STATE OF NORTH DAKOTA

TARGETED MARKET CONDUCT EXAMINATION REPORT

NORIDIAN MUTUAL INSURANCE COMPANY
DBA BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

FARGO, NORTH DAKOTA

As of May 31, 2013

By Representatives of the
North Dakota Insurance Department

STATE OF NORTH DAKOTA

INSURANCE DEPARTMENT

I, the undersigned, Commissioner of Insurance of the State of North Dakota, do hereby certify that I have compared the annexed copy of the Report of Examination of the

Noridian Mutual Insurance Company
dba Blue Cross Blue Shield of North Dakota

Fargo, North Dakota

as of May 31, 2013, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this 4th day of December, 2014.

Adam Hamm
Commissioner

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SCOPE OF EXAMINATION

Representatives of the North Dakota Insurance Department ("Department") conducted a targeted market conduct examination of the Company under authority delegated by the Commissioner pursuant to N.D.C.C. ch. 26.1-03. The examination covered the period March 5, 2010, through May 31, 2013.

The scope of the examination was limited to the following phases:

- Company Operations/Management;
- Complaints;
- Underwriting; and
- Claims.

The examination report is a report by exception. Files or material reviewed containing no improprieties by the Company have been omitted from the examination report. Procedures were performed in accordance with the Market Regulation Handbook as adopted by the National Association of Insurance Commissioners ("NAIC") and consistent with the predetermined market conduct program presented to and approved by the Department.

The purpose of the examination was to make factual determinations of business practices in which the company was engaged. The focus of the targeted examination was to determine if the company fulfilled its obligations, the nature of its operations, whether it gave proper treatment to policyholders, and its compliance with all applicable North Dakota statutes, rules, bulletins, insurer policies, and contractual obligations in the following areas:

A. For mental and behavioral health and substance abuse claims:

   1. Identify any changes to the company's criteria, policies, and procedures to determine if a claim is paid or denied and to determine denial trend and reasons for denial.

   2. Identify any changes to the company's policies or procedures in regard to the evaluation and payment of claims. If changes occurred, how were the changes communicated to providers or policyholders or both, and were those communications made in compliance with applicable requirements.

   3. Ascertain whether coverage determinations were properly made, given the policy and commonalities for treatment and diagnoses in the science.

B. Noridian Insurance Services, Inc. (NISI) announced a change of carriers for a block of group life and disability business from a Noridian-affiliated insurance company to another insurance company and offered a discount. Determine:

   1. The population of groups that switched from the Noridian-affiliated insurance company to the other insurance company.

   2. The population for which there was no change in benefits offered through the groups.

3. The rates of the Noridian-affiliated insurance company and the other insurance company and determine rating compliance with North Dakota law.

C. Effective September 23, 2010, the Affordable Care Act ("ACA") mandated coverage for dependents as defined by the Act up to age 26. N.D.C.C. § 26.1-02-29 requires compliance with the ACA in North Dakota, unless state law is more favorable. Determine:

1. If the Company made communications to policyholders or employer groups and whether those communications permitted eligibility of dependents for coverage under family policies in compliance with the ACA and North Dakota law.

2. If the Company failed to follow the Commissioner-issued Bulletin 2011-3 in a timely fashion.

3. Compliance with the ACA and North Dakota law within its underwriting guidelines, contracts, amendments to its contracts and certificates of insurance.

D. Review claims involving a coordination of benefits with other carriers. Testing for coordinated benefits with other carriers included, but was not limited to coverage arising from automobile accidents. Determine:

1. If the Company coordinated benefits correctly under North Dakota coordination of benefits law and administrative rules.

2. If the Company's underwriting guidelines, contracts, amendments to its contracts and certificates of insurance allow for compliance with North Dakota statutes and administrative rules.

COMPANY HISTORY

The Company was incorporated March 20, 1940, as the North Dakota Hospital Services Association. The Company amended its Articles of Incorporation on February 28, 1964, changing its name to Blue Cross of North Dakota. The North Dakota Physicians Service was incorporated on December 7, 1945. The Company amended its Articles of Incorporation on March 27, 1971, changing its name to Blue Shield of North Dakota. On July 1, 1986, the two companies merged becoming Blue Cross and Blue Shield of North Dakota.

The Company converted from a not-for-profit health services corporation to a nonprofit mutual insurance company on January 30, 1998. The Company's name was changed from Blue Cross and Blue Shield of North Dakota to Noridian Mutual Insurance Company. The conversion passed ownership to the policyholders. The Company is incorporated as a nonprofit mutual insurance company and is governed by N.D.C.C. chs. 10-33 and 26.1-12 and N.D.C.C. § 26.1-17-33.1.

Blue Cross Blue Shield of North Dakota is the largest health insurance provider in North Dakota, providing more than 500,000 people with healthcare coverage either directly or through administrative services agreements. The Company markets and provides individual, group and association health insurance and pharmaceutical benefits under traditional and preferred provider organization contracts. The Company also performs administrative services such as billing, collection and claim processing for other Blue Cross and Blue Shield plans, Medicare and TriCare.

A. COMPANY OPERATIONS/MANAGEMENT

I. Does the Regulated Entity have an Up-to-Date, Valid Internal or External Audit Program?

Due to the limited scope of the examination, only internal audits were reviewed for this standard. The Company provided five internal audits for the period under examination. Two of the audits addressed controls over the claims operations and were not deemed applicable. The other three concentrated on phone communications concerning enrollment, membership, claims timeliness, and calls lost. After review, it was determined these internal audits were not applicable to the scope of the examination. The Company did not appear to have a focused internal audit process concerning the accuracy of claims processing for behavioral health claims during the examination period. The internal audits that were performed selected a broad cross-section of claims for audit. This practice resulted in the selection and review of only a few behavioral health claims during the Company's regular claims testing cycles. Given the limited number of behavioral health claims selected and reviewed during the Company's regular claims testing cycles, the Company's internal audit programs failed to include an overall process for the auditing of behavioral health claims. During the examination, the Company committed to and implemented audit program enhancements to increase the testing levels of behavioral health claims.

II. The Regulated Entity is Licensed for the Lines of Business that are Being Written.

The Company is an authorized life and health insurer in the State of North Dakota.

III. Does the Regulated Entity Cooperate on a Timely Basis with Examiners Performing the Examination?

Except for an initial disagreement about the scope of the examination pertaining to the Company's affiliate, Noridian Insurance Services, Inc., the Company's personnel were mostly cooperative during the examination. The Company did not always respond timely according to original deadlines, but the Company did communicate delays to and request extensions from the examiner in charge.

B. COMPLAINT HANDLING

I. Insurance Department Complaints and Other Written Complaints Were Sampled and Tested to Determine If Any Were Pertinent to the Scope of the Examination.

The Company provided 48 written complaints received during the period under examination. Complaints were reviewed to determine if any pertinent issues fell within the scope of the examination. Thirty-eight appeared to fall within this category and, therefore, all of those files were selected for testing. Of 273 telephone complaints, 4 appeared to potentially include an issue regarding the scope of the examination. Therefore, a total of 42 complaint files were sampled for testing. Testing of files was completed to ascertain whether the Company's actions regarding the complaining members were in compliance with its underwriting and claims guidelines and North Dakota law.

The results of testing complaint files are provided in the table below:

Standard Tested	Files Tested	Files Passed	Files Failed	Percentage Failed
Written complaints	38	37	1	3%
Nonwritten complaints	4	4	0	0%

Concerning one complaint file, the Company stated denial of 23 related claims was valid because the services were not medically necessary. It also denied these claims during two appeals. After the member complained to the Department, the Company reexamined the claims at the request of the Department and ultimately determined the claims should be paid. The claims were paid without providing information substantiating why the claims were paid, and what had changed to validate the services were medically necessary as outlined in this member's certificate of coverage. The initial denial of the claims may not have been completed in compliance with the member's certificate of coverage or the Company's medical necessity guidelines. However, because the Company did not provide a reason for the payment based on medical necessity, it may have paid claims inaccurately rather than denied the claims inaccurately. Denying medically necessary claims or paying claims that are not medically necessary would not be in compliance with N.C.C.C. § 26.1-04-03(7)(b) or (9)(c). Paying claims for certain members that do not meet medical necessity guidelines would not be in compliance with N.D.C.C. § 26.1-04-03(7)(b) and (9)(c). This member's file was also a sampled appeals file.

C. UNDERWRITING

I. Dependents Under Age 26

Testing was performed on the Company's underwriting guidelines, policy endorsements, contract language, letters to policyholders, certificate holders and employers, and applicable marketing materials to determine if dependent coverage was allowed in compliance with North Dakota law in both the group and individual markets.

GROUP MARKET

The Company's marketing materials and its policy endorsements for grandfathered plans, and the certificates for small and large group non-grandfathered plans defined an eligible individual as the subscriber's or the subscriber's living, covered spouse's children under the age of 26 years, who are not eligible to enroll in an employer-sponsored health plan, other than a group health plan of a parent. This provision denied dependent eligibility when the dependent was eligible for its own employer-sponsored health coverage. While the Company believed its definition of eligible individual complied with North Dakota law when the Company's definition was implemented in summer 2010, subsequent federal clarification of the age 26 mandate caused the Department to identify an area of noncompliance and issue Bulletin 2011-3. Upon receipt of Bulletin 2011-3, the Company responded to amend its plan language and administer the eligibility definition. The Company determined North Dakota's eligibility statute would be an administrative burden too complicated and expensive to implement and, therefore, the Company extended its eligibility definition beyond the North Dakota statute beginning February 2012 by administering the grandfathered exception permitted under federal law by allowing these dependents to remain eligible under a group health plan. Therefore, the Company's plans were not in compliance with North Dakota law during the period from September 27, 2010, until February 2012.

Additional testing was performed to determine if any dependents lost coverage or were denied coverage on the basis of the dependent having their own employer-sponsored health coverage available. Testing determined three dependents covered under their parents' group health plans had their coverage terminated by the Company when it was discovered that each individual had employer-sponsored coverage available. However, it is uncertain whether the three dependents would have remained eligible for coverage even if they did not have employer-sponsored coverage available because the dependents would have needed to be full-time students and financially dependent on their parents in order to remain eligible under their parents' group health plans. All three were terminated for reasons which were not in compliance with N.D.C.C. §§ 26.1-02-29 and 26.1-36-22. One dependent was terminated when he went on active military status because his Tricare coverage was "other group coverage," and the Company contended it was permitted to terminate coverage of any member that became active in the military due to the existence of "other group coverage." The Company stated this was a general underwriting practice and was in compliance with its underwriting guidelines and contracts. However, all dependents under age 26 are guaranteed continued group coverage until age 26, with limited exception under the Affordable Care Act (incorporated under North Dakota law as of April 4, 2011, at N.D.C.C. § 26.1-02-29) and North Dakota law at N.D.C.C. § 26.1-36-22. North Dakota law has not permitted eligibility discrimination among dependents under the age of 26 since April 4, 2011. Military personnel dependents under the age of 26 should have been allowed the opportunity to remain on their parents' health plans as long as the dependents continue to satisfy the standard eligibility requirements of their parents' group health plans. It is uncertain whether the terminated active military dependent would have satisfied the standard eligibility requirements under state law.

The company has acknowledged it was not their practice during the time frame of this examination to consider whether dependents under the age of 26 would still be eligible for coverage under their parents' group health plans based on the more generous provisions of N.D.C.C. § 26.1-36-22. Therefore, the company's practices and procedures were not in compliance with N.D.C.C. § 26.1-36-22.

INDIVIDUAL MARKET

The Company's notice to members of the transitional open enrollment period stated children younger than age 26 could enroll in the policyholder's individual health plan, even if they were never previously enrolled or lost coverage because of age 26, or because they otherwise lost eligibility. The Company agreed the statement made in the letter was incorrect because the notice should not have included a specific age 26 reference, and noted that the transitional open enrollment period was administered correctly notwithstanding the scrivener's error in the notice. Therefore, the Company's notice, although inadvertently issued, did not provide language that complied with federal law for the transitional enrollment under the requirements at 45 CFR § 147.120(2) and, therefore, was not in compliance with N.D.C.C. § 26.1-04-07.

Enrollment based on health status for dependent children under the age of 19 was not permitted under North Dakota law as of April 4, 2011. The Company was requested to provide all individuals "rejected for health status" during the period from April 4, 2011, to May 31, 2013. If the applicant was rejected, the Company was allowed to deny all individuals applying for coverage including dependents. However, testing revealed the Company denied coverage for 113 dependents under age 19 due to health status during this period, where the primary applicant was allowed coverage. Therefore, the Company's actions and its practices, by denying access to coverage for dependents under age 19, was not in compliance with the requirements of the Affordable Care Act as incorporated by N.D.C.C. § 26.1-02-29.

Standards Tested	No. of Dependents Denied Coverage	Files Passed	Files Failed	% Failed
Testing of under age 19 dependents denied for medical status	113	0	113	100%

The Company stated it underwrote dependents under age 19, except during the annual open enrollment periods of May 1 through May 31. It stated all dependents were accepted and issued coverage without medical underwriting during the annual open enrollment periods. However, in order to qualify for the annual open enrollment period, the Company required the application to be signed May 1 through May 31 with a requested coverage effective date of June 1. If either of these dates were not satisfied on the application, the Company medically underwrote dependents under age 19. The following denials of coverage were noted during the open enrollment period for the files tested above: in May 2011, four dependents were declined; in May 2012, five dependents were declined; and in May 2013, seven dependents were declined.

The Company also provided listings of members for its open enrollment periods. Testing determined there were 11 dependents allowed coverage during the open enrollment periods as true open enrollees. However, the open enrollment listings also included additional dependents declined coverage during the May open enrollment periods. There were two dependents declined coverage during May 2011, none during May 2012 and five during May 2013. Although some of the above-identified dependents under age 19 eventually received the desired coverage by submitting a second application with the Company's required signature and requested effective dates, the Company did not clearly and consistently provide applicants with the specific application requirements of the open enrollment period. Therefore, the Company provided misrepresentations by omission which comprise an unfair and deceptive act in violation of N.D.C.C. § 26.1-04-03(2).

II. Discounted Policies

On March 9, 2012, the Company signed a contract with a life and disability carrier ("L&D Carrier") for the marketing of the L&D Carrier's products by the Company's affiliate, Noridian Insurance Services, Inc. ("NISI"). A marketing letter issued by NISI and Blue Cross Blue Shield of North Dakota ("BCBSND" also referred to as the "Company"), dated April 30, 2012, and a marketing letter issued only by NISI, dated March 5, 2012, stated all employers were guaranteed a 10 percent discount on their group life, STD and LTD existing Lincoln Mutual Life plans. The April 30 letter also guaranteed the discounted premiums for two years. Since the marketing materials provided for guarantees that were discussed between the Company and the L&D Carrier but not contractually guaranteed by the L&D Carrier, the Company's April 30, 2012, marketing letter provided misrepresentations and false advertising when compared to the underlying contractual provisions between the Company and the L&D Carrier. Therefore, the Company's actions were not in compliance with N.D.C.C. §§ 26.1-04-03 and 26.1-04-07 and N.D. Admin. Code § 45-06-04-05. Testing revealed that five employer plans did not receive the 10 percent discount guaranteed in the marketing materials (see file testing results on page 8).

The marketing letter issued by NISI and BCBSND, dated April 30, 2012, was intended for employer groups of 2-9 employees, and the letter issued only by NISI, dated March 5, 2012, was intended for employer groups of 10 or more employees. Based on the terms of the contract between the Company and the L&D Carrier, the employer groups should have been marketed

by the Company as the contracting party. In addition, the Company signed the contract with the new carrier on March 9, 2012, which was four days after NISI distributed the March 5, 2012, marketing document to its employer groups. The BCBSND logo should have been displayed on both documents in fairness to all of the employers that were relying on the contents of the marketing information as BCBSND was the party that entered into the contract and was responsible for marketing the product, not NISI. Therefore, NISI's marketing material, dated March 5, 2012, provided misrepresentations and false information which comprise an unfair and deceptive act concerning marketing and, therefore, not in compliance with N.D.C.C. § 26.1-04-03(2) and N.D. Admin. Code § 45-06-04-05.

The Commissioner made an inquiry of the Company regarding the issues outlined above on July 10, 2012, and in three instances the Company responded in a manner that knowingly supplied the Commissioner with incomplete information in violation of N.D.C.C. § 26.1-02-03. The Company is reminded that the Insurance Department must be provided with complete and accurate information in response to any inquiry.

There were a total of 121 employers with 50 or more employees that replaced its STD, LTD or Life insurance plans marketed by NISI. All were sampled for testing. The results of testing the sampled files are provided in the table below:

Standards Tested	No. Files	Applicable Files	N/A	Files Passed	Files Failed	% Failed
STD, LTD and Life rates compared to newly issued rates for 10% discount	121	84	37	79	5	6%

Testing determined 5 of the 84 applicable large groups tested did not receive the 10 percent premium discount guaranteed in the Company's marketing materials. Upon being apprised of the examiner's testing, the Company demanded that the L&D Carrier undertake a complete audit of the 10 percent premium discount for all groups. The L&D Carrier's audit identified a total of 21 groups out of nearly 1,200 groups that did not receive the intended 10 percent premium discount over the two-year period ranging in deficiency from $7.30 to $2,882.58 per group. The affected groups were credited the premium deficiency in August 2014. It was also noted during testing that the application for coverage for STD, LTD and Life plans contained language where the employers were not guaranteed the two-year rate guarantee provided in one marketing material. Therefore, the Company's marketing materials failed to provide information in compliance with N.D.C.C. §§ 26.1-04-03 and 26.1-04-07 and N.D. Admin. Code § 45-06-04-05.

D. CLAIMS

I. Files Were Tested to Determine Whether Claims With Coordination of Benefits Were Handled in Accordance With Company Guidelines, Policy Provisions, and North Dakota Statutes and Rules.

It was determined to test six paid and six denied claims involving coordination of benefits ("COB") with an automobile insurer to determine if the Company's handling of claims involving COB was in compliance with North Dakota law. Three of the tested paid claims were not applicable because each of the members' deductible and/or coinsurance had been met in previous claims. The results of testing are provided in the tables below:

Standards Tested	No. Files	N/A	Files Passed	Files Failed	% Failed
Paid COB auto claims	6	3	0	3	100%

Testing of the three applicable files involving COB claims after an automobile accident, determined the Company failed to provide credit for deductibles and coinsurance, which was not in compliance with N.D.C.C. § 26.1-41-13(3) and N.D. Admin. Code § 45-08-01.2-05. The Company's policies provide COB language that appears to comply with North Dakota law. However, the Company failed to settle claims in compliance with its policy language. Testing of files concerning coordination of benefit practices with automobile no-fault carriers determined the Company failed to apply calculated amounts to allowable expenses that were unpaid by the primary plan. Therefore, the Company's actions failed to comply with N.D.C.C. §§ 26.1-04-03(9) and 26.1-41-13 and N.D. Admin. Code § 45-08-01.2.

Standards Tested	No. Files	N/A	Files Passed	Files Failed	% Failed
Denied COB auto claims	6	0	6	0	0%

The Company appeared to have handled the six sampled denied automobile COB claims in compliance with North Dakota law.

It was judgmentally determined to test 28 paid claims involving COB claims with other health insurers. The results of testing are provided in the table below:

Standards Tested	No. Files	N/A	Files Passed	Files Failed	% Failed
Paid COB individual market health claims	8	0	8	0	0%
Paid COB group market health claims	20	0	20	0	0%

Testing of COB claims with members covered under another Company plan or by another insurer determined the Company had coordinated benefits in compliance with North Dakota law. For one file, the Company recognized it had failed to coordinate benefits correctly and corrected the claim during testing. Therefore, that file was not failed.

II. Preauthorization of Mental Health and Substance Abuse Benefits Were Tested to Determine If They Are Handled in Accordance With Company Guidelines, Policy Provisions, and North Dakota Statutes and Rules.

The Company provided a listing of 500 preauthorization denials for mental health and substance abuse services for the period under examination. It was determined that 17 were not applicable for testing. In addition, the Department determined that testing should concentrate on substance abuse files and, therefore, the 483 files were sorted to eliminate mental health only files. Sorting determined there were 382 denied preauthorization substance abuse files. There were 82 files selected by use of ACL for testing. Those files were tested to determine if the Company allowed medically necessary substance abuse services in compliance with its contractual obligations and the American Society of Addiction Medicine ("ASAM") guidelines. The results of testing are provided in the table below:

Standards Tested	No. Files	Files Passed	Files Failed	% Failed
Allowance of medically necessary services for substance abuse according to ASAM guidelines	82	73	9	11%

Testing of the 82 denied preauthorization files sampled determined there were 9 wrongfully denied preauthorizations for substance abuse services based on the Department's retained medical professional's interpretation and application of the ASAM guidelines. The Company disagreed with the findings for the nine failed files and asserted that the files were appropriately reviewed by its board certified psychiatrists with training in the use of ASAM and external consultants who are board certified in addiction psychiatry. The interpretation and application of the ASAM guidelines involves complicated clinical treatment and medical evaluation criteria, and due to the inherently subjective nature of the treatment and criteria, qualified medical professionals can reach differing conclusions. Therefore, the Company's decisions may have failed to allow for medically necessary services in compliance with its contractual obligations and the ASAM guidelines. The Company's misapplication of ASAM guidelines and failing to allow medically necessary services would not be in compliance with N.D.C.C. § 26.1-04-03(7)(b) and (9)(c).

The Company provided 500 denied preauthorization mental health and substance abuse services files, of which 479 appeared applicable for testing to determine accuracy of claims payments. Due to time restraints only 403 files were tested. If a file did not have a claim after the claim denial for the same level of service, it was not applicable. Claims testing was performed on applicable files to determine if claims were handled in compliance with medical necessity, utilization review guidelines, the member's certificate and North Dakota law. The results of testing are provided in the table below:

Standards Tested	No. Files	Files Not Applicable	Files Passed	Files Failed	% Failed
Payments and denials of claims after preauthorization complied with North Dakota law	403	236	104	63	38%

Testing of the 403 files determined 236 files were not applicable because they did not involve a claim submission for the denied services. Testing was performed on all claims for the member around the time of a preauthorization denial to follow the members' step-down process and all the claims handled during that process. It was determined that 167 member files involved a submission of a claim after denial at preauthorization, and for 63 members a claim failed to be paid or denied properly in compliance with the Company's utilization review guidelines, medically necessity guidelines and/or its contracts, and North Dakota law. Therefore, the Company's actions were not in compliance with N.D.C.C. § 26.1-04-03(7)(b) and (9)(c). The Company agreed it had not paid or denied the claims in compliance with its preauthorizations and/or medical necessity guidelines. In addition, the Company supplied information that it had taken or was taking steps to address the claims processing deficiencies.

The Company provided medically necessary preauthorizations with a conditional approval. The Company stated conditional approval denotes the services requested are authorized, provided the claim submitted by the provider is for the services requested and the member is still a

member at the time the services are rendered. For one of the claims failed above, the member was preauthorized for 15 days of services and met the conditional approval requirements, and the claim was denied in its entirety. The company agreed.

III. Level I, II, and Expedited Appeals for Mental Health and Substance Abuse Benefits Were Tested to Determine If They Are Handled in Accordance With Company Guidelines, Policy Provisions, and North Dakota Statutes and Rules.

The Company provided a total of 364 appeals during the period under examination. The appeals were sorted to determine how many files were coded with psychological or substance abuse services. Sixty-seven appeals files addressed these two subject matters. There were three additional appeals files where the reason for the appeal was unclear and, therefore, those files were sampled. There were a total of 70 appeals files sampled for testing.

Of the 70 appeals files sampled, 51 files concerned mental health and substance abuse services or only substance abuse services. Because of duplicative files, the 51 files were reduced to 45 due to the elimination of 6 files. There were a total of 64 files tested, 19 files pertained to mental health only and 45 involved substance abuse. The results of testing are provided in the table below:

Standards Tested	No. Files	Files Passed	Files Failed	% Failed
Appeal files - allow for medically necessary services	64	57	7	11%

Concerning 5 of the 64 appeals files tested, the members were denied preauthorization of services because the Company determined the services were not medically necessary. However, the Company subsequently allowed payment for those claims despite the denial at preauthorization. These actions appeared unfairly discriminatory because the Company paid policy benefits and services that would not have been permitted for other similarly situated members which was not in compliance with N.D.C.C. § 26.1-04-03(7)(b), (9)(a) and (9)(c)

Concerning 1 appeal file, the Company stated denial of 23 related claims was valid because the services were not medically necessary. It also denied these claims during two appeals. After the member complained to the Department, the Company reexamined the claims at the request of the Department and ultimately determined the claims should be paid. The claims were paid without providing information substantiating why the claims were paid, and what had changed to validate the services were medically necessary as outlined in this member's certificate of coverage. The initial denial of the claims may not have been completed in compliance with the member's certificate of coverage or the Company's medical necessity guidelines. However, because the Company did not provide a reason for the payment based on medical necessity, it may have paid claims inaccurately rather than denied the claims inaccurately. Therefore, the claim denials and the denials at appeal may not have complied with N.D.C.C. § 26.1-04-03(7)(b) and (9)(c).

Forty-five appeals files involving substance abuse or substance abuse and mental health combined were tested to determine if the Company allowed medically necessary substance abuse services in compliance with its contractual obligations and the ASAM guidelines. The results of testing are provided in the table below:

Standards Tested	No. Files	Files Passed	Files Failed	% Failed
Allowance of medically necessary services for substance abuse according to ASAM guidelines	45	39	6	13%

Testing of the 45 files involving substance abuse services determined there were 6 wrongfully denied appeals for preauthorization of substance abuse services based on the Department's retained medical professional's interpretation and application of the ASAM guidelines. The Company disagreed with the findings for the six failed files and asserted that the files were appropriately reviewed by its board certified psychiatrists with training in the use of ASAM and external consultants who are board certified in addiction psychiatry. The interpretation and application of the ASAM guidelines involves complicated clinical treatment and medical evaluation criteria, and due to the inherently subjective nature of the treatment and criteria, qualified medical professionals can reach differing conclusions. The Company's decisions may have failed to allow for medically necessary substance abuse services. Failing to allow medically necessary services under the ASAM guidelines would not be in compliance with N.D.C.C. § 26.1-04-03(7)(b), (9)(a) and (9)(c).

IV. Grievances Associated With a Mental Health or Substance Abuse Benefit Are Handled in Accordance with Company Guidelines, Policy Provisions and North Dakota Statutes and Rules.

A total of three grievances were provided by the Company for the period under examination. One of the grievances appeared to be applicable to the scope of testing. The file was tested and no issues were noted during testing.

Standards Tested	No. Files	N/A	Files Passed	Files Failed	% Failed
Grievances handled properly	3	2	1	0	0%

RECOMMENDATIONS

1. The Company should continue the recent internal audit program enhancements to ensure testing is performed on the timeliness and accuracy of claims processing for behavioral health claims.

2. The Company should comply with all provisions of the ACA and North Dakota law in effect as of the date of this Examination Report including the definition of dependents and the prohibition of medical underwriting.

3. The Company's marketing materials should not provide misleading or false information.

4. The Company's marketing materials should be consistently applied to all employer groups.

5. The Company should not provide incomplete information when communicating with the Department.

6. The Company should coordinate benefits with automobile insurers in compliance with its contracts and with North Dakota law.

7. The Company should only pay or deny claims when in compliance with its utilization review guidelines, the ASAM guidelines, medical necessity, contractual obligations and North Dakota law.

8. The Company should take appropriate steps to ensure NISI strictly observes all corporate formalities.