REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

CONTINENTAL GENERAL INSURANCE COMPANY

NAIC# 71404

AS OF

DECEMBER 31, 2007

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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:

CONTINENTAL GENERAL INSURANCE COMPANY

NAIC # 71404

The above examination was conducted by Sandra Lewis, CIE, MCM, Examiner-in-Charge, and James Dargavel, CIE, MCM, Senior Market Conduct Examiner.

The examination covered the period of January 1, 2007, through December 31, 2007.

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

Sincerely yours,

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James Dargavel, CIE, MCM, Senior Market Examiner, the examination of Continental General 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, MCM
Market Conduct Examiner-in-Charge

Subscribed and sworn to before me this 15th day of June, 2009

Claire Rus

Notary Public

My Commission Expires May 9, 2013

OFFICIAL SEAL
CLAIRE RUS
NOTARY PUBLIC - State of Arizona
MARICOPA COUNTY
My Comm. Expires May 9, 2013

FOREWORD

This targeted market conduct examination of Continental General 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 conduct 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 conduct examination of the Company covered the period from January 1, 2007, through December 31, 2007, 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 11.

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 on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using ACL (formerly "Audit Command Language) 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 beginning at page 11, and the examination findings are reported beginning on page 5.

1. The Company failed Standard 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), by failing to perform an adequate investigation

into other diagnoses listed on the claims on eight (9.8%) of the 82 files reviewed for claims denied under Reason Codes N01 and N04.

2. The Company failed Standard No. 2:

   a. In apparent violation of A.R.S. § 20-1342(A)(3) because the Newborn Rules do not indicate that newborn children of an Arizona insured are provided health insurance coverage for 31 days from the instant of the child's birth.

   b. In apparent violation of A.R.S. § 20-2533(D) by failing to prominently display a statement about the member's right to appeal an adverse claim decision on EOB forms sent to both the insured and the provider (no form number available).

   c. 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 to allow members and providers to appeal an adverse decision on 69 (84.1%) of the 82 files reviewed for claims denied under Reason Codes N01 and N04.

   d. 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 any reason for the denial of claims in two (7.1%) of the 28 files reviewed for a sample selected from claims where the Company's data run provided no reason for the denial of the claim.

3. The Company passed Standard No. 3 with comment. The Company was in apparent violation of A.R.S. § 20-462(A) by failing to pay interest at the legal rate on all first party claims not paid within thirty days after the receipt of an acceptable proof of loss by the insurer which contains all information necessary for claim adjudication on one (1.2%) of 82 files reviewed for claims denied under Reason Codes N01 and N04.

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 six Department of Insurance complaints, 39 consumer complaints and 15 appeals from denied claims during the examination period. The Examiners selected three Department of Insurance complaints, 20 consumer complaints, and all 15 appeals for review. No trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or EOB messages were noted during the review of the files selected from the appeal and complaint logs.

The Company provided a population of 5,004 claims denied during the examination period. Using CPT codes and EOB codes identified during the review of denied claim populations, the Examiners extracted a subpopulation of 1,814 denied claims. The Examiners selected five claim sample groups for review from the subpopulation, consisting of 136 files, using the reason for the denial of the claim as the selection criterion. In view of the findings during the review of the Phase I NC claim sample a Phase II examination was called by the Department. The Examiners selected an additional random sample of 55 NC claim files from the population of 1,195 files for review by the examiners.

The following table summarizes the samples selected and reviewed by the Examiners:

ADOI Prefix	Description	Sub-Population	Phase I Sample	Phase II Sample	Total Sample
CG-NC	Not Covered	1,195	27	55	82
CG-RE	Routine Examination	280	27		27
CG-EW	Exclusion Waiver	107	27		27
CG-RES	Rescission	204	27		27
CG-NR	No Reason	28	28		28
	Totals	**1,814**	**136**	**55**	**191**

As a result of the review of the Attachment A and B information and the 191 denied claims, the Examiners identified the following findings.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's denied health care claims, the Company failed with regard to claims denied under Reason codes N01 and N04 to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. §§ 20-461(A)(3) and (4) and A.A.C. R20-6-801

The Company failed to meet the standard for claims denied under Reason codes N01 and N04 (Sample CG-NC) as follows:

Of the 82 denied claims reviewed under Reason Codes N01 and N04, the Examiners identified eight (9.8%) claims where the Company coded the services as "This service or treatment is not a covered expense under your policy." or "This condition is not a covered expense under your policy" despite a diagnosis code indicating the services may have been provided due to illness or to symptoms of a possible medical condition.

The Company denied these eight claims without performing an adequate investigation into other diagnoses listed on the claims; therefore the Company has not met Standard No. 1 and is in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F). Reference PFs # 002 and # 010.

Recommendations 1 through 4

Within 90 days of the filed date of this report, the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company is performing and adequate investigation on all claims prior to the initial denial of the claim as prescribed by A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).
2. Perform a self audit on claims denied using the N01 and/or N04 reason codes for the period of two years prior to the filed date of this Report to determine if a reasonable investigation was completed prior to the denial of the claim and whether these claims were denied appropriately.

3. Pay restitution including interest at the legal rate of 10% per annum for any claim identified from the self-audit as having been denied inappropriately; and

4. With each payment of restitution, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification and correction of the previous denial.

Subsequent Events for Standard 1

The Company provided the Examiners copies of EOBs on the eight cited claims that were sent to claimants where the claim was reprocessed and either an additional payment was made or an amount was applied to the deductible. Claim CG-NC-017 was paid on appeal. The chart below lists the additional reprocessed claim amounts.

ADOI No.	*Billed Amount*	*Approved Amount*	*Applied to Deductible*	*Paid to Claimant*	*Interest Paid*
CG-NC-017	*$9,448.03*	*$9,448.03*		*$9,448.03*	*See Standard 3*
CG-NC-018	*$85.00*	*$70.43*		*$70.43*	*$8.10*
CG-NC-032	*$120.00*	*$120.00*	*$120.00*		
CG-NC-037	*$30.00*	*$30.00*		*$30.00*	*$7.22*
CG-NC-042	*$121.00*	*$121.00*		*$60.50*	*$13.37*
CG-NC-070	*$30.00*	*$24.00*		*$24.00*	*$2.03*
CG-NC-071	*$50.00*	*$40.50*	*$14.50*	*$16.00*	*$2.47*
CG-NC-077	*$115.00*	*$80.55*	*$30.00*	*$50.55*	*$4.85*
Totals	***$9,999.03***	***$9,934.51***	***$164.50***	***$9,699.51***	***$38.04***

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's claim procedures, 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)(5) and A.A.C. R20-6-801(G)(1)(a)

The Company failed to meet the standard for claim procedures, forms and claims denied as follows:

FORMS REVIEW

As a result of the review of the EOB forms and denial letters issued by the Company during the examination period the Examiners identified apparent violations of Standard 2. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified, and therefore recommendations are warranted.

Newborn Rules

The Newborn Rules found in the Company's claim procedures do not indicate that newborn children of an Arizona insured are provided health insurance coverage for 31 days from the instant of the child's birth, listing newborn coverage criteria for 27 other states, but not Arizona, therefore the Company has not met Standard 2 and is in apparent violation of A.R.S. § 20-1342(A)(3). Reference PF # 001.

EOB Appeal Notice

The EOB forms sent to both the insured and the provider (no form number available) failed to prominently display a statement about the member's right to appeal an adverse claim decision, therefore the Company has not met Standard 2 and is in apparent violation of A.R.S. § 20-2533(D). Reference PFs # 005, #006 and # 008.

FILE REVIEW

Insufficient Reason Given for Denial (Sample CG-NC)

Of the 82 denied claims reviewed under Reason Codes N01 and N04, the Examiners identified 69 (84.1%) files where the EOB message failed to reference a specific exclusion in the policy for the illness or medical condition diagnosed by the treating facility. The Examiners found that:

1. Thirty-one files contained denials using Reason Code N01 where the Company's explanation for the denial of services was "This service or treatment is not a covered expense under your policy," and
2. Thirty-eight files contained denials using Reason Code N04 where the Company's explanation for the denial of services was "This condition is not a covered expense under your policy"

The reasons given for the denials fail to provide a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal the adverse decision; therefore the Company has not met Standard 2 and is in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a). Reference PFs # 003 and # 009.

No Reason Given for Denial (Sample CG-NR)

The Examiners selected a sample of 28 denied claim files from a subpopulation of 28 records where the data provided by the Company failed to list a reason code for the denial. Of the 28 denied claims reviewed the Examiners identified two (7.1%) files where the EOB did not include any reason for the denial of the claim. Therefore the Company has not met Standard 2 and is in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 007.

Recommendations 5 through 8

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:

5. Has amended the Newborn Rules found in the Company's procedures to include details concerning newborn coverage in Arizona as prescribed by A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1).

6. Has modified, and implemented use of an EOB form that prominently displays a statement about the member's right to appeal an adverse claim decision as prescribed by A.R.S. §-20-2533(D).
7. Has modified the EOB message sent to the provider and the insured when a claim is denied because the condition or treatment is not covered under the terms of the policy contract, to include in the EOB message a reference to a specific exclusion in the policy for the illness or medical condition diagnosed by the treating facility as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).
8. Includes the reason for the denial of the claim on all EOB forms sent to the provider and the insured as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

Subsequent Events for Standard 2

1. *The Company provided the Examiners with a modified Explanation of Benefits form where the Appeal Notice was prominently displayed.*
2. *American Republic and affiliated companies, including Continental General, initiated a project in December 2008 to change the denial reason codes to meet the state requirements. The Company provided a copy of the revised denial reason codes, which had been previously approved by the Department.*

The Examiners have provided copies of these documents to the Department at the completion of the examination review.

EXAMINATION FINDINGS – PASSED STANDARD 3 WITH COMMENT

Based on the Examiners' review of the Company's denied health care claims, the Company failed with regard to one claim that was appealed, where the original denial of the claim was overturned and the claim was paid under Reason codes N01 and N04, to meet the following standard for review:

#	STANDARD	Regulatory Authority
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims.	A.R.S. § 20-462(A)

The Company failed to meet the standard for one (1.2%) of 82 reviewed claims denied under Reason codes N01 and N04 by failing to pay interest at the legal rate on a first party claim not paid within thirty days after the receipt by the insurer of an acceptable proof of loss that contains all information necessary for claim adjudication. This claim is identified by ADOI File Number CG-NC-017. Reference PF # 004.

Recommendation 9

Within 90 days of the filed date of this report, the Company should provide documentation that interest has been paid on the claim identified by ADOI File Number CG-NC-017, as prescribed by A.R.S. § 20-462(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 20-2533(D), 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 (With comment)	