



Report on

Market Conduct Examination

of

Federated Mutual Insurance Company

Owatonna, Minnesota

by Representatives of the
North Carolina Department of Insurance

as of

January 21, 2016

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Raleigh, North Carolina
January 21, 2016

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Commissioner of Insurance
Department of Insurance
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Raleigh, North Carolina 27603

Honorable Mike Rothman
Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, Minnesota 55101

Honorable Commissioners:

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

Federated Mutual Insurance Company
(NAIC #13935)

NAIC Exam Tracking System Exam Number: NC299-M91
Owatonna, Minnesota

hereinafter generally referred to as the Company, at the Company's office located at 121 East Park Square, Owatonna, Minnesota and at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Department conducted a target examination of the Company. This examination commenced on December 7, 2015, and covered the period of January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through January 4, 2016. This action was taken due to analysis of the market conduct annual filing submission. All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive, but included a limited review of the Company's practices and procedures in utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring. The findings and conclusions contained within the report are based solely on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 0 percent tolerance level for timeliness of utilization review, member appeal and grievance acknowledgement and determination letters. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals and grievances. Sample sizes were generated via an Audit Command Language (ACL) program with a random sample taken from a given population. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

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

Utilization Management – Failure to provide timely determinations for utilization review requests; failure to provide compliant written notification letters to covered persons for utilization reviews and member appeals; and failure to properly address appeal and grievance procedures within policy guidelines.

Policyholder Grievances – Failure to provide a compliant written acknowledgement letter to members.

Provider Availability and Accessibility - Failure to establish policies and procedures for arranging health care services outside of the service area when providers are not available within the area, including provisions for emergency services received outside of the service area.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking “INSURANCE DIVISIONS” then “Legislative Services”.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

UTILIZATION MANAGEMENT

The Company’s Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Utilization Management Program. This Program is integrated with other operational areas of the Company in adherence to the provisions of NCGS 58-50-61.

Policies and Procedures

The Company’s Utilization Management policies and procedures were examined to determine compliance with appropriate North Carolina statutes. The policy guidance within the

Company's 'State Law Matrix' for Utilization Review (revised October 2009) utilized by Telligen (Third Party Administrator) contains notice requirements for non-certification and adverse appeal decisions which do not reference the 'Health Insurance Smart NC' program, therefore the policy does not adhere to the provisions of NCGS 58-50-61.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning. Written noncertifications are communicated to members as required by the provisions of NCGS 58-50-61.

During the examination period, the Company received a total of 599 utilization review requests, consisting of prospective, concurrent, and retrospective reviews. One hundred thirty one utilization review files were examined to assess the Company's compliance with the provisions of NCGS 58-50-61, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 based on the following:

- Four files contained a noncompliant adverse determination letter which did not properly reference the availability of the 'Health Insurance Smart NC' program. This area of the letters reflected the name of an expired program.
- An adverse determination letter was neither sent to the member nor the provider within one file.
- The review was not completed and communicated within three business days within one file.

Appeals

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

Appeal Records Review

The Company received a total of ten member appeals during the examination period. The total population of ten appeal files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(k) within eight files which contained a non-compliant written adverse notification to the covered person based on the following:

- Eight files contained a notification letter which did not include a statement of the reviewer's understanding of the reason for the covered person's appeal.
- Eight files contained a notification letter which did not adequately reflect the professional qualifications and licensure of the person reviewing the appeal to the extent of justifying the reviewer's qualifications relative to the member's clinical issues.
- Four files contained a notification letter which did not reference the availability of the 'Health Insurance Smart NC' program. This area of the letters reflected the name of an expired program.

One of the first-level appeal files reviewed was escalated to a second-level grievance request. A review of this second-level grievance file revealed that the Company did not adhere to the provisions of NCGS 58-50-62(h)(8), as the written adverse notification to the covered person of the decision did not contain notice of the availability of the Commissioner's office for assistance, including contact information. In addition, the notification erroneously identified the appeal as a first-level review instead of a second-level review.

The average service time to process a member appeal was 14 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	9.1
8 - 14	4	36.4
15 - 21	5	45.4
22 - 30	1	9.1
Total	11*	100.0

*Includes first- and second-level grievance reviews.

Expedited Appeal Records Review

The Company received a total of four expedited member appeals during the examination period. The total population of four expedited appeal files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 within one file which contained a non-compliant written adverse notification to the covered person based on the following:

- The notification letter did not adequately reflect the professional qualifications and licensure of the person reviewing the appeal to the extent of justifying the reviewer's qualifications relative to the member's clinical issues.
- The notification letter did not properly reference the availability of the 'Health Insurance Smart NC' program. This area of the letter reflected the name of an expired program.

One first-level expedited appeal file reviewed was escalated to second-level grievance review. A review of this second-level grievance file revealed no adverse trends or unfair trade practices.

POLICYHOLDER GRIEVANCES

The Company received a total of four member grievances during the examination period. The total population of four grievance files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62, as within three files the acknowledgement letter to the member did not contain information on how to submit written material.

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

Service Days	Number of Files	Percentage of Total
8 - 14	2	40.0
15 - 21	1	20.0
22 - 30	2	40.0
Total	5*	100.0

*Includes first- and second-level grievance reviews.

PROVIDER NETWORK AVAILABILITY AND ACCESSIBILITY

The Company's policies and standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards were reviewed. The Company did not adhere to the provisions of 11 NCAC 20.0301(3) and 11 NCAC 20.0302(3), as it failed to establish policies and procedures during the examination period for developing a method for arranging or providing health care services outside of the service area when providers are not available in the area, as well as provisions for emergency services received outside of the service area.

COMMENTS, RECOMMENDATIONS AND DIRECTIVES

The Company must complete and reinforce corrective actions which have been drafted during and as a result of this target examination. These corrective actions must include but are not limited to: adherence to revised Utilization Management policies and procedures; compliance with statutory requirements regarding member utilization review, appeal and grievance written notification decisions and acknowledgement letters; and adherence to revised provider availability/accessibility policies and procedures.

CONCLUSION

A target examination has been conducted on the market conduct affairs of Federated Mutual Insurance Company for the period January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through January 4, 2016.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation

Handbook procedures, including analyses of Company operations in the areas of utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring.

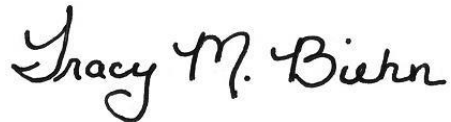
In addition to the undersigned, Darla Wright, MCM, North Carolina Market Conduct Senior Examiner, participated in this examination.

Respectfully submitted,

Handwritten signature of Scott D. Grindstaff in black ink.

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Handwritten signature of Tracy M. Biehn in black ink.

Tracy M. Biehn, MBA, MCM, LPCS
Deputy Commissioner
Market Regulation Division
State of North Carolina