer reviewed the claim including medical records and determined the medical condition was not work related. The attending physician stated the injury was not work related. The Company continued to deny benefits for lack of timely filing because the subsequent decision by workers compensation did not indicate that it replaced the original denial for untimely filing.

Based on the above information the Company did not fully investigate the claim to determine whether the facts supported a finding that the claim was work related. The Company failed to fully comply with N.D.C.C. § 26.1-04-03(9)(c) which provides:

Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

*It is recommended the Company implement procedures to ensure it takes adequate steps to investigate and to verify the work-related nature of claims when claims are denied by other insurers as being non work related.*

Also, the Company's chronology of events provided to the Insurance Department in response to this complaint omitted several pertinent events, although this information had been previously provided to the Department by the complainant and was part of the Insurance Department file. The individual responding to the complaint on behalf of the Company was aware that the Department had the information and believed that it was not necessary to provide the information.

*It is recommended the Company reaffirm with its employees that a file's complete chronology of events is to be provided to the Insurance Department.*

5. Complaint No. ND0510801367: The insured made it clear in several telephone conversations with the Company that the medical procedure would be provided out of state (out-of-network). The insured was advised more than once those

benefits would be provided as in-network as described in the members benefit booklet. The prior approval issued by the Company did not indicate benefits would be reduced to the out-of-network level.

The Company provided the insured with incorrect and misleading benefit information by failing to disclose the limitations regarding the benefits payable. The Company did not effectuate prompt, fair and equitable settlement of a claim submitted in which liability has become reasonable clear as required by N.D.C.C. § 26.1-04-03(9) (d) which provides:

Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.

*It is recommended the Company implement procedures to ensure insureds are informed of the limitations involving nonparticipating providers when inquiring about benefits and when requesting prior approval or preauthorization.*

### **Grievance Handling**

**Grievance Procedures.** The Company provided their "Appeal and Grievance Administrative Manual." The Company has written procedures for grievances, standard appeals and expedited appeals.

It is important to note how the Company defines certain terms relevant to the grievance handling procedures:

Grievance - A complaint about the manner in which the member or service had been handled. It relates not to the terms of insurance coverage, but in the fashion in which the care is provided by the Health Care Provider (i.e., access to and availability of services, choice and accessibility of Health Care Providers, quality of care, quality of service, facility, network adequacy, conduct and/or behavior).

Standard Appeal - A statement (oral or written) expressing disagreement with a decision made by the Company and requesting a change in that decision.

Expedited Appeal - An appeal (oral or written) in which the time frame for the standard appeal could seriously jeopardize the Member's life, health, or ability to regain maximum functioning.

Complaint - An expression (oral or written) of dissatisfaction that relates to terms of insurance coverage.

For grievance testing the Company's Standard Appeals were treated as grievances. The Company's definition of grievances is not the same as the examination. Company "grievances" have nothing to do with insurance coverage or benefits paid.

The Company has written procedures for handling the following types of grievances or appeals:

Expedited medical necessity appeals;  
Emergency services;  
Standard appeal;  
Preauthorization or prior approval;  
Other claims;  
Chiropractic appeals; and  
Standard medical necessity appeal.

It was initially thought that neither the member certificates nor the Appeals and Grievance Administrative Manual described the process of the second level review or the process of appealing of the standard appeal decision, but the Company had shown that it adopted written procedures for second level grievance reviews and communicated these procedures to the insureds in the member certificates or other communications to members and providers in late 2005.

**Grievance Register.** The Company was requested to provide a grievance register. The Company provided a listing of all grievances from the examination period.

The listing did not contain the line of business, function and reason for the grievances and contained incomplete information pertaining to specific details related to the listed grievance. The Company indicated the missing information is contained in the text of the "correspondence control" system which is used to document grievance, complaint and claim files. However, the system cannot be readily used as a tool to track grievances.

*It is recommended the Company implement procedures to ensure sufficiently detailed grievance information is included in its register.*

**Grievance File Review.** Twenty-five first level, twenty second level and twenty-five chiropractic grievance files were reviewed to determine if the documentation was sufficient to support the decision made.

One file in the first level grievance review did not contain enough information to determine the status or resolution of the file. The Company indicated the grievance was resolved with the hospital over the telephone but file documentation did not document the resolution.

*It is recommended that the Company reaffirm with its employees that files must include sufficient documentation to support the decision made and indicate the status or resolution of the grievance.*

All grievances tested were initiated and concluded timely.

**Written Decision Letters.** The written decision letters were reviewed to determine if they contained adequate information according to the 2006 NAIC Market Regulation Handbook. The written decisions contained the following required information:

- A statement of the reviewers' understanding of the covered person's grievance.
- The reviewers' decision in clear terms and the contract basis or medical rationale.
- A reference to the evidence or documentation used as the basis for the decision.

- The instructions for requesting a written statement of the clinical rationale.

### **Marketing and Sales**

The examination reviewed the advertising material to determine compliance with applicable statutes, rules and regulations of the North Dakota Insurance Department and the guidelines contained in the NAIC Market Conduct Examiner's Handbook.

The examination reviewed 22 printed, 6 TV, and 2 audio advertisements. Also, from the Company's website 32 advertisements and 14 TV type commercials were reviewed. It was determined that the Company's advertisements all fell into one of three types defined by N.D.C.C. § 45-06-04.

In the printed advertisements reviewed, the sample selections were made up of 20 invitations to inquire, 1 invitation to contract, and 1 institutional advertisement. The other TV and audio advertisements were all 30-second institutional advertisements.

For the printed items, television and web based advertising it was determined the Company disclosed all required information in their solicitations and sales materials as prescribed by N.D.C.C. § 45-06-04. No exceptions noted.

There were no advertisements produced by agents or producers for the exam period. Written and electronic communication between the Company and producers were handled in accordance with applicable statutes, rules and regulations. No exceptions noted.

### **Producer Licensing**

**Producer Listing.** Producer lists were obtained from the Company and the Insurance Department. The Company list was reconciled with the Insurance Department list to determine if all licensed agents were listed with the Department.

Four agents on the Company list were not found on the list provided by the Insurance Department. This appears to be a timing issue. No exceptions noted.

**Producer License.** A sample of 50 policy files was reviewed to determine if the producer was properly appointed and licensed. The producer license was then reviewed to determine if the producer was operating within the scope of their authority.

All sampled producers were writing business for which they were properly licensed. No exceptions noted.

### **Policyholder Service**

**Canceled Policies.** The sample of canceled and nonrenewed policy files was reviewed to determine if insured requested cancellations were handled in a timely manner without excessive paperwork requirements.

Cancellations requested by insureds did not require excessive paperwork and were canceled timely.

**Policy Issuance.** A sample of 50 underwriting files was reviewed to determine if policy issuance was timely. Policy issuance was made in a timely manner. There were no exceptions noted in the review of this area.

### **Underwriting and Rating**

**Underwriting Files.** *The rates charged for the policy coverage are in accordance with filed rates or the company rating plan.* A sample of 50 underwriting files was reviewed to verify all rating factors including age, sex, occupation, territory, health history, deductibles, stop losses, preferred or standard classifications were in accordance with filed rates and Company guidelines. Rates detected were in accordance with filed rates.

Each policy in the sample had the premium recalculated to verify the Company's accuracy and the amount charged to the policyholder. All premiums noted in the sample were accurately calculated and had the proper premium amount charged to the policyholder.

No exceptions were noted in this review.

*Underwriting practices are not unfairly discriminatory.* A sample of 50 underwriting files was reviewed to determine if any unfair discrimination was taking place. Files were rerated to determine if the Company was rating according to filed rates and Company guidelines. Each policy in the sample was handled and rated by the Company according to written guidelines and contained no unfair discrimination or inconsistent rating. The applications reviewed appear to be clear and straightforward. The applications request basic personal information and require the applicant to answer pertinent health-related questions for underwriting purposes.

The policies were properly underwritten. No exceptions were noted in this review.

*Underwriting file documentation adequately supports decisions made.* The sample of 50 underwriting files was reviewed to determine if file documentation adequately supports premiums charged. The files contained necessary information to support the classification, rating and selection decision made. All applications were complete and signed.

Underwriting files were properly documented. No exceptions were noted in this review.

*Medicare supplement underwriting files.* Medicare supplement files were reviewed to determine if they were being properly underwritten and that proper notices were being sent out for replacement coverage. A sample of 49 files was reviewed.

It was determined the Company had not been consistently issuing the notice required by N.D. Admin. Code § 45-06-01.1-15(4) and (5) for Medicare supplement replacement policies. The Company had a policy and procedure in place to comply with the replacement notice requirement but the procedure was not being followed consistently.

The Company has since taken corrective action and implemented system enhancements so that a Medicare supplement replacement policy will not be issued until the replacement notice is received and entered into the system.

*It is recommended that the Company comply with N.D. Admin. Code § 45-06-01.1-15(4) and (5) by providing the required notice regarding the replacement of a Medicare supplement policy for all replacement policies using updated forms.*

The Company also failed to update its Medicare supplement application form to comply with N.D. Admin. Code § 45-06-01.1-15(1) which became effective September 1, 2005. The Company also failed to update the Medicare supplement replacement notice referred to above to include the wording relevant to Medicare Part D and Medicare Advantage coverage.

The Company provided a copy of a March 31, 2006, application for a Medicare supplement policy, Form No. 20000018, with a revision date of 3-04. The form, however, did not include the questions and statements as required by regulation.

The Company's updated application Form No. 20000018 was not approved by the Department until April 18, 2006, even though the revised regulation became effective September 1, 2005.

Thus, for the period September 1, 2005, through April 18, 2006, the Company's use of Form No. 20000018, revision 3-04, violated N.D. Admin. Code § 45-06-01.1-15(1).

*It is recommended the Company revise and file its Medicare supplement forms for approval as required to comply with Department regulations related to Medicare supplement health plans as revised from time to time.*

**Cancellations and Nonrenewals.** *Cancellation/nonrenewal/discontinuance notices comply with policy provisions and state law.*; A sample of 25 canceled policy files was reviewed to determine if cancellation or nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

All cancellations were valid according to policy provisions and state law. The notices included a specific reason and when required, the insured had an "adverse underwriting decision notice" provided to them. Reasons for cancellation were not unfairly discriminatory.

In the sample of 25 policy cancellations, the insureds were provided with adequate notice of cancellation. The cancellation files including insured requested cancellations were properly documented and did not contain misleading billing notices, grace period descriptions or reinstatement offers.

No exceptions were noted in this review.

*Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.* The sample of 25 cancellations was reviewed to ensure that all unearned premiums were correctly calculated and returned to the appropriate party. Unearned premium was recalculated and compared to the amount returned to the policyholders. All unearned premiums were correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

No exceptions were noted in this review.

**Rejections and Declinations Are Not Unfairly Discriminatory.** A sample of 25 declined and rejected applications was reviewed to determine if the company was declining applications for reasons that were unfairly discriminatory. In the 25 files reviewed coverage was rejected in 11 cases due to the applicant not meeting underwriting guidelines regarding height and weight. The remaining 14 applications were rejected because the applicant did not meet underwriting guidelines relating to health. The Company rejected applications based on underwriting guidelines. Also, the Company refunded the appropriate premium.

No exceptions noted in this review.

**Rescission Is Not Made For Nonmaterial Misrepresentation.** A sample of 25 rescinded policies was reviewed to determine if the decisions were valid and decisions did not indicate in any post claim underwriting. The Company provided print outs for 25 sample selections. Rescinded policy files contained "Master", "Current and Prior Coverage", "Explanation of Current Coverage", policy "Limitations", "Invalid Members", "Limitations", and Company premium billings showing the credit of the rescinded member.

Policies were rescinded by request, or for lack of payment or for material misrepresentations in the applications. None of the rescissions indicated post claim underwriting practices. No exceptions noted.

## **Claim Handling**

### **Paid Claims**

**Initial Contact Timely.** The Company has written procedures for initial contact that comply with state laws. A sample of 100 paid claims and a sample of 125 closed-without-payment claims were selected for testing. A time study of acknowledgement times was performed to determine if acknowledgement was timely and in compliance with N.D.C.C. § 26.1-04-03(9)(b). All claims were acknowledged timely. No exceptions noted.

**Investigations Timely.** The Examiners reviewed the Company's 2004 and 2005 Timeliness Standards and the Company's Processing Overview Manual. The Company has written procedures for the investigation of claims and audits the timeliness of claims handling. A sample of 100 paid claims and 125 closed-without-payment claims were selected for testing. Investigation times were measured and determined to be timely and in compliance with N.D.C.C. § 26.1-04-03(9)(c). All claims were investigated timely. No exceptions noted.

**Resolved Timely.** The Examiners reviewed the Company's 2004 and 2005 Timeliness Standards and the Company's Processing Overview Manual. These items were reviewed to determine that Company procedures, training manuals and bulletins and all associated procedures and standards for claims resolution exist and comply with state laws.

The Company uses the Blue Cross Blue Shield Association standard for prompt payment which requires claims to be processed within 30 calendar days but N.D.C.C. § 26.1-36-37.1 requires claims to be settled (paid or denied) within 15 business days. The Company standard is not in compliance with N.D.C.C. § 26.1-36-37.1.

A sample of 100 paid claims and 125 closed-without-payment claims were tested to determine if claims settlement was timely.

One paid claim and two closed-without-payment claims were not settled within 15 business days as required by N.D.C.C. § 26.1-36-37.1.

*For the most part the Company has implemented the 15 business day standard for claims settlement to ensure claims are settled timely and in compliance with N.D.C.C. § 26.1-36-37.1. Only in a few occasions have circumstances prevented the setting of a claim as required by N.D. Cent. Code § 26.1-36-37.1.*

**Correspondence Responded to Timely and Appropriately.** The Examiners determined that all correspondence noted in the samples related to claims was responded to timely and in accordance with state requirements.

**Claim File Documentation.** The Company maintains all documents related to claims on an electronic claim system. A sample of 100 paid claims and 125 closed-without-payment claims were tested to determine if the documentation justified claim determination and evidenced compliance with N.D.C.C. § 26.1-04-03(9).

The Company provided access to their computer systems and associated claims system for the review of claims. Within the company's system, all appropriate locations and screens were reviewed to verify proper handling of each paid claim. Claim files were properly documented and no exceptions were noted.

**Closed-Without-Payment Claims Are Handled in Accordance With Policy Provisions and State Law.** A sample of 125 closed-without-payment claims was selected for testing to determine if denial of claims was based on policy provisions and applicable state laws.

No cases were detected in claims testing where denial of benefits was unfairly discriminatory. Denial of claims were based on policy provisions and effectively communicated to the insured in the Explanation of Benefits.

### **Litigated Claims**

The Company had no litigated claims for the examination period.

### **COB Savings for Claims**

**COB Savings Process.** For the examination period, the Coordination of Benefits Regulation (COB), N.D. Admin. Code § 45-08-01.1-04 states, in part, *"the amount by which the secondary plan's benefits have been reduced must be used by the secondary plan to pay allowable expenses, not otherwise paid, that were incurred during the claim determination period by the person for whom the claim is made."*

To determine compliance with the statute the Company was requested to provide the following information:

1. An explanation of the procedure or process for COB savings and expense accumulators.

2. A list of insureds eligible for COB savings refunds.

Claims in which the Company is the secondary plan process through the claims system ignoring any Other Party Liability (primary insurer) amounts and calculate the amount the Company would have paid on the claim if it were the primary insurer.

The claim system then applies the other insurance payment to the claim and determines if there is a balance left to pay as a secondary payer.

If the balance left to pay is less than what the Company would have paid as prime, the balance is paid in full.

If the balance left to pay is greater than what the Company would have paid as prime, and the service is a covered service by either insurer, and there are dollars available in the member's savings accumulator, the Company would utilize those additional banked dollars to pay the claim.

The Company indicated the member's savings accumulators run on a calendar year basis. Every January 1 the accumulators are restarted at zero.

**Eligible Insureds For COB Savings.** The Company was requested to provide a list of insureds eligible for COB savings refunds. The Company provided a listing of COB banked savings less disbursements for each qualifying member.

To verify the Company was executing the COB savings process a sample of 15 COB savings accounts (by claim) were selected. The data run included the claim number, charged amount, total paid, banked savings amount, savings used and net dollars saved. The Company was requested to provide evidence of COB savings accumulator and disbursement (credit or payment) to the member.

From the listing of banked savings disbursements the amount the Company would be liable for was traced to the claim screen. The COB savings accumulators and eligible expense accumulators were also traced to the claim system. The Explanation of Benefits was then reconciled with the COB savings. The review determined there were COB savings accounts in place.

There were no exceptions noted in this review.

### **Utilization Review**

The Company has a group titled the Utilization Management staff that is responsible for Utilization Review and other duties. This group is responsible for preauthorization requests, prior approvals, admission notification review, and concurrent review. The main responsibility of Utilization Management is the area concerned with procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.

Concurrent review is "the ongoing review for continued medical appropriateness and necessity of the admission to the institutional health care provider." The Company has a Nurse Reviewer perform an initial review of the insured's medical records and all appropriate information. If it

does not meet medical criteria by the Nurse Reviewer, the case is then referred to the Medical Director for peer review.

The information obtained and used for the reviews includes:

- Member's current medical condition
- Any secondary/tertiary diagnosis/procedures
- Physician orders/physician progress notes
- Estimated length of additional stay
- Discharge planning that has been done

The peer review is performed by the Medical Directors based on the information provided at the time the request is received. The Medical Director is charged with contacting the health care provider within one business day of a peer-to-peer conversation request.

The Company has established timeliness and notification standards for this program stated in their processing and handling guidelines. For the examination period the Company was accredited by the Utilization Review Accreditation Committee (URAC) of the American Accreditation HealthCare Commission.

The company has an adequate Utilization Review process in place. There were no exceptions noted in this review.

## **SUMMARY OF RECOMMENDATIONS**

1. *It is recommended the Company implement written record retention policies to ensure compliance with N.D.C.C. § 26.1-03-19.2(1) which requires financial examinations at least every five years. (Page 4)*
2. *It is recommended the Company implement internal procedures to ensure that sufficient information is included in the Complaint Register to enable analysis in areas developing complaints. (Page 7)*
3. *It is recommended the Company implement internal procedures for the preparation of reports to analyze and identify areas developing complaints. (Page 8)*
4. *It is recommended the Company advise insureds of their right to contact the Insurance Department, and include the address or telephone number in correspondence involving complaints. (Page 8)*
5. *It is recommended the Company implement procedures to ensure that all communications involving complaints, appeals and grievances are date-stamped the day they are received to ensure timely handling. (Page 9)*
6. *It is recommended the Company implement procedures to ensure responses to complaints are specific and clearly identify the reason for the denial or limitation of benefits. (Page 9)*

7. *It is recommended the Company implement procedures to ensure all insureds are treated consistently. Furthermore, when guidelines are changed, it is recommended the Company take the appropriate steps to ensure all insureds, not just those filing complaints or appeals, are treated equally and the benefits provided are consistent with policy provisions. (Page 9)*
8. *For terms used in documents other than its benefit plans and summary plan descriptions, it is recommended the Company define terms such as the term "significant progress" that may be used to settle claims so claimants and providers have the opportunity to intelligently appeal claims. (Page 10)*
9. *It is recommended the Company implement procedures to ensure it provides responses to all complaints which are sufficiently specific and clear rather than referring complainants/appellants to previous EOBs for an explanation. (Page 10)*
10. *It is recommended the Company implement procedures to ensure new and revised policies that adversely affect insureds are communicated to insureds and providers at the time of or prior to their implementation. (Page 10)*
11. *It is recommended the Company implement procedures to reprocess claims and prior approvals when necessary and to ensure unfair discrimination in the benefits provided does not exist between insureds who file complaints or appeals and those who do not. (Page 11)*
12. *It is recommended the Company implement procedures to ensure it takes adequate steps to investigate and to verify the work-related nature of claims when claims are denied by other insurers as being non work related. (Page 11)*
13. *It is recommended the Company reaffirm with its employees that a file's complete chronology of events is to be provided to the Insurance Department. (Page 11)*
14. *It is recommended the Company implement procedures to ensure insureds are informed of the limitations involving nonparticipating providers when inquiring about benefits and when requesting prior approval or preauthorization. (Page 12)*
15. *It is recommended the Company implement procedures to ensure sufficiently detailed grievance information is included in its register. (Page 13)*
16. *It is recommended that the Company reaffirm with its employees that files must include sufficient documentation to support the decision made and indicate the status or resolution of the grievance. (Page 13)*
17. *It is recommended that the Company comply with N.D. Admin. Code § 45-06-01.1-15(4) and (5) by providing the required notice regarding the replacement of a Medicare supplement policy for all replacement policies using updated forms. (Page 16)*
18. *It is recommended the Company revise and file its Medicare supplement forms for approval as required to comply with Department regulations related to Medicare supplement health plans as revised from time to time. (Page 16)*

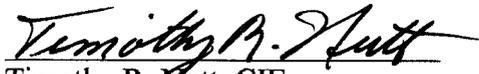
## ACKNOWLEDGMENT

The customary insurance examination practices and procedures as promulgated by the National Association of Insurance Commissioners have been followed in the performance of this Market Conduct Examination of **Noridian Mutual Insurance Company** as of December 31, 2005, consistent with the Insurance Laws of the State of North Dakota.

In addition to the undersigned, the following representatives of Huff, Thomas & Company and the North Dakota Insurance Department participated in the examination of Noridian Mutual Insurance Company:

Cecil W. Thomas, CIE, CFE	Supervising Examiner
James P. Benham, CIE	Participating Examiner
Charles Simon, CFE, AIE	Participating Examiner
Craig Burns Esq.	Participating Examiner
Brandon Thomas	Participating Examiner

Respectfully submitted,



Timothy R. Huff, CIE  
Examiner-In-Charge  
Huff, Thomas & Company  
For the State of North Dakota  
Insurance Department

