Report on

Market Conduct Examination

of

Standard Security Life Insurance Company of New York

New York, New York

by Representatives of the

North Carolina Department of Insurance

as of

June 6, 2014

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Raleigh, North Carolina
June 6, 2014

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
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Honorable Benjamin M. Lawsky
Superintendent of Financial Services
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One State Street
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Honorable Commissioner and Honorable Superintendent:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a target examination has been made of the market conduct activities of the Preferred Provider Organization (PPO)

Standard Security Life Insurance Company of New York
(NAIC #69078)
NAIC Exam Tracking System Exam Number: NC170-M96
New York, New York

hereinafter generally referred to as the Company, at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

FOREWORD

The examination reflects the North Carolina insurance activities of Standard Security Life Insurance Company of New York. The examination is, in general, a report by exception. Therefore, much of the material reviewed will not be contained in this written report, as reference to any practices, procedures, or files that revealed no concerns were omitted.

SCOPE OF EXAMINATION

The target examination commenced on April 15, 2013, and covered the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Company being conducted through May 21, 2014.

The examination was arranged and conducted by the Department. It was made in accordance with Market Regulation standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC) and accordingly included tests of provider relations and delivery system, claims practices, policyholder treatment, and delegated oversight.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for grievances and the use of contract forms that were neither filed with nor approved by the Department; 7 percent for claims practices; and 10 percent for all other areas reviewed.

EXECUTIVE SUMMARY

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

Provider Relations and Delivery System – Failure to monitor provider availability standards and appointment wait times annually and/or provide sufficient documentation of oversight.

Claims Practices – Failure to process paid and denied claims in accordance with statutory provisions, including failure to pay applicable interest correctly. Recoveries related to claims processing totaled $84,737.46.

Policyholder Treatment – Failure to develop internal policies and procedures for processing member grievances; and failure to process member grievances according to statute.

Delegated Oversight – Failure to execute an approved intermediary agreement for utilization of the MedCost, LLC provider network; failure to monitor: delegated utilization management activities, intermediary provider contracts, and delegated member grievance activities; failure to implement policies and procedures which address required oversight of: delegated utilization management activities, executed intermediary provider contracts, and delegated member grievances; failure to provide sufficient documentation to demonstrate that semiannual reviews had been conducted on two Third Party Administrators (TPAs) in 2007; failure to utilize a statutorily compliant utilization management plan; failure to ensure the delegated entity utilized statutorily compliant policies and procedures for: appeals, grievances, prospective reviews, concurrent reviews, and retrospective reviews; failure to initially submit intermediary certification as required; and failure to submit accurate grievance data in the annual filing submission for data years 2007-2008.

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

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company’s practices and provide consumer protection.

COMPANY OVERVIEW

History and Profile

The Company is a wholly-owned subsidiary of Independence Holding Company and is domiciled in New York. The Company was founded in 1958 and is licensed in 50 states as well as the District of Columbia, the Virgin Islands, and Puerto Rico. The Company was issued its license from the North Carolina Department of Insurance on May 24, 1983. The Company

offers group term life insurance, small group major medical, short-term medical, and employer medical stop-loss. It also offers Disability Benefit Law in the State of New York.

PROVIDER RELATIONS AND DELIVERY SYSTEM

The Company's provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Provider Availability and Accessibility

The Company has not annually monitored or provided any oversight of compliance with its provider availability standards and its appointment wait times throughout the examination period, a deemed violation of the provisions of 11 NCAC 20.0304. In addition, the Company failed to provide a detailed description of its monitoring processes to ensure compliance.

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine compliance with the appropriate North Carolina statutes and rules and policy provisions.

Paid Claims Sample Review

One hundred paid claim files were randomly selected for review from a population of 42,356. The claim files were reviewed to determine compliance with the provisions of NCGS 58-3-225. The review revealed the following deemed violations of NCGS 58-3-225:

- Twenty-three claims (23.0 percent error ratio) were processed beyond 30 days from receipt of the claim. Applicable interest for these claims was either not initially paid in full or not paid at all. Interest payments on these claims totaled $32.18. Upon the Department's instruction, the Company paid the remaining interest amounts due to the claimants.

- Five claims (5.0 percent error ratio) contained lines denied due to participating provider procedure coding issues, and the Explanation of Benefits (EOB) erroneously reflected member responsibility/liability for these charges.

The average service time to process a claim payment was 24 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	2	2.0
8 - 14	23	23.0
15 - 21	24	24.0
22 - 30	28	28.0
31 - 60	18	18.0
Over 60	5	5.0
Total	**100**	**100.0**

Self-Audit on Claims Requiring Retrospective Interest Payments

As a result of the paid claims sample review, it was determined that the Company was not properly adjudicating interest payments on claims paid beyond 30 days of receipt. Therefore, the Department requested that the Company conduct a self-audit of claims requiring interest payments which remained unpaid or underpaid. The time period specified for this self-audit was calendar year 2007 (when the Company acquired PPO membership in North Carolina) through calendar year 2013. The Company was instructed to retroactively pay these interest payments to all claimants. The Company reported a total of 3,842 interest payments which totaled $84,705.28.

Denied Claims Sample Review

One hundred denied claim files were randomly selected for review from a population of 7,703. The claim files were reviewed to determine compliance with statutory provisions and revealed the following deemed violations of NCGS 58-3-225:

- Thirty-one claims (31.0 percent error ratio) were processed beyond 30 days from receipt of the claim without proper notification to the claimant.
- Eighteen claims (18.0 percent error ratio) contained lines denied due to participating provider procedure coding issues, and the EOB erroneously reflected member responsibility/liability for these charges.

The average service time to process a claim denial was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	18	18.0
8 - 14	11	11.0
15 - 21	22	22.0
22 - 30	18	18.0
31 - 60	26	26.0
Over 60	5	5.0
Total	**100**	**100.0**

Claims Processing Standards

The Company's timeliness standard for processing claims is ten business days. The Company did not meet this standard during any month of the examination period. The Company was advised by the Department that an additional standard more reflective of the provisions of NCGS 58-3-225 should include monitoring claims processed within 30 days of receipt.

The Company has established a standard of 98 percent for monetary and procedural accuracy of claims processing. The Company's monitoring reports reflect that this standard was met throughout the examination period.

Policies and Procedures

The Company does not have a formally executed policy and procedure which reflects the provisions of NCGS 58-3-225 "Prompt claim payments under health benefit plans".

POLICYHOLDER TREATMENT

The Company's policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Telephone Access

The Customer Service Department has established service standards and monitors actual performance. Review of the monthly telephone reports revealed that the Department

failed to meet the established service level standard in 2007 and 2008 for average speed to answer, as outlined in the chart below:

Performance Measure	Standard	2007 Actual Results	2008 Actual Results
Average speed to answer (seconds)	≤ 30	61.4	38.4
Call abandonment rate (%)	< 5	3.2	3.4

Note: Monitoring results are not North Carolina specific.

Member Grievances

The Company was deemed to be in violation of the provisions of NCGS 58-50-62 as it failed to develop internal policies and procedures for its written grievance/appeals processes throughout the examination period. The Company provided a "Non-Clinical Appeal Process-Plan Administrator" document; however, it appears to be an extraction of an appeals notice for its members and was not dated or formerly approved as an implemented policy.

Member Grievances Sample Review

The Company's total population of 50 member grievances was reviewed to assess the Company's timeliness and compliance with the provisions of NCGS 58-50-62. This review revealed one or more of the following violations of the provisions of NCGS 58-50-62:

- In 44 files (88.0 percent error ratio), the acknowledgement letter did not contain all of the required provisions such as the name, telephone number, address of the coordinator, and information on how to submit written material.

- In 16 files (32.0 percent error ratio), the determination letter did not contain all of the required provisions such as including a statement advising the covered person of his or her right to a second level grievance and the notice of the availability of assistance from the Managed Care Patient Assistance Program (MCPAP), including the telephone number and address of the Program.

- In six files (12.0 percent error ratio), the acknowledgement letter was not sent within three business days of receipt of the grievance.

- In two files (4.0 percent error ratio), the review was not completed within 30 days.

- In two files (4.0 percent error ratio), the determination letter was not sent.

- In one file (2.0 percent error ratio), the acknowledgement letter was not sent.

- In one file (2.0 percent error ratio), there was insufficient documentation to determine the outcome.

The average service time to process a first-level member grievance was 15 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	11	22.0
8 - 14	8	16.0
15 - 21	19	38.0
22 - 30	11	22.0
31 - 60	1	2.0
Total	**50**	**100.0**

DELEGATED OVERSIGHT

Intermediary Contracts and Management Agreements

Review of the Company's executed contracts with delegated entities revealed the following violation regarding the agreement:

- The Company was deemed to be in violation of the provisions of 11 NCAC 20.0204 as until February 1, 2007, the Company was utilizing an unapproved base contract form with MedCost, LLC which had initially been executed by the entity formerly known as Avemco Insurance Company.

Review of Actual Monitoring and Oversight

The Department reviewed the Company's oversight and monitoring of all intermediary and other contracted entities performing delegated functions. The Company conducted oversight and monitoring activities of entities to which activities had been delegated during the examination period, with the following exceptions:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(b) as it failed to monitor the utilization management activities which had been delegated to Insurers Administrative Corporation, which subsequently had been sub-delegated to Med-Valu, Inc. through an agreement executed February 4, 2005. In addition, the Company did not have any policies and procedures in place to address the required monitoring and oversight of the utilization management activities, a deemed violation of the provisions of NCGS 58-50-61(b)(3).

- The Company has not established written policies and procedures for reviewing its intermediary organization's provider contracts and was unable to provide supporting documentation to demonstrate that it had conducted a formal review of the contracts to ensure compliance with the provisions of 11 NCAC 20.0202. Therefore, the Company was deemed to be in violation of the provisions of 11 NCAC 20.0202 and 20.0204.

- The Company did not have a formal oversight program and/or policies and procedures for monitoring delegated grievance activities to ensure compliance with the provisions of NCGS 58-50-62. In addition, the Company did not produce documentation to demonstrate that it had conducted sufficient annual oversight of the member grievance activities which were delegated to Insurers Administrative Corporation. The Company stated and certified in its annual filing submissions for data years 2007 and 2008 that it had conducted oversight of the delegated grievance program in December 2007 and December 2008; however, the Company could not provide documentation to demonstrate that proper review of the grievance program occurred during the examination period. Therefore, the Company was deemed to be in violation of the provisions of NCGS 58-3-100(a)(3) and 58-3-191(a)(1).

- The Company failed to provide sufficient documentation to demonstrate that semiannual reviews had been conducted on its TPAs (Insurers Administrative Corporation and Employers Direct Health) in 2007. Therefore, the Company was deemed to be in violation of the provisions of NCGS 58-56-26(c).

Utilization Management

The Company was deemed to be in violation of the provisions of NCGS 58-50-61, 58-50-62, and/or 58-50-77 as its Utilization Management Plan (program document) utilized during the examination period did not meet the following statutory requirements:

- Noncompliant/incomplete definitions for: medically necessary services or supplies; noncertification; and retrospective review;

- Failure to require/state that a medical doctor licensed in the state of North Carolina must evaluate the clinical appropriateness of a noncertification;

- Noncompliant/incomplete procedures for nonexpedited appeal decision letter, as it did not include a description of the procedure for submitting a second-level grievance and information regarding the MCPAP, including the address and phone number of the Program; and

- Expedited appeal procedures did not state the decision letter requirements and did not require consultation with a North Carolina licensed medical doctor.

The Company was also deemed to be in violation of the provisions of NCGS 58-50-61, 58-50-62, and 58-50-77 as the appeal and grievance procedures utilized by its delegated entity, Med-Valu, Inc., did not include all of the statutory requirements.

The Company relied on its Utilization Management Plan with MedCost, LLC for complete policies and procedures for processing prospective, concurrent, and retrospective review requests. These policies and procedures were deemed to be in violation of the provisions of NCGS 58-50-61(h) and 58-50-77(a)(1) as they did not state that the insurer must inform the covered person in writing about the availability of assistance from the MCPAP, including the telephone number and address of the Program, and also failed to notify the covered person in writing of his/her right to request an external review (along with the pertinent information).

Required Reporting

The Company was deemed to be in violation of the provisions of 11 NCAC 20.0204 and Bulletin 97-B-3 as it failed to submit timely the initial intermediary certification for MedCost, LLC. The regulatory provisions require the Company to submit the initial certification at the same time the Company enters into a relationship with an intermediary.

The Company was also deemed to be in violation of the provisions of NCGS 58-3-191(a)(1) as it failed to submit accurate grievance data in the annual filing submissions for data years 2007-2008.

CONCLUSION

A target examination has been conducted on the market conduct affairs of Standard Security Life Insurance Company of New York for the period of January 1, 2007, through December 31, 2008, with analysis of certain operations of the Company being conducted through May 21, 2014.

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 provider relations and delivery system, claims practices, policyholder treatment, and delegated oversight.

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

Respectfully submitted,

Jill H. Dale

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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

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