REPORT OF MARKET CONDUCT EXAMINATION

UNITEDHEALTHCARE INSURANCE COMPANY

4 Research Drive
Shelton, CT 06484

NAIC Company Code 79413

NAIC Examination Tracking System Number ME114-1

Examination Period:

January 1, 2015 through December 31, 2015

December 8, 2017

Honorable Eric A. Cioppa
Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Superintendent Cioppa:

Pursuant to 24-A M.R.S. §§ 211 and 221, and in accordance with your instructions, a targeted market conduct examination ("Examination") has been made of:

UnitedHealthcare Insurance Company

The Examination reviewed UnitedHealthcare's ("Company") Maine appeal handling practices and claim denials for the Accident and Health line of business. The Examination covered the period from January 1, 2015, through December 31, 2015 ("Review Period"). The Maine Bureau of Insurance ("Bureau") staff conducted the on-site phase of the Examination, from September 19, 2016, through September 23, 2016, at the Company's offices located at 4 Research Drive, Shelton, CT. Due to issues with the initial population provided by the Company, Bureau staff conducted a desk exam of a new sample of files from April 11, 2017, through April 20, 2017. Additional examination work conducted at the Bureau included preliminary review of information provided by the Company, transactional testing, and follow-up communications.

The following report is respectfully submitted.

Mary Masi

Mary Masi, CPCU, CIE, MCM
Senior Market Conduct Examiner

Pursuant to 24-A M.R.S. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of UnitedHealthcare Insurance Company. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

Honorable Eric A. Cioppa

12-8-17
Date

Superintendent
Maine Bureau of Insurance

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COMPANY PROFILE

UnitedHealthcare Insurance Company is licensed as a life, accident, and health insurer that is domiciled in the State of Connecticut. It was incorporated on March 24, 1972. It is licensed to sell life, accident, and health insurance in all states except New York and the District of Columbia. Its primary business is group accident and health policies issued to employers and associations. It also offers comprehensive commercial products to individual and employer groups. The Company participates in individual and small group exchange business in fourteen states and the District of Columbia.

The Company is a wholly owned subsidiary of UHIC Holdings, Inc., which is part of the ultimate parent company, UnitedHealth Group Inc. UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug coverage under a contract with the Centers for Medicare and Medicaid Services. The Company also provides health insurance products and services to members of the American Association of Retired Persons (AARP) under a supplemental health insurance program.

The Company's 2015 Maine Annual Report Supplement (Rule 945) reflects that there were 5,708 covered lives (line 5a[1]) in force as of December 31, 2015. The Report also reflects that the Company realized $15,140,399 million in total revenues (line 14).

[1]See, http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule945/rule945_reports.html

EXECUTIVE SUMMARY

In 2009, 24-A M.R.S. §221 was amended with the addition of subsection 5. Subsection 5, Examination of Health Carriers, states in its entirety that "[t]he superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State."

The examination was called as a statutorily required examination.

The examination was a targeted examination of the Company's Accident and Health product line focusing on whether the Company is complying with certain provisions of Maine Bureau of Insurance Rule 850. Rule 850 sets forth certain rights and protections available to individuals who are insured by health plans in Maine. The examiners specifically tested compliance with sections 8 and 9 of Rule 850. These sections list the required notices that must be sent to Maine consumers with all adverse benefit determinations and adverse appeal decision letters. These notices ensure, among other things, that Maine consumers are provided with specific instructions on how to proceed with an appeal of an adverse decision and that they are made aware of their rights to appeal, to contact the Bureau of Insurance, to proceed with an external review of a carrier's appeal decision, and to file a complaint against their health insurer. These sections of Rule 850 also describe the requirements that are the responsibilities of the insurers who will be conducting first and second level appeal reviews. The examiners tested the Company's compliance with sections 8 and 9 of Rule 850 by reviewing 60 randomly selected denied claim files and the only appeal received by the Company during the review period.

The only appeal file tested was a 1st level appeal that did not involve a health care treatment decision. The claim denials reviewed did not involve medical issues. The benchmark for claims practices is 93% compliance. Overall, the Company was 0% compliant in its handling of the 60 denials and was 0% compliant with its handling of the one appeal.

Some tests were marked "n/a" because the subsection of Rule 850 being tested for did not apply to that particular file. For example, some reasons for claim denials do not involve specific plan provisions, and, therefore, the provision of 850 requiring a denial notice to include reference to a specific plan provision would not be applicable.

Overall, the examiners found that the Company was not compliant with Bureau Rule 850 in its handling of denials and of first level appeals.

SCOPE OF EXAMINATION

The objective of the Examination was to review appeal files and denied claims for the Company's Accident and Health product line to ensure that they contained the appeal rights information required by Rule 850. The examiners used transactional testing[2] to determine compliance with the applicable regulations.

The Examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223. It was conducted in a manner that was consistent with the standards set forth in the Market Regulation Handbook (MRH) as required by 24-A M.R.S. § 223(2). The MRH was used for purposes of sample determination and overall guidance. Some unacceptable or non-compliant practices may not have been discovered in the course of the Examination. Failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by test rather than by exception. Each test applied is stated, and the results are reported.

[2] Transactional testing is the review of actual denied claims.

METHODOLOGY

Using the standards set forth in the MRH as guidance in accordance with 24-A M.R.S. § 223(2), the examiners reviewed the Company's handling of appeal files and denied claims to ensure that the sole appeal file and all denied claims contained the appeal rights required by Maine law. All files reviewed were initiated during the Review Period. The one appeal file and a random sample of denied claims were tested to ensure that they contained the appeal rights information required by Rule 850.

FINDINGS

1. Claims – Adverse Benefit Determinations (Denials)

Standard: For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required [by § 9(A)(1) through § 9(A)(11)].

Bureau Rule Chapter 850 § 9(A)

A. TEST 1: Did the Company comply with Rule 850 § 9 when issuing its written notices of adverse benefit determinations not involving medical issues?

B. REVIEW PROCESS: A sample population of 60 files was reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier's written notification include the principal reason or reasons for the determination? Ch. 850 § 9(A)(1)

Result: 60 pass, 0 n/a; 100 % compliance

Subsection 2: Did the health carrier's written notification include reference to the specific plan provisions on which the determination is based? Ch. 850 § 9(A)(2)

Result: 8 pass, 7 fail, 45 n/a; 53% compliance

Subsection 3: Did the health carrier's written notification include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request? Ch. 850 § 9(A)(3)

Result: 59 pass, 1 fail, 0 n/a; 98% compliance

Subsection 4: Did the health carrier's written notification include a description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary? Ch. 850 § 9(A)(4)

Result: 22 pass, 11 fail, 27 n/a; 67% compliance

Subsection 5: Did health carrier's written notification include the instructions and time limits for initiating an appeal or reconsideration of the determination? Ch. 850 § 9(A)(5)

Result: 60 pass, 0 fail, 0 n/a; 100% compliance

Subsection 6: Did the health carrier's written notification include notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process? In addition, did the explanation of benefits (EOB) must comply with the requirements of 24 A M.R.S. § 4303(13) and any rules adopted pursuant thereto? Ch. 850 § 9(A)(6)

Result: 0 pass, 60 fail, 0 n/a; 0% compliance

Subsection 7: Did the health carrier's written notification include if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 9(A)(7)

Result: 2 pass, 0 fail, 58 n/a; 100% compliance

Subsection 8: Did the health carrier's written notification include a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria? Ch. 850 § 9(A)(8)

Result: 0 pass, 60 fail, 0 n/a; 0% compliance

Subsection 9: Did the health carrier's written notification include a description of the expedited review process applicable to claims involving urgent care? Ch. 850 § 9(A)(9)

Result: N/A

Subsection 10: Did the health carrier's written notification include the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 9(A)(10)

Result: 58 pass, 2 fail, 0 n/a; 97% compliance

Finding 1

The Company did not comply with Bureau Rule 850 § 9 when issuing its written notices of adverse benefit determinations not involving medical issues.

0 files contained all required notices and followed all required procedures tested.

60 files had at least one violation.

The Company was 0% compliant.

2. Claims – 1st Level Appeals of Adverse Benefit Determinations

Standard: All requests for review of "adverse benefit determinations," other than "health care treatment decisions," are subject to the grievance review procedures set forth in section 9.

Bureau Rule Chapter 850 § 3(A)

A. TEST 2: Did the Company comply with the subsections of Rule 850 § 9 that are applicable to Level 1 appeals of adverse benefit determinations that did not involve health care treatment decisions?

B. REVIEW PROCESS: A total population of one file was reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier provide notice of the right to file a complaint with the Bureau of Insurance? Ch. 850 § 9(A)(6)

Result: 1 pass; 100% compliance

Subsection 2: Did the health carrier provide a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria? Ch. 850 § 9(A)(8)

Result: 1 fail; 0% compliance

Subsection 3: Did the health carrier provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier? Ch. 850 § 9(B)(2)

Result: 1 fail; 0% compliance

Subsection 4: Did the health carrier make these rights known to the covered person within 3 working days after receiving a grievance? Ch. 850 § 9(B)(2)

Result: 1 pass; 100% compliance

Subsection 5: Did the health carrier issue a written decision to the covered person within 30 days after receiving a grievance? Ch. 850 § 9(B)(2)(a).

Result: 1 pass; 100% compliance

Subsection 6: Did the appeal decision contain the names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers)? Ch. 850 § 9(B)(2)(b)(i)

Result: 1 fail; 0% compliance

Subsection 7: Did the appeal decision contain a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts? Ch. 850 § 9(B)(2)(b)(ii)

Result: 1 fail; 0% compliance

Subsection 8: Did the appeal decision contain a reference to the specific plan provisions on which the benefit determination is based? Ch. 850 § 9(B)(2)(b)(iii)

Result: 1 pass; 100% compliance

Subsection 9: Did the appeal decision contain the reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination? Ch. 850 § 9(B)(2)(b)(iv)

Result: 1 fail; 0% compliance

Subsection 10: Did the appeal decision contain a reference to the evidence or documentation used as the basis for the decision? The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. Ch. 850 § 9(B)(2)(b)(v)

Result: 1 pass; 100% compliance

Subsection 11: Did the appeal decision include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person? Ch. 850 § 9(B)(2)(b)(v)

Result: 1 pass; 100% compliance

Subsection 12: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 9(B)(2)(b)(vi)

Result: N/A

Subsection 13: Did the appeal decision contain a description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second

level grievance review, and the rights specified in subparagraph C(3)(c)? Ch. 850 § 9(B)(2)(b)(vii)

Result: 1 fail; 0% compliance

Subsection 14: Did the appeal decision contain a notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S. § 4312(3)? Ch. 850 § 9(B)(2)(b)(vii)

Result: N/A

Subsection 15: Did the appeal decision contain notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 9(B)(2)(b)(viii)

Result: 1 pass; 100% compliance

Subsection 16: Did the appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Ch. 850 § 9(B)(2)(b)(ix)

Result: 1 fail; 0% compliance

- Note: The Company failed this test because the appeal decision letter contained a website address that linked to a blog.

Finding 2

The Company did not comply with the applicable subsections of Bureau Rule 850 § 9 in its handling of first level appeals of adverse benefit determinations that did not involve health care treatment decisions.

The one appeal file did not contain all required notices and did not follow all required procedures tested

The Company was 0% compliant.

RECOMMENDATION

The Bureau recommends that the Company enact practices and procedures to ensure compliance with Rule 850.

ACKNOWLEDGMENT

The courtesy and hospitality extended by the officers and employees of the Company during the course of the Examination are gratefully acknowledged. The Examination was conducted and is respectfully submitted by the undersigned.

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Mary Masi, CPCU, CIE, MCM, Examiner in Charge, being duly sworn according to law, deposes and says that in accordance with the authority vested in her by Eric A. Cioppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, she has made an Examination on the condition and affairs of

UnitedHealthcare Insurance Company

as of December31, 2015, and that the foregoing report of Examination, subscribed to by her, is true to the best of her knowledge and belief.

The following examiner from the Bureau assisted:

Allan C. Armstrong, MCM, CWCLA

Mary Masi, CPCU, MCM, CIE
Senior Market Conduct Examiner

Subscribed and sworn to before me

This 8 day of December 2017

Notary Public

My commission expires:

KARMA LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2023