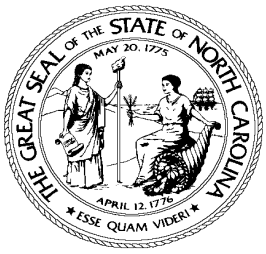

Report on

Market Conduct Examination

of

FirstCarolinaCare Insurance Company, Inc.

Pinehurst, North Carolina

by Representatives of the

North Carolina Department of Insurance

as of

November 6, 2015

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Raleigh, North Carolina
November 6, 2015

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
State of North Carolina
Dobbs Building
430 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Commissioner:

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

FirstCarolinaCare Insurance Company, Inc.
(NAIC #12962)
NAIC Exam Tracking System Exam Number: NC299-M86
Pinehurst, North Carolina

hereinafter generally referred to as the Company, at the Company's office located at 42 Memorial Drive, Pinehurst, North Carolina 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 September 28, 2015, and covered the period of January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through November 5, 2015. 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, provider and facility credentialing, provider availability/accessibility standards and monitoring, and underwriting practices. The findings and conclusions contained within the report are based solely on the work performed and are referenced within the appropriate section 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; listing of providers/facilities in the provider directory prior to being fully credentialed, and the use of unapproved underwriting methodology and factors. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals and grievances; and for credentialing errors. A tolerance level of 5 percent was applied to underwriting/rating errors. 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 member appeal review acknowledgements and compliant written notification letters to covered persons; and failure to properly address appeal and grievance procedures within policy guidelines.

Provider Availability and Accessibility - Failure to properly address certain provider accessibility parameters within policy guidelines.

Provider Credentialing – Failure to maintain sufficient documentation within credentialing files; and failure to conduct timely provider recredentialing activities.

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

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 titled '*Member Appeal and Grievance Process'* (revised May 2012) did not adhere to the provisions of NCGS 58-50-61 and/or 58-50-62 based on the following:

- The provisions for Expedited Appeal do not specify that if the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination.

- The notice requirements for adverse appeals and grievances reference availability of the Managed Care Patient Assistance Program. This notice requirement was changed within the statute to the Health Insurance Smart NC program effective July 2012. (It was noted that the policy was revised to meet this requirement as of March 2015.)

- The notice requirements for adverse Second-level grievances do not reflect notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

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 4,440 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 within one concurrent review request file, the noncertification decision letter to the member did not adequately explain the clinical and benefit rationale for the decision.

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 34 member appeals during the examination period. The total population of 34 appeal files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and 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 based on the following:

- Eight files contained a non-compliant written notification to the covered person of the decision, as the notification did not include a statement of the reviewers' understanding of the reason for the covered person's appeal.
- Four files contained an acknowledgement letter which was not sent to the covered person within three business days after receiving the request for appeal.

Two of the first-level appeal files were escalated to second-level grievance reviews. A review of these two second-level grievance files revealed that within one file, the Company did not adhere to the provisions of NCGS 58-50-62(h) as the written notification to the covered person of the decision did not list the professional qualifications and licensure of the members of the review panel.

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

Service Days	Number of Files	Percentage of Total
1 - 7	7	19.4
8 - 14	15	41.7
15 - 21	11	30.6
22 - 30	3	8.3
Total	**36***	**100.0**

*Includes first- and second-level grievance reviews.

POLICYHOLDER GRIEVANCES

The Company received a total of two member grievances during the examination period. The total population of two 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. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process a member grievance was 10 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	50.0
8 - 14	1	50.0
Total	**2**	**100.0**

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 policy titled 'Provider Availability and Accessibility Standards' (all iterations effective during the examination period) does not adhere to the provisions of 11 NCAC 20.0302 (1) and (4) respectively based on the following:

- The accessibility standards for proximity of network providers (driving distance) do not clarify consideration of geographic considerations (i.e. urban, suburban, rural vs. statewide).
- The accessibility standards for average expected waiting time do not reflect waiting times for specialist appointments.

PROVIDER CREDENTIALING

The Company's provider and facility credentialing activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statues and rules.

The Company has a written Credentialing Plan which outlines a program to verify its network providers and facilities are credentialed in adherence to the provisions of 11 NCAC 20.0400.

Provider Credentialing Files

One hundred thirty one provider credentialing files were randomly selected for review from a population of 490. The files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-230 and 11 NCAC 20.0400, as well as its own policies and procedures.

The review revealed that the Company did not adhere to the provisions of 11 NCAC 20.0400 based on the following:

- Nine files did not contain sufficient documentation to ascertain the credentialing committee and/or Medical Director credentialing approval date.
- Three files revealed that the provider was re-credentialed in excess of three years.
- One file contained an attestation which was not applicable to the Company.
- One file contained a North Carolina Uniform Application which was not dated.

Facility Credentialing Files

The total population of 22 facility credentialing files was reviewed to assess the Company's compliance with the provisions of 11 NCAC 20.0400, as well as with the Company's Credentialing Plan provisions. The review revealed that the Company did not adhere to the provisions of 11 NCAC 20.0407, as in one file, the facility was recredentialed in excess of three years.

UNDERWRITING PRACTICES

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

Employer Group Underwriting

One hundred nineteen employer group underwriting files containing initial or renewal information were randomly selected from a population of 229 and were reviewed to determine adherence with rating practices and compliance with applicable North Carolina statutes and rules. Included in this sample were 91 files for small groups and 28 files for large groups. A review of these files revealed that within five small group underwriting files, the Company applied an incorrect mental health parity factor which caused a deviation of 0.1%. This resulted in an aggregate undercharge of $506.37 for these five employer groups during 2014.

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 include but are not limited to: adherence to revised Utilization Management policies and procedures; compliance with statutory requirements regarding member appeal written notification decisions and acknowledgement letters; adherence to revised provider availability/accessibility policies and procedures; and compliance with regulatory requirements regarding provider credentialing, including sufficient documentation within files and timely recredentialing practices.

CONCLUSION

A target examination has been conducted on the market conduct affairs of FirstCarolinaCare Insurance Company for the period January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through November 5, 2015.

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, provider and facility credentialing, provider availability/accessibility standards and monitoring, and underwriting practices.

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

Respectfully submitted,

Scott D. Grindstaff

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.

Tracy M. Biehn

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