Department of Consumer
and Business Services

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION REPRODUCTIVE HEALTH EQUITY ACT

OF

UnitedHealthcare Insurance Company

AS OF DECEMBER 31, 2020

NAIC COMPANY CODE: 79413

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FOREWORD

January 23, 2022

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:

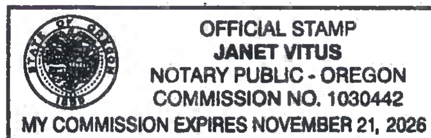
This market conduct examination report of UnitedHealthcare Insurance Company (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers 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
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



EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill 3391, known as The Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as 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 coverages defined in the law.

The focus of this targeted market conduct examination included, but was not limited to, insurer policyholder services and complaints and claims as related to the coverage and cost sharing provisions of RHEA, and 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 proper claims adjudication and the cost sharing requirements established under RHEA for the time period under review. The examination findings indicate that the insurer claims processing system is not paying all RHEA claims accurately and is applying improper cost sharing or denials. The results of the examination and related findings are discussed in more detail in the sections below.

Examiners identified instances of noncompliance with RHEA in the insurer's administration of claims. The examiners concluded that claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. The examination team found that the insurer's claims processing system did not accurately adjudicate all RHEA claims and applied improper cost sharing. The results of the examination and related findings are discussed in more detail in the sections 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.

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.

SCOPE OF EXAMINATION

The Oregon Division of Financial Regulation (division) called a targeted market conduct examination of UnitedHealthcare Insurance Company 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 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 Insurance Company, licensed as a life, accident, and health insurer, 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 UHIC Holdings, Inc. (UHIC). UHIC is a wholly owned subsidiary of United HealthCare Services, Inc. (UHS), a 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, domiciled in the state of Connecticut (state), was incorporated on March 24, 1972, as a life, accident, and health insurer, and operations commenced in April 1972. The insurer is licensed to sell life and accident and health insurance in all states and the District of Columbia, with the exception of New York, and primarily issues group accident and health insurance contracts to employers, government sponsored plans, and associations.

The insurer offers comprehensive commercial products to individual and employer groups. Each contract outlines the coverage provided and renewal provisions.

The insurer serves as a plan sponsor offering Medicare Parts A and B, along with Medicare Part D prescription drug insurance coverage, as well as Medicare specialized programs including a Dual Special Needs Plan (DSNP) and an Institutional Special Needs Plan (ISNP and collectively Medicare Plans) under contracts with the Centers for Medicare and Medicaid Services (CMS).

The examiners utilized examination by sample. Examination by sample involves the review of a selected number of records from within the population. File sampling was based on a review of

complaints and RHEA medical and prescription drug claims incurred during the period under examination and selected at random using computer software applied to data files provided by the company. Samples are tested for compliance with standards established by the NAIC and adopted by the division.

Further, the examiners asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance being issued regarding that claim.

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's 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 company) for the examination period; and
    - All denied RHEA claims (as identified by the company) for the examination period.
- Sample testing of paid and denied RHEA claims (please note: the insurer did not provide remote access on a timely basis for 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.

The cooperation level of the Insurer created an examination process that required several requests for claim files to fill the sample populations. Those requests would not have been necessary if claims system access was provided at the beginning of the examination. Remote claims systems access was not possible within the early exam timelines established by the division, although system access was provided in a limited manner at the end of the exam. In addition, a letter regarding Oregon's 30-day claim handling requirements was requested but not provided in the manner outlined by the examiners.

b. Interrogatory analysis and observations

The insurer's claims department consists of a senior vice president (VP), a chief of staff, two VPs of claims, four senior directors, seven directors, six associate directors, and six managers.

The claims department's responsibilities include, but are not limited to the following:

- Accurate adjudication of claims;
- Understanding and applying plan benefits utilizing appropriate tools and procedures;
- Analyzing and identifying relevant trends;
- Consistently meeting established productivity and quality standards;
- Providing expertise or general claims support by reviewing, researching, investigating, processing, and adjusting claims;
- Conducting data entry and data re-working as necessary;
- Identifying more complicated claims and referring them to the senior claims processor or supervisor; and
- Working claims to ensure the appropriate eligibility and provider records are matched to the appropriate claim.

Additionally, the claims department's responsibilities include:

- Updating and maintaining the claims tracking database;
- Reviewing, researching, solving, and processing assigned work which includes the navigation of multiple computer systems and platforms;

- Communicating the status of all claims in accordance with reporting requirements; communicating with members and providers using clear, simple language; and
- Learning and leveraging new systems and training resources to help apply claims processing and procedures appropriately.

PacifiCare, a subsidiary of the insurer, assists with claims processing. 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 are paid or denied.

System updates

The insurer states that when a new or revised Oregon law is passed, internal policies and procedures are reviewed to determine if changes to the claims processing system are required. If needed, the claims system is 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 policies.

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 the manner requested by the examiners.

Prompt payment law

The UNET claims system is programmed in accordance with Oregon guidelines. Paper and electronic claims must be adjudicated within 30 calendar days or accrue 12 percent annual interest, beginning on the 31st day. An insurer is not required to pay interest that is in the amount of $2 or less. Therefore, the system is also programmed with a threshold to only pay when interest is calculated at $2.01 or higher.

Pharmacy claims

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

Changes to claims procedures

The insurer provides that updates to claims procedures are made regularly to accommodate legislative needs and that changes may occur during the course of an examination. The insurer did not describe any specific changes in its claims procedures that were made due to the RHEA.

c. Data analysis and observations

The claims data[1] provided by the Insurer indicated the following total and RHEA claims:[2]

		Paid claims	Denied claims
Individual market	All claims	0	0
	RHEA claims	0	0
Small group market	All claims	299,848	45,219
	RHEA claims	15,585	1,465
Large group market	All claims	731,014	122,140
	RHEA claims	29,768	3,089
Totals	All claims	1,030,862	167,359
	RHEA claims	45,353	4,554

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, the calculated sample sizes were 109 for paid claims and 108 for denied claims.

The examiners ensured equitable representation of the small group and large group markets in the samples by proportional selection based on total population.[3] Therefore, the samples selected were as follows:

	Paid RHEA claim samples	Denied RHEA claim samples
Individual market	0	0
Small group market	37	35
Large group market	72	73
Total	109	108

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

[2] RHEA claims as identified by the insurer

[3] The insurer does not provide products in the individual market at the time of examination and therefore there were no claims sampled in the individual market for this examination.

All sampling utilized for the Oregon RHEA exams was based on the Market Regulation Handbook guidance using a random selection methodology and following the acceptance sample tables and/or ACL calculations as appropriate. The samples were selected from RHEA only claims as provided by the insurer. The paid sample contained 109 files. Thirty of the original sample files were unusable as they did not contain RHEA services. Of 36 replacement sample files provided, six were unusable as they also did not contain RHEA services. The denied sample contained 108 files. Forty-two of the original sample files were unusable as they did not contain RHEA services. Of 70 replacement sample files provided, 28 were unusable as they also did not contain RHEA services.

d. "Virtual on-site" observations

The Insurer provided a "virtual onsite," which consisted of the Insurer demonstrating the TOPS claim platform. 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 uses a claims system called "TOPS."

The insurer stated that member cost share on the TOPS claims platform is primarily driven based on CPT/HCPCS codes and plan set up. Each plan is loaded into the TOPS platform along with its associated benefits, these benefits are called benefit categories. Every service code billed on a claim (CPT and HCPCS for HCFA claim forms; and UB revenue codes for UB claim forms) is checked against the service code table to assign service groups within the TOPS platform, which is used for internal coding. TOPS will recognize multiple factors within the claim to determine if RHEA processing applies, including review of diagnosis and service codes.

If there is more than one CPT/HCPCS code billed, the claim will process at the line level to determine each benefit applicable. Each service group has been given a dominance, and this can also carve out whether additional benefits are applied in addition the primary service benefit.

Finding 1: Non-compliance 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. 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 109 paid claims reviewed, five claims had impermissible cost sharing under RHEA. Of the 108 denied claims reviewed, two claims contained impermissible cost sharing or denial under RHEA. The insurer does not track RHEA complaints and claims separately from other complaints and claims.

The insurer's claims classification method does not properly identify claims containing RHEA services. All of the random sampling was done from populations which the insurer stated contained RHEA claims. As noted above,[4] 32.8 percent of files identified by the insurer as containing RHEA services were mislabeled. This indicates the insurer's claims classification method does not properly identify claims containing RHEA services.

The total sample population (paid and denied) was 217 claims. In that sample, six claims (3 percent of the sample) contained RHEA services with improper cost sharing applied.[5] As noted above, the total claims identified as RHEA by the insurer is 49,907. Using the 32.8 percent error rate above, the actual population is estimated to be 33,538 claims. Based on the examination's results of the sample population, applying improper cost-sharing to 3 percent of total claims during the examination period results in 1,006 potential claims with impermissible cost-sharing under RHEA.

Number of sample claims with improper cost sharing	Total sample RHEA claim population	Percentage of total adjusted RHEA claims with improper cost sharing
6	217	3%

Please see Appendix B for a complete list of diagnosis and CPT codes identified from the sample populations which contained impermissible cost sharing for RHEA services.

FINDINGS AND OBSERVATIONS – POLICYHOLDER 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. 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

[4] Due to the improper identification of RHEA claims, examiners reviewed 145 paid samples in order to obtain a sample of 109 RHEA-specific claims. Similarly, examiners reviewed 178 denied samples in order to obtain a sample of 108 RHEA-specific claims.
[5] Out-of-network (OON) claims with cost sharing were excluded from the error population due to the language in RHEA which allows for cost sharing in limited situations.

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

Observations from the examination's data analysis and "virtual onsite" confirmed the assertions made by the insurer in its interrogatories, described in the "Interrogatory analysis and observations" section above. The insurer utilizes the ETS system to track and record appeals, complaints, and inquiries. Coverage inquiries are recorded in the insurer's online routing documentation system. Behavioral health complaints are tracked in the insurer's CARTA System.

The results of the examination indicate that complaints and grievances related to RHEA claims are not tracked separately. 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 preservice 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 – Diagnosis and CPT codes with inappropriate cost sharing

Population: paid or denied	Examination review item	Diagnosis code(s)	CPT code	Finding
Paid	2	0200 Z369	84702	Cost share
Paid	2	0200 Z369	86780	Cost share
Paid	16	Z30013	81025	Cost share
Paid	30	Z0000	36415	Cost share
Paid	45	Z01419	87491	Cost share
Paid	45	Z01419	87591	Cost share
Paid	45	Z01419	87480	Cost share
Paid	45	Z01419	87510	Cost share
Paid	45	Z01419	87660	Cost share
Paid	60	Z01419 Z3200	81025	Cost share
Denied	12	Z113 Z3009 N898	99214	Denied