REPORT OF TARGETED EXAMINATION

OF

AMERICAN REPUBLIC INSURANCE COMPANY

NAIC# 60836

AS OF

JUNE 30, 2006

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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:

AMERICAN REPUBLIC INSURANCE COMPANY

NAIC# 60836

The above examination was conducted by Sandra Lewis, CIE, Examiner-in-Charge, and Mel Mohs, CIE, Senior Market Examiner.

The examination covered the period of July 1, 2005, through June 30, 2006.

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

Sincerely yours,

Paul J. Hogan, JD, FLMI, ALHC, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Mel Mohs, CIE, Senior Market Examiner, the examination of American Republic 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
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 12 day of February, 2008.

Notary Public

OFFICIAL SEAL
GREG MITCHELL
NOTARY PUBLIC - State of Arizona
MARICOPA COUNTY
My Comm. Expires June 1, 2011

My Commission Expires June 1, 2011

FOREWORD

This targeted market examination of American Republic Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market 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 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 examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the line 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 7.

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 in part on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on a statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, DeDee Birdsall, Compliance Manager. 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.

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 at page 7, and the examination findings are reported beginning at page 4.

1. The Company failed Standard No. 2, in apparent violation of A.R.S. §§ 20-461(A)(15) and 20-2533(D), by failing to prominently display a member's right to appeal on the Explanation of Benefits ("EOB") form.

2. The Company failed Standard No. 2, 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 for the denial of claims in sufficient detail, including the specific policy provision relied upon in denying the claim, to allow members and providers to appeal an adverse decision. The following categories of denied claims failed Standard No. 2:

a. Twenty-seven (36%) of 76 Phase I and Phase II files reviewed for claims that involved physical therapy services;

b. Twelve (55%) of 22 files reviewed for claims that involved services related to maternity and complications of pregnancy;

c. Eight (30%) of 27 files reviewed for claims that involved ineligible services; and

d. Nine (33%) of 27 files reviewed for claims that involved not covered services.

3. The Company passed Standards 1 and 3.

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 Company provided appeal and complaint logs indicating it had processed seven appeals, nine provider grievances and two complaints from denied claims during the examination period. The Examiners selected all 18 appeals, grievances and complaint files for review. No apparent trends were noted from among the 18 files.

The Company provided a population of 18,101 claims denied during the examination period. The Examination Data Specialist used ACL software to analyze the 18,101 denied claims, and extracted a subpopulation of 3,887 denied claims by selecting the most commonly denied services by procedure codes and/or EOB denial reason codes. The Data Specialist then selected a stratified random sample of 143 denied claims for the Phase I review, and 110 denied claims for the Phase II review.

As a result of the review of the 253 denied claims, the Examiners identified the following findings.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's EOB forms and denied health care claims, 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)

Forms Review

The Examiners issued a preliminary finding on the EOB form that failed Standard 2. During the examination period, the Company used an EOB form that failed to prominently display a member's right to appeal an adverse claim decision, as prescribed by A.R.S. § 20-2533(D). No form number was available for the Company's EOB form. In the area of forms review, the Standard is "not met" if any violation is identified. This is an apparent violation of Standard 2: A.R.S. § 20-461(A)(15). Reference PF #008.

Subsequent Events

The Company stated that they requested a system change to begin producing the EOB appeal statement in all capital letters. A copy of the revised EOB statement was provided to the Examiner.

Recommendation 1

Within 90 days of the filed date of this report, the Company should provide documentation that procedures and controls are in place to ensure that the Company uses EOB forms that contain a compliant right to appeal statement as prescribed by A.R.S. §§ 20-461(A)(15) and 20-2533(D).

Denied Claims Review

Claims Denied – Physical Therapy

The Examiners identified a subpopulation of 904 denied claims for services billed under CPT Codes 97110, 97112, 97116 and 97140 (physical therapy). The Examiners reviewed a sample of 14 (Phase I) and 62 (Phase II) of the 904 denied claims billed under CPT Codes 97110, 97112, 97116 and 97140.

Twenty-seven (36%) of 76 claims billed under CPT Codes 97110, 97112, 97116 and 97140 were denied for the following reasons: "Services were reviewed and not medically indicated;" "Coverage does not provide benefit for this service;" and "Your policy does not provide benefits for the charges incurred." These denials failed Standard 2 because the Company failed to provide a reasonable explanation for the denial, including the specific policy provision relied upon in denying the claim, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PFs #002 and #009.

Claims Denied - Maternity/Complications of Pregnancy

The Examiners identified a subpopulation of 23 denied claims for services billed under CPT Code 59025 (fetal non-stress). The Examiners reviewed a sample of 22 of the 23 denied claims billed under CPT Code 59025.

Twelve (55%) of 22 claims billed under CPT Code 59025 were denied for the following reasons: "Coverage does not provide benefit for this service;" and "Not a covered service." These denials failed Standard 2 because the Company failed to provide a reasonable explanation for the denial, including the specific policy provision relied upon in denying the claim, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #003.

Claims Denied – "Excluded"

The Examiners identified a subpopulation of 1847 denied claims which were denied using EOB Reason Codes C21, CH, CN, ED, EP, UL and SI for the following reasons: "Not a covered service;" and "Condition excluded by restrictive endorsement."

The Examiners reviewed a sample of 27 of the 1847 files denied using EOB Reason Codes C21, CH, CN, ED, EP, UL and SI. Eight (30%) of the 27 claims denied using EOB Reason Codes C21, CH, CN, ED, EP, UL and SI failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision. The eight claim files included one file that contained an EOB which stated that the claim was denied due to a "condition excluded by restrictive endorsement," although neither the claim file nor the policy certificate involved with this claim contained evidence of a restrictive endorsement. These are apparent violations of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #005.

Claims Denied – "Not Covered"

The Examiners identified a subpopulation of 927 denied claims which were denied using EOB Reason Codes C12 and C42 for the following reasons: "Not a covered service;" and "Non-covered service under policy."

The Examiners reviewed a sample of 27 of the 927 files denied using EOB Reason Codes C12 and C42. Nine (33%) of the 27 claims denied using EOB Reason Codes C12 and C42 failed Standard 2 because the Company failed to provide a reasonable explanation for the denial, including the specific policy provision relied upon in denying the claim, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #006.

Summary of Findings – File Review

Files Reviewed	Population	Phase I Sample	Phase II Sample	Total Sample	Exceptions	Error Ratio	PF #
Physical Therapy	904	14	62	76	27	36%	002, 009
Maternity/Complications	23	22	0	22	12	55%	003
"Excluded"	1847	27	0	27	8	30%	005
"Not Covered"	927	27	0	27	9	33%	006
Totals =	**3,701**	**90**	**62**	**152**	**56**	**37%**	

An error ratio of 37% does not meet the standard; therefore a recommendation is warranted.

Subsequent Events

The Company stated, in its response to PF 009, that it plans to move to a new claims system within the next 18 months. The new system will allow the Company to more easily and cost effectively make the suggested changes to the EOB messages. The Company requested the Department's consideration of the 18 month timeframe in completing the changes. No other documentation was provided to the Examiner.

Recommendation 2

Within 90 days of the filed date of this report, the Company should 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, including the specific policy provision relied upon in denying the claim, to allow members and providers to appeal an adverse decision as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

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	