STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

UnitedHealthcare of Oregon, Inc.

AS OF

DECEMBER 31, 2020

NAIC Company Code: 95893

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FOREWORD

January 23, 2023

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
Division of Financial Regulation
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director Stolfi:

This market conduct examination report of UnitedHealthcare of Oregon Inc. (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers licensed to conduct business in the state of Oregon. The examiners conducted the examination of the insurer in accordance with the Oregon Revised Statutes (ORS) 731.300. All work papers and data developed in the production of this report are the sole property of the division. The examiner in charge was Timothy R. Nutt CIE, AIRC, MCM.

Certain unacceptable or noncomplying 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 Commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

Respectfully submitted.
Tashia Sizemore
Tashia Sizemore
Life and Health Program Manager

Signed and acknowledged before me on January 24, 2023 by Janet Vitus as notary in Marion County, State of Oregon.
Janet Vitus

OFFICIAL STAMP
JANET VITUS
NOTARY PUBLIC - OREGON
COMMISSION NO. 1030442
MY COMMISSION EXPIRES NOVEMBER 21, 2026

EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill (HB) 3391, known as The Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as Oregon Revised Statutes (ORS) 743A.067. RHEA requires, among other things, that a health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirements on the specific reproductive health services.

The focus of this targeted market conduct examination includes, but was not limited to, insurer policyholder services and complaints and claims as related to the coverage and cost-sharing provisions of RHEA, other state laws, and federal law.

This report is generally written in a "report by error" format. The report does not present a comprehensive overview of the insurer's practices. The report provides details of the noncompliant or problematic practices that were discovered during the course of the examination. All unacceptable or noncompliant activities may not have been discovered. Failure to identify, comment upon or criticize noncompliant practices does not constitute acceptance of such practices.

This report is intended to provide a summary of the findings discovered during this targeted examination. Findings observed during the examination are included in the body of the report as well as collected in the comments, findings, and recommendations sections.

The examination covered claims identified by the insurer as subject to RHEA to assess whether the insurer was in compliance with the cost-sharing requirements established under RHEA. The examination findings indicate that the insurer's claims processing system is adequately identifying RHEA claims, however, the company's unwillingness to cooperate with exam requirements was a barrier to a successful examination and resulted in examination delays. As indicated below, the company's unwillingness to cooperate with the exam requirements should be referred for enforcement consideration. The results of the examination and related findings are discussed in more detail in the sections below.

Specific findings related to the examination are summarized below:

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share such as copays, coinsurance, and deductible in the adjustment and payment of the claims. This occurred in multiple instances for paid and denied medical claims.[1]

This examination report, relating to RHEA claims for the period of January 1, 2019, to December 31, 2020, may be forwarded to the division's Enforcement Unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

[1] The insurers poor cooperation early in the examination prevented an adequate examination of the pharmacy claims.

SCOPE OF EXAMINATION

The Oregon Division of Financial Regulation (division) called a targeted market conduct examination of UnitedHealthcare of Oregon to determine compliance with Oregon's RHEA. The examination was called pursuant to Oregon Revised Statutes (ORS) 731.308.

The examination protocols generally follow the Market Regulation Handbook as adopted by the NAIC to the extent that it is consistent with Oregon laws. The focus of the examination was to determine if the company was in compliance with both federal and state law requiring proper cost sharing in health claims. The examination covered claims and complaints with dates of service between January 1, 2019, and December 31, 2020. Representatives from the firm of Examination Resources were engaged to administer the examination.

UnitedHealthcare of Oregon, Inc. , licensed as a health care service contractor (HCSC), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The insurer is a wholly owned subsidiary of United HealthCare Services, Inc. (UHS), a Health Maintenance Organization (HMO) management corporation that provides services to the insurer under the terms of a management agreement (agreement). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated (UnitedHealth Group). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The insurer was incorporated on August 28, 1985, as an HCSC and operations commenced in February 1987. The company is certified as an HCSC by the state of Oregon Department of Consumer and Business Services – Division of Financial Regulation. The insurer has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. The insurer is licensed in the states of Oregon and Washington.

The insurer offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions. Effective January 1, 2021, the insurer also participates in the ACA individual exchange market in Washington.

The insurer serves as a plan sponsor offering Medicare Parts A and B, along with Medicare Part D prescription drug insurance coverage (collectively Medicare Plans) under contracts with the Centers for Medicare and Medicaid Services (CMS).

This targeted market conduct examination evaluated the company's compliance with the Oregon Insurance Code within the statutes and Oregon Administrative Rules (OAR) in fulfilling its contractual obligations to policyholders relating to both policyholder services and complaints and claims. In the review of policyholder services and complaints, the examination focused on the procedures for complaints to be recorded in compliance with state and federal law, specifically OAR 836-053-1080, in facilitating proper compliance with cost-sharing. The scope of the claims examination specifically reviewed compliance by the company for proper cost sharing for all claims including not imposing cost-sharing on preventive services, as defined by the U.S. Department of Health and Human Services (HHS) and the U.S. Health Resources and Services

Administration (HRSA) and for the reproductive health and related preventive services required under Section 2 of the Oregon Reproductive Health Equity Act (hereinafter also known as RHEA) enacted in Oregon House Bill 3391 (2017) and codified at ORS 743A.067.

To determine compliance with RHEA, the following examination procedures were used:

- The insurer responded to initial interrogatories concerning the insurer business practices.
- Review of insurer financial information.
- The insurer provided requested data files of the following populations:
  - All paid claims for the examination period;
  - All denied claims for the examination period;
  - All paid RHEA claims (as identified by the insurer) for the examination period; and
  - All denied RHEA claims (as identified by the insurer) for the examination period.
- Sample testing of paid and denied RHEA claims (please note: The insurer did not provide remote access in order to accomplish the testing, as required by the division. Instead, sample testing was performed using electronic copies of claim documents).
- Review of the insurer's complaint log.

This examination report, relating to RHEA claims for the period of January 1, 2019, to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the company responds to the corrective actions identified in the examination report.

FINDINGS AND OBSERVATIONS – CLAIMS

a. Lack of examination cooperation

Under ORS 731.296, 731.308, 733.170, and OAR 836-080-0188, insurers are required to facilitate the examinations and make available requested and accurate information. The insurer failed to promptly, timely and conveniently make available information to readily ascertain treatment of policyholders by not providing data and files responsive to the examiners' requests.

b. Interrogatory analysis and observations

The insurer's claims department consists of a director, two associate directors, two managers, five supervisors and 122 claims adjusters. Each manager oversees two to three supervisors. Each supervisor manages a team of 20-32 claims adjusters.

The claims department is responsible for providing accurate and timely claims payments. The transactions leadership team reviews several key metric reports and performs analysis of the audit data quality. Key timeliness and quality metrics are also reviewed with plan leadership, including the vice president of transaction oversight.

PacifiCare, a subsidiary of the insurer, assists with claims processing. Both electronic and paper claims are processed. Paper claims are sorted by P.O. Box and form type. Both electronic and paper claims are uploaded into the Newly Integrated Computing Environment (NICE) and distributed to the imaging workflow system. Benefit determinations are made and claims payments are provided or denied.

The insurer uses the following claims administration computer systems: 1) the online processing system; 2) NICE; and 3) RxClaim. The insurer did not provide the required description of these systems[1]. The medical claims processing system used by the insurer was developed in-house. The insurer indicated it implements comprehensive upgrades to systems on a quarterly basis.

When a new or revised Oregon law is received, the insurer's claims processing policy is reviewed to determine if changes are required. The claims system is then updated with the newly configured information relating to the new or revised Oregon law. If a system enhancement is not possible, then a manual step action is added to the standard operating polices and company personnel are educated on the changes.

30-day letters

The division requested that the insurer "provide a sample claims acknowledgement letter (or electronic notice) for claims not processed within 30 days." The insurer responded that "A claims acknowledgement letter will be included when in the claim sample packets are selected by the DFR." A sample claims acknowledgement letter (or electronic notice) for claims not processed within 30 days was not included in any of the claim submissions provided by the insurer.

Prompt payment law

The insurer's claims payment system is programmed to automatically calculate interest on claims not processed within their "predetermined time frame as mandated by state regulations."

Pharmacy claims

Pharmacy claims are handled by the insurer's affiliate and pharmacy benefit manager, OptumRx. RxClaim (an electronic claims system) was developed in-house and is used by OptumRx for adjudicating pharmacy claims

c. Data analysis and observations

The claims data[2] provided by the insurer indicated the following totals and RHEA claims:[3]

[2] All references to data is specific to the examination period (January 1, 2019 through December 31, 2020)

[3] RHEA claims as identified by the insurer

		Paid Claims	Denied Claims
Individual market	All claims	0	0
	RHEA claims	0	0
Small group market	All claims	0	0
	RHEA claims	0	0
Large group market	All claims	6,335	315
	RHEA claims	454	14
Totals	All claims	6,335	315
	RHEA claims	454	14

The examination data analysis was performed utilizing Microsoft Excel and Audit Command Language (ACL) Analytics. Sample sizes were calculated using the National Association of Insurance Commissioners (NAIC) handbook sampling criteria, which provides two scenarios. For populations of 50,000 and less, the Acceptance Samples Table (AST) may be used to determine sample sizes. For populations greater than 50,000, ACL may be used to generate sample sizes by utilizing a 95 percent confidence level, a 5 percent upper error limit, and 2 percent expected error rate. Using sample sizes as determined by the NAIC handbook for the total populations above, our calculated sample sizes were 82 for paid claims and 14 for denied claims, as follows:

	Paid RHEA claim Samples	Denied RHEA claim samples
Individual market	0	0
Small group market	0	0
Large group market	82	14
Total	82	14

The samples were selected from RHEA-only claims as provided by the insurer. However, 24 paid claims were replaced with new paid claims samples during claims testing, as the initial sampled claims were for services other than the RHEA covered services as stated in ORS 743A.067. Five of the 14 denied claims were also for services other than RHEA covered services as stated in ORS 743A.067. Those claims could not be replaced as the examiners initial sample contained the entire population of denied RHEA claims.

d. "Virtual onsite" observations

The insurer provided a "virtual onsite", which consisted of the insurer demonstrating the claims system to the examiners, specifically the insurer demonstrated the NICE claims system. During the virtual claims walkthrough, the examiners focused on the identification of RHEA services and if there had been application of cost share.

The insurer stated that member cost share on the NICE claims platform is primarily driven on CPT/HCPCS codes and plan setup. Each plan is loaded into the NICE platform

along with its associated benefits, called benefit categories. Every service code billed on a claim is checked against the service code table to assign service groups within the NICE platform. Each service group has been assigned a hierarchical dominance in NICE. When claims include more than one CPT/HCPCS code, the NICE system uses dominant service group logic to determine if additional benefit categories will be applied in addition to the primary service benefits.

Finding 1: Noncompliance with ORS 743A.067 relating to the processing of claims

The specific focus of this examination was to determine the insurer's compliance with RHEA requirements. The insurer does not track RHEA complaints and claims separately from other complaints and claims. After review of the insurer's claims systems and sample claim files, the examination team found that the claims system does not accurately adjudicate all RHEA claims. Of the 82 paid claims reviewed, two claims had impermissible cost sharing under RHEA. Of the nine denied claims reviewed (five out of the 14 denied claims sampled were not related to RHEA), the exam found no impermissible denials under RHEA.

All of the random sampling was done from populations which the insurer stated contained RHEA claims. As noted above, some of the sample files were replaced as the initial samples contained no RHEA services. This indicates that the insurer's claims classification method does not properly identify claims containing RHEA services.

The total sample population (paid and denied) was 96 claims. In that sample, two claims (2 percent of the sample) contained RHEA services with improper cost sharing applied. As noted above, the total claims identified as RHEA by the insurer is 468.

Total number of sample claims with improper cost sharing	Total sample claims population	Percentage of total adjusted RHEA claims with improper cost sharing
2	96	2%

FINDINGS AND OBSERVATIONS – POLICYHOLDERS SERVICES AND COMPLAINTS

a. Interrogatory analysis and observations

To track consumer complaints, the insurer utilizes a database, the Escalation Tracking System (ETS), to track and record appeals, complaints, and inquiries. The ETS system enables connection to the insurer's other computer systems and business areas. Behavioral health complaints are tracked in the Complaint and Appeal Routing, Tracing, and Appeal (CARTA) system. Inquiries are additionally recorded in in the insurer's online routing system and the insurer does not use a third-party administrator (TPA) to

administer reproductive benefits.

The insurer prepares daily, weekly, and monthly appeals and grievances reports for appeals and grievances. The reports are reviewed by insurer leadership to verify they are within compliance for the established turnaround time for appeals and grievances. Also, performance metrics are reported to senior leadership during quarterly meetings.

The insurer represents that internal reporting is utilized to monitor compliance with "all legislation." The insurer did not assert that it tracks RHEA claims separately from other claims. The complaint policy and procedure neither states that the insurer will separately track RHEA claims nor explicitly addresses such claims.

b. Data analysis and observations, and "virtual onsite" observations

The results of the examination indicate complaints and grievances related to RHEA claims are not tracked separately and the complaint policy and procedure does not state that the insurer will separately track RHEA claims. Furthermore, a review of the quarterly reports and the supplied complaint log show no RHEA-specific complaint or grievance tracking in place.

RECOMMENDATIONS

As a result of the examiners' observations, it is recommended that the insurer should ensure that the following processes and procedures are implemented:

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.

2. The insurer review its claims adjudication system and make all necessary adjustments to assure that claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.

3. The insurer submit accurate, timely, and complete information to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.

4. The insurer provide education for personnel to be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA related services.

5. The insurer identify all pertinent CPT codes for services, drugs, devices, products and procedures listed in ORS 743A.067, and where applicable diagnosis codes required to properly adjudicate RHEA claims. The insurer should also consider that the purpose of ORS 743A.067 is to improve access the services identified in statute and limit medical management of those services to ensure access consistent with the purpose.

APPENDIX

Appendix A – Definitions

During the exam the examiners found the following definitions useful in understanding the insurer's handling of policyholder complaints:

i. The insurer defines a "complaint" as any written or oral communication by an enrollee or authorized representative, broker, employer, or network provider regarding dissatisfaction relating to the insurer's products, benefits, coverage services, operations, policies or network providers, plan errors or service failures, review or reconsideration of an adverse notification determination, an adverse plan determination of all or part of a pre-service request, or dispute over a denial of payment of a claim for a service that has already been provided to the enrollee. The insurer classifies complaints into the following categories:
   a. Division of Financial Regulation complaints, or other state agency complaints are any written communication by an enrollee or authorized representative, broker, employer, or network provider address to the Division of Financial Regulation.
   b. Executive complaints are any written or oral communication by an enrollee or authorized representative, broker, employer, or network provider received by an executive of UnitedHealth Group (e.g., M.D., chairman and chief executive officer).
   c. Formal complaints are any written or oral communication by an enrollee or authorized representative, broker employer, or network provider.
   d. "Quality of care complaints" are any written or oral communication by an enrollee or authorized representative, broker, employer, or network provider, alleging an adverse patient event that is unexpected and not typically a result of the patient's condition or course of treatment.

ii. An appeal is a timely request by a member, contracted provider, or an authorized representative of the member or contracted provider to change a plan denial decision (adverse determination), including a rescission, made by the insurer.

iii. An external review is available following the completion of the internal appeals process, or if the insurer fails to respond to the member's appeal in accordance with applicable regulations regarding timing for adverse benefit determination.

Appendix B – RHEA CPT codes with cost sharing

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Cost share amount	Finding
Paid	64R	R7303, Z975	99213	$3	Improper Cost Share

Paid	69R	T7421X, J307	99212	$3	Improper Cost Share