REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

GUARANTEE TRUST LIFE INSURANCE COMPANY

NAIC# 64211

AS OF

DECEMBER 31, 2007

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Department of Insurance
State of Arizona
Market Oversight Division
Examinations Section
Telephone: (602) 364-4994
Fax: (602) 364-4998

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

GUARANTEE TRUST LIFE INSURANCE COMPANY
NAIC # 64211

The above examination was conducted by Sandra Lewis, CIE, MCM, Market Conduct Examiner-in-Charge; Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; and James R. Dargavel, CIE, MCM, Examinations Data Specialist.

The examination covered the period of January 1, 2007, through December 31, 2007.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, and James R. Dargavel, CIE, MCM, Examinations Data Specialist, the examination of Guarantee Trust Life Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

Sandra Lewis, CIE, MCM
Market Conduct Examiner-in-Charge

Subscribed and sworn to before me this 2ND day of JUNE, 2009.

Notary Public

My Commission Expires 12/24/2011

FOREWORD

This targeted market conduct examination of Guarantee Trust Life Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent market conduct examiners contracting with the Department. A targeted market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following components of the Company's major medical and other health insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims; and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from January 1, 2007, through December 31, 2007 for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to

determine compliance with the standard. The standards applied during the examination are stated in this Report at page 22.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners utilized both examination by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

Denied claim file sampling was based on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, Theresa A. Tyc, Director, Product Approval and Compliance. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was generally less than 5%, the standard was considered as "met." A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

COMPANY BACKGROUND

The Company processes claims in its Home Office (HO). In addition claims are processed by three Third Party Administrators (TPA's). The TPAs processing claims on behalf of the Company are Insurers Administrative Corporation (IAC), Allied National Companies (ANC) and First Administrators, Inc. (FA). The Examiners selected samples from each of the four claim processing systems. The table below lists the lines of business processed by each of the four entities.

Name	Lines of Business Processed
HO	Individual Specified Disease; Individual Hospital Indemnity; Individual Accident; Blanket Accident and Sickness; Group High Deductible Major Medical
IAC	Individual Major Medical
ANC	Individual Short-Term Major Medical
FA	Group Major Medical

The Examination Report has been broken down to show the findings by examination standard for each of the claim processing offices.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 22, and the examination findings are reported beginning on page 8.

1. The Company failed Standard No. 1, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to conduct a timely and reasonable investigation of claims before denying claims. The Examiners found that:
    a. For claims processed by the HO claim system, the Company:
        1. Failed to investigate before denying claims for physical therapy prior to October 1, 2007, although the contract form GC-1200 did not specifically exclude coverage;
        2. Also appeared to violate A.R.S. § 20-448(B), by paying claims for physical therapy on and after October 1, 2007, but failing to reprocess claims incorrectly denied prior to that date;
        3. Failed to investigate eight (24%) of 34 HO claims denied using Reason Code LT; and
        4. Adopting a business practice of considering only one of multiple underlying diagnoses in determining whether coverage was to be denied for a preexisting condition.
    b. For claims processed under the IAC claim system, the Company failed to investigate 11 (24%) of 45 files reviewed.

2. The Company failed Standard No. 2 (file review), in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a), by failing to provide a reasonable explanation, including reference to the specific policy provision(s) relied upon, for the denial of the claim in sufficient detail to allow members and/or providers to appeal the adverse decision.

    a. For claims processed and denied as "not covered" under the HO claim system, the Company appeared to violate this standard in 91 (71%) of 129 files reviewed;

    b. For claims processed and denied using "free form text" under the HO claim system, the Company appeared to violate this standard in eight (24%) of 34 files reviewed; and

    c. For claims processed and denied as "not covered" under the IAC claim system, the Company appeared to violate this standard in seven (16%) of 45 files reviewed.

3. The Company failed Standard No. 2 (forms review), in apparent violation of A.R.S. §§ 20-461(A)(1) and (A)(15) and 20-2533(D). The Examiners found that:

    a. For claims processed by the HO claim system, the Company used one EOB form and one denial letter reviewed that failed to notify the member of the right to appeal.

    b. For claims processed by the IAC claim system, the Company:

        1. Used one EOB form that to fail to notify the member of the right to appeal; and

        2. Used one denial form letter that failed to prominently display appeal information and to provide the correct information about the time allowed for filing an appeal.

    c. For claims processed under the ANC claim system, the Company:

        1. Used one notice of that right to appeal that:

            a. Misstated the time allowed for filing an appeal;

            b. Misstated the available levels of appeal; and

            c. Failed to correctly state the name of the issuing insurer;

        2. Used one EOB form that:

a. Misstated the time allowed for filing an appeal; and

b. Failed to correctly state the name of the issuing insurer.

d. For claims processed under the FA claim system, the Company used one EOB form that

1. Failed to provide the correct information about the time allowed for filing a claim; and

2. Failed to correctly state the name of the issuing insurer.

4. The Company failed Standard No. 3 with regard to the IAC and HO claim processing systems in apparent violation of A.R.S. § 20-462(A) by underpaying interest to insureds on first party claims not paid within 30 days after the receipt of an acceptable proof of loss.

PROCEDURES PERFORMED

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted. The Examiners conducted a review of the claim forms associated with the denial of claims during the examination period, as well as policies and procedures for calculating and paying interest on reprocessed claims.

Home Office (HO)

The Examiners reviewed the one claims-related request for reconsideration processed during the examination period. No trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or EOB messages were developed from this source.

The Company provided a population of 1,054 Arizona claims denied during the examination period. The Examination Data Specialist used ACL software to analyze this information to determine the most frequently denied procedure codes and/or most frequently used reasons for denial. This analysis was used to extract a subpopulation of 462 denied claims in six categories based on the reasons given for denial. During the Phase I review, the Examiners selected six random samples of 158 files based on the categories of denial code reasons identified during the claims analysis. Based on the results under the Phase I examination, the Department initiated a Phase II examination selected three additional samples

totaling 82 denied claims for review. Therefore, a total of 240 files were reviewed during the Phase I and Phase II examinations as shown by the table on page 7.

Insurers Administrative Corporation (IAC)

The Examiners reviewed one ADOI complaint and a sample of one claims-related request for reconsideration selected from the Company's appeal log containing a population of nine appeals. No trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or EOB messages were developed from this source.

The Company provided a population of 566 Arizona claims denied during the examination period. The Examination Data Specialist used ACL software to analyze this information to determine the most frequently denied procedure codes and/or most frequently used reasons for denial. This analysis was used to extract a subpopulation of 67 denied claims in three categories based on the reasons given for denial. During the Phase I review, the Examiners selected three random samples totaling 45 files based on the categories of denial code reasons identified during the claims analysis. Based on the results under the Phase I examination, the Department initiated a Phase II examination selected one additional sample totaling 18 denied claims for review. Therefore, a total of 63 files were reviewed during the Phase I and Phase II examinations as shown on the table on page 7.

Allied National Corporation (ANC)

The Examiners did not review any claims-related requests for reconsideration. Therefore, no trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or EOB messages were developed from this source.

The Company provided a population of 241 Arizona claims denied during the examination period. The Examination Data Specialist used ACL software to analyze this information to determine the most frequently denied CPT-4 codes, procedure codes and/or the most frequently used reasons for denial. This analysis was used to extract a subpopulation of 102 denied claims in two categories based on the reasons given for denial. During the Phase I review, the Examiners selected two random samples of 102 files based on the categories of denial code reasons identified during the claims analysis as shown on the table on page 7.

First Administrators (FA)

The Company did not process any denied claims during the examination period. Therefore, no denied claim file samples were available for review, and the Examiners' review was limited to a review of procedures and forms provided by the Company.

Summary of Claim Sampling by Claim Processing System

The following table summarizes the samples selected and reviewed by the Examiners:

ADOI Prefix	Description	Sub-Population	Phase I Sample	Phase II Sample	Total Sample
HO-MM-NC	Medicare Payment	31	31		31
HO-HIP-PX	Preexisting Condition	20	20		20
HO-HIP-NC	Not Covered	207	27	53	80
HO-ACC-NC	Not Covered	71	27	22	49
HO-ACC-FF	Free Form	54	27	7	34
HO-ACC-NA	Other Insurance	79	26		26
	HO Subtotal =	**462**	**158**	**82**	**240**
IAC-NR	Blank	11	11		11
IAC-PR	Preexisting Conditions	7	7		7
IAC-NC	Not Covered	49	27	18	45
	IAC Subtotal =	**67**	**45**	**18**	**63**
ANC-STM-PXN	Pre-ex limitation or exclusion	41	41		41
ANC-STM-PXCV	Pre-ex limitation or exclusion	61	61		61
	ANC Subtotal =	**102**	**102**		**102**
	Totals =	**631**	**305**	**100**	**405**

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's appeals, denied claims, policy forms, EOB forms and appeal forms, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F)

No denied claims were processed by FA during the examination period. The Examiners reviewed six claim samples from HO, three claim samples from the IAC, and two claim samples from ANC and found apparent violations of Standard 1 as described below:

Home Office (HO) Claim System

The Examiners reviewed six samples of denied claims processed by HO and found apparent violations of Standard 1 as described below. Based on the Examiners' review of the Company's denied health care claims, policy forms and EOB forms, the Company failed to meet Standard 1 for review with regard to:

1. Physical therapy claims processed under policy form GC-1200 (Plan Code 805);
2. Claims denied under Reason codes LT; and
3. Claims containing multiple diagnoses.

Physical therapy claims processed under policy form GC-1200

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 49 (69%) Accident Only (ACC) denied claim files from a subpopulation of 71 files denied using one or more of the following four reason codes indicating the claim was not a covered expense under the terms of the policy: 55, C2, NC and S9. The Company failed to meet the standard for the sample of claims denied under Reason code S9, which states "Not a covered expense under the terms of you policy." The Examiners identified nine claims for physical therapy, all submitted for insureds covered under policy form GC-1200 (Plan Code 805), that had been denied using this Reason Code.

Company documents show that on or about October 1, 2007, as the result of an appeal, the Company concluded that there was no actual exclusion in the policy form for physical therapy. On and after that date, the Company began to pay claims for physical therapy submitted

by or on behalf of its insureds covered under policy form GC-1200. The Company failed, however, upon realizing its mistake, to reprocess and pay claims previously denied incorrectly prior to October 1, 2007.

The Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation before denying claims prior to October 1, 2007. The Company also appears to have violated A.R.S. § 20-448(B) by making or permitting unfair discrimination among individuals of the same class in the benefits payable under a disability policy by failing to reprocess claims it had previously denied in error. Reference PF # 007.

Claims Denied Under Reason Code LT

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 34 (63%) files from a subpopulation of 54 ACC "free form" claim files denied using reason codes 98 and/or LT, indicating the claim was denied by letter or by language entered as free-form text on the EOB by the claims examiner. Fifteen of the 34 claims reviewed were denied using Reason Code LT, which states: "For further information refer to letter."

Company failed Standard 1, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F), by failing to conduct a reasonable investigation prior to the denial of eight (24%) of 34 claims denied under Reason code LT. Reference PF # 011 and PF # 016.

Subsequent Events

Subsequent to the issuance of Preliminary Finding 011 and #016, the Company reprocessed seven of the eight claims denied under Reason code LT. One claim was not reprocessed, because it had been paid by other insurance. The Company paid benefits of $656.45 to the insured on the seven reprocessed claims. The Company also paid interest on the previously denied claims in the amount of $34.91, for a total payment of $691.36. The Examiners have provided this information and supporting documentation to the Department. (Note: Additional interest was later paid on these claims, as discussed below under the discussion of Standard 3.)

Claims with Multiple Diagnoses Denied for Preexisting Conditions

Of the six categories of denied claims, the Examiners selected samples during Phase I totaling 20 (100%) files from a subpopulation of 20 files denied due to preexisting conditions. Based on information provided by the Company, the Company failed Standard 1 in apparent

violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by adopting as its stated business practice the consideration of only the first diagnosis listed on the claim in determining whether a claim should be paid, denied or investigated further. This business practice led to the inappropriate denial of one of the 20 claims reviewed for the stated reason of a preexisting condition where one of the multiple diagnoses listed on the claim was a covered benefit under the policy. Reference PF # 015.

Insurers Administrative Corporation (IAC)

The Examiners reviewed three samples of denied claims processed by IAC and found apparent violations of Standard 1 as described below. Based on the Examiners' review of the Company's denied health care claims, policy forms and EOB forms, the Company failed to meet Standard 1 for review with regard to claims denied under Reason codes 17 and 21.

Of the three categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 45 (92%) files from a subpopulation of 49 files denied using one or more of the following four reason codes indicating the claim was denied as "not covered" under the policy: 17, 21, 31 and 5C. Of these files, 11 were denied using Reason Code 17, and 33 were denied using reason Code 21.

The Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F), with regard to 11 (24%) of 45 claims reviewed, because the Company failed to conduct a reasonable investigation prior to the denial of claims. Reference PF # 004 and PF # 018.

- Two claims were denied under Reason code 17, which states: "This service is not covered under the Plan/Policy".
- Nine claims were denied under Reason code 21, which states: "This condition is not covered, please refer to policy rider".

Subsequent Events

Five claims denied under Reason code 21 were reprocessed by the Company as a result of this examination. The Company paid benefits of $414.83 on four of the five reprocessed claims. The Company also applied $141.40 to the deductible of one insured as a result of

reprocessing the fifth claim. The Examiners have provided this information and supporting documentation to the Department.

Summary of Findings – Standard 1 File Review

ADOI Prefix	Population	Sample	Exceptions	Error Ratio	PF #
HO-ACC-NC	71	49	Business Practice	n/a	007
HO-ACC-FF	54	34	8	24%	011/016
HO-HIP-PX	20	20	Business Practice	n/a	015
IAC-NC	49	45	11	24%	004/018
Totals =	**194**	**148**	**19**	**13%**	

A 13% error ratio does not meet the standard; therefore recommendations are warranted.

Recommendations 1 through 10 (Standard 1)

Within 90 days of the filed date of this Report, the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company conducts timely investigation of claims and does not deny claims without conducting a reasonable investigation to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);
2. Provide documentation that procedures and controls are in place to ensure that the Company does not permit unfair discrimination among individuals of the same class in policy benefits payable as prescribed under A.R.S. § 20-448(B);
3. Provide documentation that procedures and controls are in place to ensure that the Company conducts a timely investigation of claims where multiple diagnoses are included on the claim form and does not deny claims as a preexisting condition if other covered diagnoses were treated during the service;
4. Reprocess claim HO-HIP-PX-013 identified under Preliminary Finding #015 which was denied as preexisting, to determine if this claim was denied inappropriately and without adequate investigation as "not covered" when the provider billing indicated that treatment was rendered for services that were not preexisting and not excluded under the policy;
5. Reprocess claims IACNC-007, IACNC-010, IACNC-026, IACNC-027, IACNC-031 and IACNC-040 identified under Preliminary Finding #004 and Preliminary Finding #018, which were denied under Reason codes 17 and 21, to determine if

these claims were denied inappropriately and without adequate investigation as "not covered" when the provider billing indicated that treatment was rendered for services not excluded under the policy;

6. Perform a self-audit of all HO claims involving multiple diagnoses denied for preexisting conditions during the three years prior to the date the Report is issued to the Company to determine whether other claims denied as preexisting have been denied inappropriately;

7. Perform a self-audit of all HO physical therapy claims denied under policy form GC-1200 during the two years prior to October 1, 2007, to determine whether other physical therapy claims had been denied inappropriately and without adequate investigation due to the fact that physical therapy services were covered under the policy;

8. Perform a self-audit of all IAC claims denied under Reason codes 17 and 21 during the three years prior to the date the Report is issued to the Company to determine whether other claims denied under Reason codes 17 and 21 have been denied inappropriately and without adequate investigation due to the fact that the covered services were provided along with services that were not covered under the policy;

9. Pay restitution including interest at the legal rate for any claim identified from the self-audits as having been denied inappropriately; and

10. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's appeals, denied claims, policy forms, EOB forms, appeal forms and claim denial letters, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.	A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a)

No claims were denied by the FA claim system during the examination period. The Examiners reviewed six claim samples from the HO claim system, three claim samples from the IAC claim system, and two claim samples from the ANC claim system. The Examiners found apparent violations of Standard 2 as described below:

FILE REVIEW

Home Office (HO)

Based on the Examiners' review of six samples of the Company's denied health care claims, policy forms, EOB forms and claim denial letters, the Company failed to meet Standard 2 for review with regard to:

1. Accident Only Policy (ACC) Claims denied under Reason code S9;
2. Hospital Indemnity Policy (HIP) Claims denied under Reason code S9;
3. Claims denied under Reason code 98 and LT; and
4. One EOB Form and one claim denial letter.

ACC Claims Denied Under Reason Code S9

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 49 (69%) files from a subpopulation of 71 Accident Only (ACC) claim files denied using one or more of the following four reason codes indicating the claim was not covered under the policy: 55, C2, NC, and S9. Of the files selected for review, 33 claims were denied using Reason Code S9, which states: "Not a covered expense under the terms of your policy."

The Company failed Standard 2 in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a) with regard to 32 (65%) of the 49 files reviewed by failing to provide a reasonable explanation, including reference to the specific policy provision(s) relied upon, for the denial of the claim in sufficient detail to allow members and providers to prepare a meaningful appeal of the adverse decision. Reference PF # 006 and PF # 020.

HIP Claims Denied Under Reason Code S9

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 80 (39%) files from a subpopulation of 207 Hospital Indemnity Policy (HIP) claim files denied using one or more of the following three reason codes indicating the claim was not covered under the policy: 73, A1, and S9. Of the files selected, 66 claims were denied using Reason Code S9, which states: "Not a covered expense under the terms of your policy."

The Company failed Standard 2 in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a) with regard to 59 (74%) of the 80 files reviewed, by failing to provide a reasonable explanation, including reference to the specific policy provision(s) relied upon, for the denial of the claim in sufficient detail to allow members and providers to prepare a meaningful appeal of the adverse decision. Reference PF # 009 and PF # 018A.

Claims Denied Using Reason Code LT

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 34 (63%) files from a subpopulation of 54 Accident Only (ACC) files denied using one or more of the following two reason codes indicating the claim was denied by letter or by language entered on the EOB by the claims examiner: 98 and LT. Of the files selected, 15 claims were denied using Reason Code LT, which states: "For further information refer to letter." The letter provided a reason for the denial; however, the Examiners were unable to locate, and the Company was unable to provide, any policy exclusion for the specific care provided.

The Company failed Standard 2 in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a) with regard to 8 (24%) of the 34 files reviewed, by failing to provide a reasonable explanation, including reference to the specific policy provision(s) relied upon, for

the denial of the claim in sufficient detail to allow members and providers to prepare a meaningful appeal of the adverse decision. Reference PF # 012 and PF # 017.

Subsequent Events

As noted under the discussion of Standard 1 above, the Company reprocessed and paid seven of the eight claims cited. The Company did not pay the eighth claims because it had been paid under other coverage.

Insurers Administrative Corporation (IAC)

Based on the Examiners' review of three samples of the Company's denied health care claims, policy forms, EOB forms and claim denial letters, the Company failed to meet Standard 2 as described below:

Claims Denied Under Reason Codes 17 and 21

Of the three categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 45 (92%) files from a subpopulation of 49 IAC claim files denied using one or more of the following four reason codes indicating the claim was denied as "not covered" under the policy: 17, 21, 31, and 5C. Of these, 11 claims were denied using Reason Code 17, which states: "This service is not covered under the Plan/Policy." Thirty-three claims were denied using Reason Code 21, which states: "This condition is not covered, please refer to policy rider."

The Company failed Standard 2 in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a) with regard to seven (16%) of the 45 files reviewed, by failing to provide a reasonable explanation, including reference to the specific policy provision(s) relied upon, for the denial of the claim in sufficient detail to allow members and providers to prepare a meaningful appeal of the adverse decision. Six of the cited files were denied using Reason Code 17; one of the cited files was denied using Reason Code 21. Reference PF # 005 and PF # 019.

Summary of Findings – Standard 2 File Review

ADOI Prefix	Population	Sample	Exceptions	Error Ratio	PF #
HO-ACC-NC	71	49	32	65%	006/020
HO-HIP-NC	207	80	59	74%	009/018A
HO-ACC-FF	54	34	8	24%	012/017
IAC-NC	49	45	7	16%	005/019
Totals =	**381**	**208**	**106**	**51%**	

A 51% error ratio does not meet the standard; therefore recommendations are warranted.

FORMS REVIEW

As a result of the review of the EOB forms and denial letters issued by the Company during the examination period the Examiners identified apparent violations of Standard 2. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified, and therefore recommendations are warranted.

Home Office (HO)

During the examination period, the Company used one EOB form and one denial letter that each failed to notify the member of the right to appeal an adverse claim decision. Neither of the forms identified in this review contained a form number.

The Company therefore failed Standard 2 in apparent violation of A.R.S. § 20-2533(D). Reference PF # 014.

Insurers Administrative Corporation (IAC)

During the examination period, the Company used:

- One EOB form that failed to notify the member of the right to appeal; and
- One denial letter that
    i. Failed to prominently display the notice of the right to appeal; and
    ii. Misstated the time for filing a first level appeal as 90 days.

Neither of the forms identified in this review contained a form number.

The Company therefore failed Standard 2 in apparent violation of A.R.S. § 20-2533(D). Reference PF # 003.

Allied National Corporation (ANC)

During the examination period, the Company used:

- One notice of appeal rights (#ANI Form A2 01/01/03) that:
  i. Misstated the time allowed for filing a first level appeal as180 days;
  ii. Misstated the pertinent levels of appeal by indicating that the second-level review was the final level, and therefore failing to notify the member of the right to an external independent review; and
  iii. Misstated the name of the issuing insurer.
- One EOB form that
  i. Misstated the time allowed for filing a first-level appeal as 60 days; and
  ii. Misstated the name of the issuing insurer.

The EOB form cited did not contain a form number.

The Company therefore failed Standard 2 in apparent violation of A.R.S. §§ 20-461(A)(1) and 20-2533(D). Reference PF # 013.

First Administrators (FA)

During the examination period, the Company used an EOB form that:

- Misstated the time allowed for filing an appeal as 180 days; and
- Misstated the name of the issuing insurer.

The EOB form cited did not contain a form number.

The Company therefore failed Standard 2 in apparent violation of A.R.S. §§ 20-461(A)(1) and 20-2533(D). Reference PF # # 001.

Recommendations 11 through 15 (Standard 2)

Within 90 days of the filed date of this Report, the Company should:

11. Provide documentation that procedures and controls are in place to ensure that the Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision to comply with A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a);

12. Provide documentation that all EOB messages and claim denial letters have been modified to notify the member of the right to appeal to comply with A.R.S. § 20-2533(D);

13. Provide documentation that all EOB messages and claim denial letters have been modified to prominently display appeal information to comply with A.R.S. § 20-2533(D);

14. Provide documentation that all EOB messages and claim denial letters have been modified to provide the correct information regarding the time for filing an appeal and/or levels of available appeal, to comply with A.R.S. §§ 20-2533(D), 20-2535(A) and/or 20-2536(A); and

15. Provide documentation that all appeal notices and/or EOB forms have been modified to correctly state the name of the issuing insurer to comply with A.R.S. § 20-461(A)(1).

EXAMINATION FINDINGS – FAILED STANDARD 3

Based on the Examiners' review of appeals, denied claims, policy forms, EOB forms and the information provided by the Company in response to Attachment B-Interrogatories, the Company failed, with regard to claims paid to insured's, to meet the following standard for review:

#	STANDARD	Regulatory Authority
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims.	A.R.S. § 20-462(A)

Home Office (HO)

Based on the Examiners' review of the Company's denied health care claims, policy forms, EOB forms and claim denial letters, the Company failed to meet Standard 3 for review with regard to:

1. Reprocessed claims HO-ACC-NC-035 through 047; and
2. Reprocessed claims HO-ACC-FF-018 through 022 and HO-ACC-FF-032 through 034.

Reprocessed Claims HO-ACC-NC

During the examination, the Examiners reviewed 13 denied claims (HO-ACC-NC-035 through HO-ACC-NC-047) that had been voluntarily reprocessed by the Company before the start of this examination. At the time of the claim payment the Company paid interest on each of the 13 reprocessed claims. The Company paid these claims, including interest, directly to the insured. The Company underpaid the interest due based on the formula prescribed by A.R.S. § 20-462(A).

The Company failed Standard 3 with regard to 13 (100%) of 13 reprocessed claims, in apparent violation of A.R.S. § 20-462(A). PF #021.

Subsequent Events

Subsequent to the issuance of Preliminary Finding 021, the Company reprocessed the 13 claims and paid additional interest to the insured in the amount of $66.42. The Examiners have provided this information and supporting documentation to the Department.

Reprocessed Claims HO-ACC-FF

During the examination, the Examiners criticized eight denied claims (HO-ACC-FF-018 through HO-ACC-022 and HO-ACC-032 through HO-ACC-034) for allegedly being improperly denied. Subsequent to the criticism of these files, the Company voluntarily reprocessed these eight claims. No payment was made on file HO-ACC-FF-033 because it had been paid by other insurance. As discussed under Standard 1 above, the Company paid benefits on the remaining seven claims and paid these benefits, including interest, directly to the insured. The Company underpaid the interest at the time these claims were reprocessed and paid.

The Company violated Standard 3 with regard to seven (88%) of eight reprocessed claims, in apparent violation of A.R.S. § 20-462(A). PF #022.

Subsequent Events

Subsequent to the issuance of Preliminary Finding 022, the Company reprocessed the seven claims and paid additional interest to the insured in the amount of $5.21. The Examiners have provided this information and supporting documentation to the Department.

Insurers Administrative Corporation (IAC)

Based on the Examiners' review of the information provided by the Company in response to Attachment B-Interrogatories, the Company failed to meet the standard for claims paid to insured's as follows:

In response to Request 003 IAC provided a copy of a document titled "ARIZONA TIMELY PAYMENT OF CLAIMS PROCEDURES", which describes the Company's procedures for calculating and paying interest. The Company's procedures for calculating and paying interest result in the underpayment of interest, because:

- The statute requires the use of calendar days in computing interest, rather than working days as specified in IAC's procedures; and
- The procedure pays interest starting on and after the 30th day from the date the claim is received, whereas the statute requires interest to be paid from the date the claim was received.

Based on information provided by the Company, the Company failed Standard 3 by adopting procedures that result in the underpayment of interest to insureds on first party claims not paid within 30 days after the receipt of an acceptable proof of loss, in apparent violation of A.R.S. § 20-462(A). Reference PF # 002

Recommendations 16 through 19 (Standard 3)

The Examiners recommend that, to comply with A.R.S. § 20-462(A), the Company, within 90 days of the filed Report, should:

16. Provide documentation that the Company has appropriate policies and procedures in place for the payment of interest at the legal rate of 10% per annum on all claims submitted by or paid directly to an insured whenever such claims are paid more than 30 days; after receipt of adequate proofs of loss, as prescribed by A.R.S. § 20-462(A);
17. Perform a self-audit of all claims paid directly to the insured during the three years prior to the date of the Report, to determine if appropriate interest was paid on those claims not paid within 30 days after receipt of adequate proofs of loss;
18. Pay interest at the legal rate of 10% per annum from the date the claim was received until the date the claim was paid for any claim identified from the self-audit as not having been paid within 30 days of receipt of an acceptable proof of loss; and
19. With each payment of interest, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification of claims were interest was owed.

SUMMARY OF STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).		X