



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

**AMERICAN FAMILY MUTUAL INSURANCE COMPANY
MADISON, WISCONSIN**

NAIC COMPANY CODE 19275

AS OF

DECEMBER 31, 2002

TABLE OF CONTENTS

| | |
|---|-----------|
| EXECUTIVE SUMMARY | 4 |
| SCOPE OF EXAMINATION..... | 4 |
| COMPANY OPERATIONS/MANAGEMENT..... | 7 |
| COMPANY HISTORY | 7 |
| MANAGEMENT AND CONTROL..... | 7 |
| <i>Board of Directors</i> | 7 |
| <i>Officers</i> | 8 |
| PROMPT PAYMENT OF CLAIMS | 9 |
| FINDINGS | 9 |
| CONCLUSIONS/RECOMMENDATIONS | 15 |
| ACKNOWLEDGMENT | 17 |
| AFFIDAVIT | 18 |
| APPENDIX A | 19 |
| CLAIMS PROMPT PAY | 19 |

December 1, 2004

Honorable Cory Streisinger, Director
Department of Consumer and Business Services
State of Oregon
350 Winter Street, NE, Room 440
Salem, OR 97301-3883

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

**American Family Mutual Insurance Company
6000 American Parkway
Madison, Wisconsin 53783-0001**

NAIC Company Code 19275

hereinafter referred to as the "Company." The following report of examination is respectfully submitted.

EXECUTIVE SUMMARY

American Family Mutual Insurance Company (the Company) was examined at their offices at 5000 American Parkway in Madison, Wisconsin during October 2003. The purpose of the examination was to determine if the Company was in compliance with Prompt Payment statutes, rules and regulations, specifically ORS 743.866, ORS 743.868, OAR 836-080-0080 and OAR 836-080-0085.

The examination included the review of claims samples along with the Company's written claims procedures, provider contracts and provider manual to evaluate compliance with the following four standards:

- Prompt Pay Standard #1 – The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable rules and regulations.
- Prompt Pay Standard #2 – The Company's provider contracts are in compliance with applicable statutes, rules and regulations.
- Prompt Pay Standard #3 – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.
- Prompt Pay Standard #4 – The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.

The Company failed Prompt Pay Standards #1, #3 and #4.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of December 31, 2002, covering the period of January 1, 2002 through December 31, 2002, and included a review of

material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target market conduct emphasis examination was performed. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners to the extent that it is consistent with Oregon law. The purpose of the examination was to determine if the Company was in compliance with Prompt Pay statutes, rules and regulations. It was further intended to identify and assess the practices and procedures implemented by the Company to comply with Prompt Payment statutes. The findings in this examination demonstrate that the Company needs to develop an action plan to ensure they comply with Prompt Payment statutes.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following two phases:

| | |
|-------------------------------|--------------------------|
| Company Operations/Management | Prompt Payment of Claims |
|-------------------------------|--------------------------|

The Company’s underlying data was measured against an established standard. A list of all standards considered can be found in Appendix A at the end of the report. The examiner used the following three classifications to disclose the examination results:

| | |
|------------------------|---|
| Passed without Comment | The standards the Company passed are displayed in a chart at the beginning of the Findings section of each phase. Items included in this category passed the standard and the examiner did not find it necessary to comment on the findings. |
| Passed with Comment | Standards the Company passed with some errors noted are included in this classification. Items in this category are not considered to be indicative of a general business practice of noncompliance. Usually, a recommendation is not warranted, but in certain instances a recommendation might be made. |
| Failed | The Company has not demonstrated compliance with standards that fall into this category. A recommendation for compliance is usually made for each standard the Company fails. |

Information regarding some items might be noted in the examination report without remarks.

Some 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 which would serve to assist the Director. Failure to identify or criticize specific Company practices does not constitute acceptance by the Oregon Insurance Division. Examination findings may result in administrative action or further inquiry.

Other areas of concern discovered during the examination that do not fall within the scope of the standards might appear in the report as the last section of each phase and be titled Additional Findings and Procedures.

COMPANY OPERATIONS/MANAGEMENT

Company History

The Company began as Farmer's Mutual Insurance Company and was founded on October 3, 1927, in Madison, Wisconsin. In 1963, Farmers Mutual Insurance Company changed its name to American Family Mutual Insurance Company to reflect its broader customer base. The Company began marketing insurance in the State of Oregon in 1998.

American Family Insurance Company is a multi-line insurance provider with a wide variety of products available for individuals and businesses. Insurance products are presently written in the following 17 states: Arizona; Colorado; Idaho; Illinois; Indiana; Iowa; Kansas; Minnesota; Missouri; Nebraska; Nevada; North Dakota; Ohio; Oregon; South Dakota; Utah; and Wisconsin.

Management and Control

Board of Directors

The members of the Board of Directors as of December 31, 2002 were:

| <u>Name</u> | <u>Location</u> | <u>Principal Affiliation</u> |
|---------------------|------------------------|--|
| David R. Anderson | Madison, WI | President and COO, American Family Insurance Group |
| Ted D. Kellner, CFA | Milwaukee, WI | Chairman and CEO, Fiduciary Management, Inc. |
| Dale F. Mathwich | Madison, WI | |
| Thomas J. Mohs | Madison, WI | Chairman, Placon |
| Walter M. Oliver | Falls Church, VA | Vice-President, Human Resources and Administration, General Dynamics |

| | | |
|--------------------------|------------------|---|
| Barbara A. Parish | Watertown, WI | President, Wis-Pak |
| Harvey R. Pierce | Madison, WI | Chairman and CEO, American Family Insurance Group |
| Eliot G. Protsch | Cedar Rapids, IA | |
| Richard R. Renk | Sun Prairie, WI | Chairman, William F. Renk & Sons |
| Beverly S. Simone, Ed.D. | Madison, WI | President and CEO, MATC |
| John D. Wiley | Madison, WI | Chancellor, University of Wisconsin-Madison |
| Thomas J. Zimbrick | Madison, WI | Chairman and CEO, Zimbrick, Inc. |

Officers

The principal officers of the Company as of December 31, 2002 were:

| Name | Title |
|------------------------|---|
| Harvey R. Pierce | Chairman and CEO |
| David R. Anderson | President and COO |
| Darnell Moore | Executive Vice-President, Administration |
| Vicki L. Chvala | Vice-President, Human Resources |
| Byrne Chapman | Vice-President, Information Services |
| Richard J. Haas | Vice-President, Office Administration |
| Jack C. Salzwedel | Vice-President, Personal Lines |
| James F. Eldridge | Executive Vice-President, Corporate Legal Secretary |
| Terese A. Taarud | Vice-President, Claims |
| Nancy M. Johnson | Vice-President, Education |
| Mark V. Atable | Vice-President, Government Affairs and Compliance |
| Christopher S. Spencer | Vice-President, Legal |
| Richard A. Fetherston | Vice-President, Public Relations |
| James W. Behrens | Assistant Secretary |
| J. Brent Johnson | Executive Vice-President, Finance and Treasurer |
| Bradley J. Gleason | Vice-President, Actuarial |
| Daniel R. Schultz | Vice-President, Controller |
| Thomas S. King | Vice-President, Investments |
| William J. Smith | Assistant Treasurer |
| Daniel R. DeSalvo | Executive Vice-President, Sales |
| Joseph W. Tisserand | Vice-President |
| Jerry G. Rekowski | Vice-President, Commercial Lines |
| Alan E. Meyer | Vice-President, Marketing |
| David N Krueger | Sales Vice-President, Great Lakes Region |
| Michael "Ranger" Duran | Sales Vice-President, Midland Region |
| Donald Altermann | Sales Vice-President, Mountain Region |

| | |
|--------------------|--|
| Jeffrey E. Burke | Sales Vice-President, Northwest Region |
| M. J. "Jeff" Bosco | Sales Vice-President, Valley Region |

PROMPT PAYMENT OF CLAIMS

From a population of 1,951 claims finalized during the examination period, a random sample of 25 was selected for review. In addition, from a population of 172 claims for which the Company had previously provided detailed information regarding claims handling to the Department of Consumer and Business Services (DCBS), a random sample of 25 was selected for review. The Company’s written claims procedures, provider contracts and Provider Manual were also reviewed.

Findings

The Company passed the following standard without comment:

| <u>Standard</u> | <u>Regulatory Authority</u> |
|---|------------------------------------|
| <u>Prompt Pay Standard #2</u> - The Company's provider contracts are in compliance with applicable statutes, rules and regulations. | ORS 743.866(2) |

The following exceptions were noted:

Prompt Pay Standard #1 - The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations.

Reference: ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2).

Findings: Failed – 50% compliance.

This standard applied to all 50 of the claims reviewed. Of those claims, 25 (50%) failed this standard. Following is a chart summarizing the reasons for failure:

| <u>Reason for Failure</u> | <u># of Claims</u> |
|--|---------------------------|
| The Company did not notify the provider of service that information had been requested from the insured and/or another provider. | 11 |
| The Company did not notify the provider of service that information had been requested from the insured and/or another provider. Also, the Company did not request all additional information necessary to process the claim within 30 days. | 3 |
| The Company did not notify the provider of service that information had been requested from the insured and/or another provider. Also, the Company did not process the claim within 30 days of receipt of the additional information. | 2 |
| The Company sent the provider of service a delay letter within 30 days, but the letter did not specify what information was needed from the insured and/or another provider to process the claim. | 5 |
| The Company sent the provider of service a delay letter within 30 days, but the letter did not specify what information was needed from the insured and/or another provider to process the claim. Also, the Company did not request all additional information necessary to process the claim within 30 days. | 1 |
| The Company sent the provider of service a delay letter within 30 days, but the letter did not specify what information was needed from the insured and/or another provider to process the claim. Also, the Company did not request all information necessary to process the claim within 30 days. In addition, the Company did not process the claim within 30 days of receipt of the additional information. | 1 |
| The Company sent the provider of service a delay letter, but the letter was not sent within 30 days and did not specify what information was needed from the insured and another provider. | 1 |
| The Company did not finalize the claim within 30 days and did not request any additional information. | 1 |

In addition to the claims reviewed that were not handled in compliance with Prompt Payment requirements, the following problems were found with the Company's written procedures:

- The written procedures initially provided did not specify how the Company calculated the number of days for which interest was paid. During the examination, the Company revised

their written procedures to specify they use the first business day following the date paid to calculate interest due to allow time for mailing.

- During the examination period, when the Company delayed payment for repricing information from a provider network, they notified neither the insured nor the provider of the additional information necessary to process the claim. They advised they do not consider sending a bill for repricing to be a request for additional information as the network repricers function on the Company's behalf. However, the Company did not treat the bill like a claim pending for internal review. In fact, when the bill was returned with the repricing information, the Company treated it as a new claim, assigned a new document number and considered the date the repricing information was received as the date the claim was received. This resulted in incorrect information being reported to DCBS. See Standard 4 for additional information on this issue.
- During the examination period, when the Company delayed payment for information from the insured, they did not have a process for routinely notifying the provider of the additional information necessary to process the claim. They indicated they implemented a new process in October 2003 to automatically notify the provider of the delay. However, the letter used only indicated the claim was pending. It did not specify what additional information was needed to process the claim. The Company subsequently revised the letter to incorporate additional text by use of variable codes. However, one such code resulted in the following text: "Additional information requested from entity." That does not indicate what additional information is needed to process the claim. Also, one sample letter to a provider stated: "When we have received all necessary information, we will honor the assignment of

insurance benefits if the claim is compensable or will advise you if it is not." Again, this does not indicate what additional information was needed to process the claim.

- During the examination period, when the Company delayed payment on a claim from one provider for information from a different provider, they did not have a process for routinely notifying the provider of the additional information necessary to process the claim. Again, they indicated they implemented a new process in October 2003, to automatically notify the provider of the delay. However, as noted above, the letter used did not specify what additional information was needed to process the claim.

I recommend the Company process all claims that are subject to the application of prompt payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2) and OAR 836-080-0080(1) & (2).

Prompt Pay Standard #3 – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.

The Company advised their primary point of contact and method of communicating with providers is the identification card. They advised the identification card contains the necessary addresses and contact information for providers and, if providers were to inquire about their filing requirements using the number on the identification card, their claims adjusters would provide them with the filing requirements contained in the policy.

However, the identification cards are issued to insureds, not to providers. In addition, although the identification card provides the address to which claims are to be submitted, it does not

specifically address the issue of procedures and information necessary to complete claim forms. Unless the provider happens to call the telephone number on the identification to request additional information, such procedures and information are not provided.

The Company's method of communicating to providers the procedures and information necessary to complete claim forms does not make such procedures and information reasonably accessible to providers.

The Company advised they plan to put information on such procedures on their web site.

I recommend the Company revise their disclosures to providers to comply with ORS 743.866(3) and OAR 836-080-0080(3).

Prompt Pay Standard #4 - The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations. Reference: ORS 743.866(5), OAR 836-080-0085.

Findings: Failed – 32% compliance.

This standard applied to the 25 claims reviewed for which the Company had previously provided detailed claims information to DCBS. Of those claims, 17 (68%) failed this standard because one or more of the pieces of information reported were in error. The following chart describes the errors and indicates the number of files reviewed in which each type of error was found:

| Type of Error | # of Files |
|---|-------------------|
| Reported Date Additional Information Received was in error. In four cases, the date additional information received reported was the date the additional information was reviewed rather than the date it was received. In one case, it was | 6 |

| | |
|---|---|
| a date on which additional information was received, but not the latest date information necessary to process the claim was received. In the other case, no date was reported even though the additional information had been received. | |
| In all cases, the claim status reported was denied rather than paid. However, eligible charges had been applied to deductible, not denied. The Company indicated they internally refer to claims on which no payment is made because they are applied entirely to deductible as denied claims, but will categorize them as paid claims for future reports. | 5 |
| Reported Date Additional Information Received and Claim Status were in error. In two cases, the date additional information received reported was the date the additional information was reviewed rather than the date it was received. In the other case, it was a date on which additional information was received, but not the latest date information necessary to process the claim was received. In all cases, the claim status reported was denied, but eligible charges had been applied to deductible, not denied. | 3 |
| The claim should not have been included in the list of claims that took over 30 days to finalize because payment was made within 30 days of receipt. | 1 |
| The claim should not have been included in the report because, although it was finalized during 2002, it was received in 2001. For future reports, subject claims finalized during the year being reported are to be included regardless of received date. However, in accordance with OAR 836-080-0085(6), for the purpose of the report due for calendar year 2002, only those claims received as well as finalized during 2002 were to be included. | 2 |

In addition to errors found in the information reported on the above claims, based on the Company's standard procedures, the Company reported erroneous information on any PPO claim they received without repricing information. Those procedures were as follows:

- A document number was assigned to the claim.
- The claim was sent to the PPO for repricing.
- When the claim was returned, a new document number was assigned.
- The date received for the first document number was the date the claim was first received.
- The date received shown for the second document number was the date the claim was received with the repricing information.

- The first document number was noted as a duplicate and no action was taken under that number.
- The second document number was the number under which the claim was processed for payment or denial.

The above procedures resulted in the following errors:

- Information reported for the first document number assigned to such a claim was incomplete because it did not include a date finalized.
- The date the claim was returned for repricing information was not reported as the date additional information was requested.
- The date the repricing information was received was not reported as the date additional information was received.
- Information reported for the second document number assigned to such a claim was incorrect because, for date received, it showed the date the repricing information was received rather than the date the claim, itself, was first received. Therefore, the number of days to finalize the claim was also incorrect.

I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085.

CONCLUSIONS/RECOMMENDATIONS

| <u>No.</u> | <u>Recommendation</u> | <u>Page</u> |
|-------------------|--|--------------------|
| 1 | I recommend the Company process all claims that are subject to the application of prompt payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2) and OAR 836-080-0080(1) & (2). | 12 |

| | | |
|---|--|----|
| 2 | I recommend the Company revise their disclosures to providers to comply with ORS 743.866(3) and OAR 836-080-0080(3) | 13 |
| 3 | I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085. | 15 |

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the Examination Coordinators for their courtesy and assistance providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of their regular assigned duties.

Respectfully submitted,

Cindy J. Jones, AIE, CPCU, CRM
Manager Market Surveillance
Insurance Division
Department of Consumer and Business Services
State of Oregon

APPENDIX A

**OREGON INSURANCE DIVISION
MARKET CONDUCT EXAMINATION
American Family Mutual Insurance Company**

Claims Prompt Pay

| <u>#</u> | <u>Standard</u> | <u>Regulatory Authority</u> |
|-----------------|--|---|
| 1 | The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations. | ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2) |
| 2 | The Company's provider contracts are in compliance with applicable statutes, rules and regulations. | ORS 743.866(2) |
| 3 | The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations. | ORS 743.866(3), OAR 836-080-0080(3) |
| 4 | The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations. | ORS 743.866(5), OAR 836-080-0085 |