MARKET CONDUCT REPORT ON EXAMINATION

OF THE

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, INC.

UNITED HEALTHCARE OF NEW YORK, INC.

AND

UNITED HEALTHCARE OF UPSTATE NEW YORK, INC.

AS OF

DECEMBER 31, 1999

DATE OF REPORT	**JANUARY 22, 2001**
EXAMINER	**BRUCE E. BOROFSKY**

TABLE OF CONTENTS

STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

January 22, 2001

Honorable Neil Levin
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 021359, 021360 and 021361, each dated February 16, 1999 and annexed hereto, I have made an examination into the condition and affairs of three domestic United HealthCare Companies. These entities are as follows:

- United HealthCare Insurance Company of New York, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law;
- United HealthCare of New York, Inc, a health maintenance organization licensed under Article 44 of the New York Public Health Law; and
- United HealthCare of Upstate New York, Inc., a health maintenance organization licensed under Article 44 of the New York Public Health Law.

The following report as respectfully submitted deals with the manner in which the United HealthCare Companies conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

Reports dealing with matters pertinent to the financial condition of the New York United HealthCare Companies will be issued under separate cover.

Whenever the terms “the Company”, “UHC” or “United HealthCare” appear herein without qualification, they should be understood to mean the New York United HealthCare Companies.

Whenever the term “Insurance Company” appears herein without qualification, it should be understood to mean United HealthCare Insurance Company of New York, Inc.

Whenever the terms “Upstate HMO” and “Upstate Plan” appear herein without qualification, they should be understood to mean United HealthCare of Upstate New York, Inc.

Whenever the terms “Downstate HMO” and “Downstate Plan” appear herein without qualification, they should be understood to mean United HealthCare of New York, Inc.

Whenever the term “the Plans” appears herein without qualification, it should be understood to mean both United HealthCare of New York, Inc. and United HealthCare of Upstate New York, Inc.

1. SCOPE OF EXAMINATION

As part of the Department's examination of United HealthCare, a review of the manner in which United HealthCare conducts its business practices and fulfills its contractual obligations to policyholders and claimants has been performed. This review contains significant findings and covers transactions occurring through December 31, 1999.

The purpose of this report is to assist United HealthCare's management in addressing problems that are of such a nature that corrective action is required. Accordingly, this report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

2. MANAGEMENT

During May 1999, the Department issued Circular Letter No. 9 on the subject "Adoption of Procedure Manuals." The letter states that it is critical that the board of directors of each Article 44 Health Maintenance Organization and insurer licensed to write health insurance adopt specified procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. The letter also recommended the following:

> "that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations."

Finally, the letter requested confirmation that Circular Letter No. 9 would be distributed to all board members and, if applicable, to the board members of the parent corporation prior to the respective board's next regularly scheduled meeting. Such distribution, receipt and any subsequent discussion should have been recorded in the minutes of the respective board's meeting.

Examination of the board minutes for all three NY United HealthCare entities revealed that the recommended discussions did not take place. Further, an annual certification recommended by the Circular Letter was not obtained for calendar year 1999. When asked why these measures had not been adopted, the examiners were advised the Company believed the Circular Letter was only advisory in nature and thus, not obligatory on the Company. The Company also indicated that it believed that its ongoing efforts and more recently proposed action plans to correct any deficiencies and to ensure adequate claim handling were in keeping with the principles outlined in the letter.

It was the intent of the Circular Letter to remind companies that it was ultimately the board of directors who oversee management's handling of the claims adjudication process. As such, the processes described serve to further the Department's goal of enhancing regulatory compliance.

It is recommended that the Company implement the notification and certification requirements of Circular Letter No. 9 (1999).

Subsequent to the finding, the Company was able to show that it complied with this recommendation.

One of the online systems (the Preference System) that was being used by claim processors to determine New York mandates did not contain several recent initiatives, including prompt pay and community rating. The system in question also contained standards that had expired or been changed. Examples include emergency room procedures, and mandates regarding pregnancy and pre-existing conditions, among others. When this was pointed out to the Company, the examiners were advised that the Preference System was being phased out in favor of an Intranet process. The examiner expressed concern that the existence of conflicting information can serve to confuse the issues. Such conflicting information also runs counter to the Department's Circular Letter No. 9 (1999). The Company contended that in the future it would be able to demonstrate that its Intranet based system would follow the guidance contained in the Circular Letter.

It is recommended that the Company comply with Circular Letter No. 9 (1999) and update all processing guidelines, regardless of format, to ensure they are consistent and in compliance with New York's mandates on health care.

Any violations resulting from lack of clear guidance on New York statute or regulation are detailed later herein under the appropriate section of the report.

3. SALES/UNDERWRITING

A. Open Enrollment

Prospective direct pay subscribers can obtain a telephone number to get information on enrollment with United HealthCare through the Company website, through advertisements and through the Insurance Department. Contact with those sources, however, provides a telephone number that has a toll charge. Once the toll number is dialed, interested consumers must answer a series of voice mail prompts before they are given a different, but toll-free phone number to call. When the toll-free telephone number is dialed, consumers are given seven voice mail options to choose from. None of the options offered pertains to enrollment information.

Pursuant to New York Insurance Law §4321(a), United HealthCare has an obligation to provide health insurance to eligible consumers who seek to purchase it. The informational procedures it has implemented, however, work against the Company's ability to fulfill that obligation.

For this reason, it is recommended that the Company provide its toll-free telephone number to potential subscribers in its advertising medium. Further, the toll-free telephone number should include enrollment information as a voice mail option.

During testing of the phone line, the examiners were advised on two occasions that small group coverage is considered to be five or more employees. This is inaccurate information and is thus misleading in that §4317 of the New York Insurance Law defines a small group as between two and fifty employees.

During June 1998, the Company issued an alert marked “Urgent” to its agents and brokers indicating the Company would not cover groups with two lives who are husband and wife even if both are employees on a quarterly wage and tax statement. United HealthCare does cover other employer groups where the members are not husband and wife. This practice rendered the Company’s denial of group coverage in the situation a violation of New York Insurance Law §4317.

It is recommended that the Company comply with §4317 of the New York Insurance Law and offer small group policies to groups of between two and fifty, regardless of marital status.

B. Underwriting

At the time of the examination, the Company was utilizing a “New Member Letter” that was in violation of §4318(a) and (b) of the New York Insurance Law, "Pre-

existing Condition Provisions." Subsection (a) of the law states that an enrollee is considered to have maintained continuous coverage for pre-existing condition purposes if they have not had a gap of more than 63 days between the termination of their previous coverage and the enrollment date of their new coverage. Subsection (b) of the law defines enrollment date as the date the enrollee files a substantially complete application for coverage.

The “New Member Letter" in question stated that there were two dates during each month when new members could be enrolled; the 1st and the 15th. In order to be enrolled on the closest effective date, the enrollee had to submit his or her application more than five days prior to that date. If the enrollee submitted his/her application in less than five days, they were required to wait until the following enrollment date. This meant that potentially, an enrollee had to wait as many as 20 days before their coverage began.

The letter goes on to indicate that the Company counts the 63-day limit from the termination of the old coverage to the *effective* date of the new coverage. The effect of this rule is that an enrollee must submit their application as many as 20 days prior to their effective date in order to maintain coverage under the pre-existing coverage rules, thus effectively shortening the 63-day limit to as little as 41 days. This penalizes the subscriber in violation of New York law.

It is recommended that the revised New Member Letter use the application date and not the effective date, for the purpose of calculating continuing coverage as required by New York Insurance Law §4318(a) and (b).

It is recommended that the Company determine how the document that was violative of New York Insurance Law §4318 was originally approved for distribution in order to prevent a reoccurrence.

After this violation was brought to the Company's attention, they discontinued use of the letter and formed a Compliance Department with a dedicated compliance manager to oversee and monitor health plan compliance with state regulations.

C. Premium Rates of Community-Rated Contracts

New York Insurance Law §4308(b) sets forth the standard for the filing and approval of community rates. As an alternate, under §4308(g), the Company may use rates filed with the Superintendent without his prior approval under certain circumstances. A review of the Company's underwriting activities revealed that they were not in compliance with the provisions of §4308. Specifically, seven percent, or five, of the 75 HMO groups tested were not being charged the rate that had been approved by the Department. The Company found thirty-seven additional enrolled groups that were being charged incorrect rates after the examiners requested that a further search be made on the population as a whole using the parameters of the errors that were located in the sample.

The causes of the errors were as follows:

- One group was billed the rate for a different United HealthCare entity.
- Two groups were charged incorrect rates because of system constraints. Specifically, an override that was required to overcome the fact that only one set of tier relationships are allowed within the system was not applied. Thus, the wrong tier price was used.
- Two groups were billed at the wrong quarterly rate for two separate reasons. In one instance, the proper rate had not yet been installed in the system. In the second instance, the proper rate was inappropriately overridden.
- Most of the remaining differences were due to variations in rounding.

It is recommended that the Company take steps to ensure that rates charged are approved and properly billed as required by New York Insurance Law §4308(b).

The HMO Plus product is a Point of Service ("POS") coverage plan containing both, in-network coverage, and out-of-network coverage. For this product, the HMO covers in-plan visits while the Insurance Company covers out-of-plan visits.

For the HMO Plus product, United HealthCare experience rates groups of 50+ employees using the total experience of the group. The overall rate is compared to the filed large group community rate for the HMO portion of the contract to ensure that the

total POS product rate is higher than the filed large group community rate for the HMO portion of the contract. If needed, the total POS product rate is adjusted upward to make the total at least 5% higher than the filed HMO large group community rate. The use of this methodology to determine the rate appears to be in violation of New York Insurance Law §4308(b) in that the experience rating formula approved by the Department is being applied to the entire contract, but is only approved for use on the out-of-network portion of the policy that is written by United Health Insurance Company of New York.

New York Insurance Law §4308(b) states the following:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums, or if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof."

It is recommended that the Company comply with New York Insurance Law §4308(b) and utilize an experience-rating formula that has been approved by the Department.

D. Agent and Broker Licenses

§2116 of the New York Insurance Law states:

> "No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article."

The examiners sampled 40 of UHC's 8,500 external producers. UHC was not able to provide copies of licenses for eight percent or three of these individuals. Another 20%, or eight, of the producers had expired licenses on file. While the Department's Consumer Services Bureau was able to confirm the producers within the sample did have current licenses, the Company needs to monitor the licenses to ensure it does not violate the law.

It is recommended that the Companies maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York Insurance Law.

Subsequent to the finding, the Company was able to demonstrate that it had initiated steps to ensure that it maintained current licenses of all of its producers.

United HealthCare uses two types of external agents. The first type of external agents it uses are individual agents. The second type it utilizes are general agents or agencies that consist of multiple salespersons. General agents represent the Downstate HMO and the Insurance Company in the sale of small group medical insurance. The relationship to each of these entities is that of an independent contractor in that the general agents are only paid for the business they produce. Currently, the Company utilizes a written agreement between itself and its general agents to clearly spell out the rights and responsibilities of the agency. This practice serves to protect the Company in its relationship with the general agents. It is noted, however, that there are no such

written agreements between the general agents and the Upstate HMO. Additionally, there are no such agreements between any of the United HealthCare companies and the individual agents. As the agreement serves to protect the Company in its relationship with agencies, so would it protect it in its relationship with the individual agents.

It is recommended that the Company initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate Plan formalize an agreement with its general agents.

§2114(a)(3) of the New York Insurance Law states:

> "No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting or procuring in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

This section requires United HealthCare employees to have licenses if they will be soliciting business and earn income on a commission basis. UHC utilizes approximately 76 such salaried employees. All licenses for these individuals were requested for testing by the examiners. UHC was not able to fulfill 71% of the license requests. Nor was the Department's Consumer Services Bureau able to confirm such licenses exist. The use of unlicensed agents is a violation of NY Insurance Law §2114(a)(3).

It is recommended that United HealthCare license its internal agents to confirm compliance with NY Insurance Law §2114(a)(3).

E Appointment of Insurance Agents with the Department

§2112(a) of the New York Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

Each of the Companies is required under NY Insurance Law §2112(a) to file certificates of appointment for their agents. The examiners requested that the United HealthCare companies provide a sample of 30 appointment letters from the Company's list of appointed agents. The Company was not able to produce 20%, or six letters of that sample. In addition, none of the agents utilized by United HealthCare of Upstate New York, Inc. were appointed to that entity.

It is recommended that United HealthCare of Upstate New York, Inc., file certificates of appointment for each of its agents as required by New York Insurance Law §2112(a).

The examiners then checked the list of appointments as provided by the Department against the list provided by the Company. A total of 17% of the appointed agents, as noted on the Department's list, were not on the lists provided by the Insurance

Company or the Downstate HMO. In other words, there appeared to be agents appointed by the Company that they are not aware of. This would seem to imply poor record keeping on the part of the Company.

It is recommended that the United HealthCare Companies improve their record keeping as regards agents and brokers.

4. CLAIM PROCESSING

A. Electronic Data Interchange

United HealthCare encourages its providers to submit claims electronically, instead of through the US mail. The process used to do this is referred to as Electronic Data Interface ("EDI"). The company's goal is to have 65% of all claims received in this manner.

The way electronically submitted claims enter the system is through EDI intermediaries. The EDI claims are received by the intermediaries who then proof the claims before sending them on to United HealthCare. Claims that are not complete are rejected and returned to the sender.

The EDI companies have a contractual obligation to submit 99% of the claims they receive within 24 hours of receipt.

This standard is monitored through visits by United HealthCare to the intermediaries. Additionally, United HealthCare monitors the rates of claims submissions to ensure consistency. There are, however, no computerized statistical analyses of the submission rates. In this regard, there was insufficient monitoring of the EDI companies.

United HealthCare indicates that an independent auditor will be auditing certain of the EDI companies for compliance with the claim submission standards and it is recommended they do so.

B. Schedule H Reporting

A review of United HealthCare's filed Schedule H (Aging Analysis of Unpaid Claims) was performed. This review evidenced United HealthCare's inability to adequately ascertain the aging of its unpaid claims.

Schedule H, which is a quarterly report, is used to report claims that have been received by the company, but are not yet paid.

Contrary to Department instructions, United HealthCare did not utilize actual claim inventory to complete Schedule H. Instead, the Company completed the form utilizing two sources; for accounting purposes, the sources of confirmation were claims

that were adjudicated and awaiting payment, and an estimate of the inventory and value of claims within the system that were not yet adjudicated.

The Company had stated that it was difficult, if not impossible, to determine the New York entities' Schedule H inventory because of the nature of the Company's processing systems. Those systems do not determine the entity to which a subscriber belongs until the claim is adjudicated.

When the Department advised the Company that the system they were using to complete Schedule H was inadequate, the Company submitted a plan that it maintained would allow it to obtain an estimate of the open claim population as required by Schedule H. The Department accepted the plan and for First Quarter 1999, the Company used the new methodology as agreed.

During the second quarter of 1999, however, both the Upstate HMO and the Downstate HMO failed to utilize the new plan. Instead, both entities utilized the previous method, making the Schedule H numbers not valid for that quarter. When this was pointed out to the Company, the systems and accounting error was acknowledged, and an amended Schedule H was immediately filed.

The Company's inability to determine the exact count and value of HMO claims awaiting adjudication appears to be a violation of 10 NYCRR Part 98.11. This NY Health Department rule requires that the HMO function be clearly distinguished from any

other functions through the maintenance of separate records, reports and accounts for the HMO function. Further, this points to the Company's apparent inability to comply with New York Insurance Law §308, which mandates that the Company reply to a request by the Superintendent for a special report.

The underlying theory behind the Department's promulgation of Schedule H was to have health care companies accurately report and age their claims, so that a measure of claim processing efficiency could be readily obtained. As long as the Companies' Schedule H filings do not report exact counts, such a measure is not possible.

It is recommended that the Company develop a system that will permit it to determine the exact count and inventory of NY claims at any given point in time as required by the Department and in the case of the two HMOs as required by 10 NYCRR Part 98.11(a).

It is recommended that the Company utilize its approved plan on a consistent basis or otherwise accurately report claim counts and values in its Schedule H filings in compliance with New York Insurance Law §308.

C. Emergent Care

Sections 3216(i), 3221(k)(4) and 4303(a)(2) of the New York State Insurance Law require that health insurance contracts include a provision permitting emergency room treatment using a prudent lay person standard. During the examination period,

United HealthCare utilized a list of sixteen emergency room diagnoses that it deemed not eligible for emergent care. Several of these diagnoses, including pharyngitis (sore throat), menstrual disorder, and strep throat, do fit within the prudent lay person standard of emergency care and should be considered eligible for emergent care. Other diagnoses on the list, (backache, headache) indicate the ailment will be covered if it is treated with intravenous medication upon arrival at the emergency room. Clearly, an insured cannot know prior to the emergency room visit what treatment will be used. As such, this standard is unreasonable. These processing procedures appear to be a violation of New York Insurance Law §2601(a), which states in part:

> … Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claims settlement practices…
>
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear…

Emergency room claims were reviewed to determine whether the Company was in compliance with the prudent lay person standard of care. During that review, several claims were noted as being denied as not medically necessary when the diagnosis involved fit within the parameter of the prudent lay person standard.

It is recommended that United HealthCare discontinue its use of a prepared list of emergency room diagnoses it declares ineligible for coverage. Instead, it is recommended that the Company consider each claim separately on its merits.

It is recommended that the Company adhere to provisions within the contract setting forth a prudent lay person standard as defined in §3216(i), §3221(k)(4) and §4303(a)(2) of the New York State Insurance Law.

It is further recommended that the Company comply with the provisions of New York Insurance Law §2601(a)(4) in its the settlement of all emergency room claims.

D. Foreign Claims

United HealthCare's procedure for the payment of claims for services rendered outside the US allows claims payable directly to the insured and valued at a certain level to be paid without additional auditing. Claims payable to a provider where payment value falls into a second threshold require confirmation of service by the subscriber, while claims meeting a third dollar threshold are referred to the Company's fraud oversight group.

Typically, service outside of the US is difficult to confirm, so insurance fraud is easier to commit. Providers are often unknown and thus even their credentials are unconfirmable. Further, the possibility for collusion is high. For these reasons, direct payment and simple confirmation are insufficient to provide assurance that claims are legitimate.

Thus, it is recommended that the Company reevaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment.

E. Explanation of Benefit Statements

As part of the review of United HealthCare's claims practices and procedures, an analysis of the Explanation of Benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and United HealthCare. It should clearly communicate to the subscriber and/or provider that United HealthCare has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers. Analysis of the Explanation of Benefit statements yielded the following findings:

For certain products, when a United HealthCare subscriber goes to a specialist for medical attention, it is necessary for that subscriber to have obtained authorization from their primary care physician beforehand. If authorization is not obtained, submitted claims for service will be denied and an Explanation of Benefits statement ("EOB") sent out to the subscriber and to the provider advising them of the following:

> "According to our records, a network health care provider was used. According to your plan, a pre-authorization was required but not obtained. Therefore, we have declined payment for the service because the health care provider did not obtain the authorization. According to the network contract, the member may not be billed for the declined amount. However, the member is responsible for the network plan co-pay, deductible or coinsurance amounts."

Often, however, the specialist or the subscriber will have submitted their claim to the Company before the Company has had an opportunity to enter the necessary authorization into the system or before the Company has been notified of the authorization by the primary care physician. When this occurs, the initial EOB may confuse the subscriber because the denial does not leave room for the possibility that the authorization may simply not have been entered into the system or may be late.

This same situation holds true with the EOB used for emergency room treatment. In that case as well, emergency room treatment is denied when it is simply the intent of the insurer to obtain additional information about the emergency room visit.

It is recommended that the Explanation of Benefits text on denied claims be amended to indicate to subscribers and providers that if additional information is provided, the denied claim will be reconsidered upon receipt of the information. Additionally, when the Company is aware that additional specific information is needed to allow the processing of a claim, said Explanation of Benefits form or system generated letter should indicate such clearly.

The EOB forms do not provide a sufficient description of the submitted charges. In many cases, non-specific terms such as “Medical Care”, and “Other”, are routinely used to describe the submitted charges. During United HealthCare’s processing of claims, services and procedures are designated by a five digit code (CPT code) taken from the “Physician’s Current Procedural Terminology” manual, published by the

American Medical Association. If United HealthCare would display these CPT codes on its EOBs along with a brief description, a satisfactory explanation of the submitted charges could be provided to the subscriber. This addition could also have the added effect of decreasing the possibility of provider fraud by ensuring that the subscriber has an opportunity to see what procedures are being billed.

It is recommended that the Company display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes.

The provider's address is not reflected on the EOBs. This information is helpful to the subscriber to assist in identifying the location of the provider performing the service.

It is recommended that EOBs sent to subscribers include the address of the provider performing the services.

United HealthCare does not include the date a claim was received on the EOB. This claim receipt date is of particular importance to subscribers and/or providers given the enactment of §3224-a of the New York Insurance Law ("Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services"). Without disclosure of the receipt date, a subscriber and/or the provider cannot determine if any interest is due relative to a claim that took longer than 45 days to process.

It is recommended that the Company modify their Explanation of Benefits statement form to include the date the claim was received in order to comply with the intent of the prompt pay laws.

Section 3234(b) of the New York Insurance Law states in part:

> "(b) The explanation of benefit statement form must include at least the following:…"
>
> "(7)…a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

The text on the Company's EOB states the following:

> "A review of this benefit statement may be requested by following the steps outlined in your benefit booklet under "How to Appeal a Claim" or "Your Rights Under ERISA". The request must be made within 60 days of receiving this statement."

The statement used by the Company does not include all of the requisite information on their Explanation of Benefits Statements. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights.

It is recommended that United HealthCare modify their Explanations of Benefits statement form to comply with §3234(b) of the New York Insurance Law regarding rights of appeal.

F. New York Bad Debt and Charity Pool Surcharge

The Company did not withhold the New York Bad Debt and Charity Pool Surcharge on certain capitated agreements as required by New York Public Health Law §2807-s and §2807-t.

It is recommended that the Company retroactively calculate and pay the New York Health Law §2807-t Debt and Charity Pool on capitated groups it failed to properly account for.

It should be noted that subsequent to this finding, the Company was able to demonstrate it had complied with this recommendation.

The Company has also acknowledged several surcharge errors that resulted from a claim processor's failure to manually calculate the surcharge as required. Additionally, the Company acknowledged certain surchargeable providers were inadvertently neglected from the surcharge calculation.

It is recommended that the Company retroactively determine any surcharge amounts due but not paid as a result of eligible providers not being listed in the system as so eligible.

5. PROMPT PAY

A. Claim Sampling

Claims were tested to determine the Company's compliance with §3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlements of claims for health care and payments for health care service". Said section contains provisions outlining the time frames within which claims must be paid or have interest paid on the unpaid portions thereof. Initial review indicated that the Company paid no interest on any claims, except Medicare/Medicaid claims, between January 23, 1998, the inception date of the Prompt Pay Law, and December 31, 1998.

The claims tested were selected from the population of claims submitted during May 1998 and December 1998. This population consisted of 283,069 claims valued at $38,799,457. In order to obtain a random sample, statistical sampling was performed on the population.

First, claims that took greater than 45 days to adjudicate were tested to determine the Company's compliance with subsection (b) of §3224-a. The subsection reads in pertinent part as follows:

> "In a case where the obligation of an insurer … is not reasonably clear… the corporation shall…notify the policyholders, covered person or health care provider in writing within 30 days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional

> information needed to determine liability to pay the claim or make the health care payment."

There were 8,275 claims not paid within 45 days. A sample of 87 claims from this population was tested to determine whether letters were sent. Of the 87 claims tested, forty-six percent, or forty, of the sample were found to be in violation. This statistic can be extrapolated to a conclusion that there may be as many as 3,346 violations of this law in the referenced two month period.

Second, claims that were unpaid after 45 days that appeared to be otherwise eligible for interest were sampled to determine whether interest was paid as required by subsection (c) of §3224-a of the New York Insurance Law. The subsection reads in pertinent part as follows:

> "…any insurer … that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim,… the amount of the claim or health care payment plus interest on the amount of such claim or health care payment…"

Where interest was not paid, this sample was then tested to determine the cause for such failure.

There were 1,911 claims valued at $2,629,192 that may have been eligible for interest. One hundred thirty-three claims from this population were tested. Forty-two percent, or 56 of this sample were found to have been eligible for interest but did not have such interest paid. This statistic can be extrapolated to a possible total of 802 violations of this law in the referenced two-month period.

The Company's failure to pay these claims within a 45 day period also appears to be a violation of subsection (a) of New York Insurance Law §3224-a, which requires that "clean claims" be paid within forty-five days of receipt.

Subsequent to this finding, the Company calculated and paid interest on those claims that were found to be interest-eligible in the examiner's sample.

Reasons for the failure to pay interest included the following:

- Claims that either had their denials reversed or were adjusted upwards as a result of company error did not have interest paid.
- Claims that were held up in Medical Review were not deemed eligible for interest even when no additional information was sought from either the subscriber or the provider. Such claims are held to be interest eligible because, with no clarification sought, the obligation of the insurer should have been reasonably clear.
- Claims were legitimately delayed as a result of requests for Coordination of Benefits ("COB") data. When the data arrived, however, all such claims within the subscriber's history were not re-opened and paid. Then, when the claims were re-opened, the interest was not applied.
- Payment schedules for providers were not loaded into the system in a timely manner. As a result, many payments were below the contracted rate. Once loaded, the providers would receive retroactive compensation, but not interest for the unpaid portion.

- Claims that were held up pending the negotiation of new provider contracts were not considered interest-eligible.
- The Company withheld claim payments for the employees of policyholders who did not pay their premiums within the policy grace period. When the premiums were ultimately paid, the withheld claims were not deemed to be interest-eligible. The decision to maintain delinquent policyholders is entirely that of the Company. Unless the Company actually cancels the employees of such delinquent groups, there is an obligation to pay legitimate claims when submitted by providers.

Overall, it may be concluded that the Company was remiss in its application of the Prompt Pay Law. While the Company did establish procedures to comply with the law, no steps had been taken to ensure those procedures were followed. The strength of this conclusion is especially noted in the Company's failure to make any interest payments other than for its Medicare/Medicaid business from January 23, 1998, the date of the inception of the Prompt Pay Law through December 31, 1998.

It is recommended that the Company take steps to ensure that the provisions of §3224-a of the New York Insurance Law regarding the prompt payment of claims are fully implemented and complied with.

Subsequent to the finding, the Company presented the examiners with a detailed action plan that was developed to bring the Company into compliance with the provisions

of the Prompt Pay Law. This action plan, implementation of which was not verified, appears to address the case specific causes behind the Company's failure to pay interest.

It is further recommended that the Company review all claims that may have been eligible for interest since January 23, 1998 to determine whether interest is due on such claims. Where the claims are found to be eligible for interest, such interest should be paid in compliance with New York Insurance Law §3224-a(c).

B. Interest Calculations

Processing procedures require that interest be calculated by hand. When a claim has interest due, a mathematical formula must be computed on a battery-operated calculator. Once calculated, interest due must be manually inputted into the system for payment and accounting purposes. Such processes are flawed in that the possibility of human error exists.

It is recommended that the Company install an automated procedure to calculate and pay interest.

Subsequent to the finding, the Company presented a request to its Information Systems Department to automate the processes used to calculate the payment of prompt pay interest. Such change was not implemented during the course of the examination.

It is further recommended that the Company's Quality Assurance Department establish a procedure to test New York claims for the appropriate application of interest.

C. Supervisory Notification

When a claim is determined to be eligible for interest, internal procedures require that claim processors notify their supervisors. The Company maintains this requirement was implemented with the intent of expediting the claims paying process by having late claim referred to more senior staff. In light of the fact that no interest was paid on non-Medicare/Medicaid claims during the calendar year 1998, the Company should consider whether the requirement that supervisors be notified may discourage processors from paying interest in order to avoid having to communicate the fact to their supervisor.

It is recommended that those who calculate interest be given autonomy to pay interest without having to notify their supervisors.

D. Bulk Payments

The Company has a policy whereby claim payments are withheld for shipment until a sufficient number of claims has been accumulated. The Company maintains this is done for the convenience of its providers. The Company's position is that bulk payments are easier for the providers to handle and the amount of their paperwork is reduced. Although there were no written agreements, the Company indicates the providers have accepted this arrangement and have made no requests for removal from

the bulk payment process. The Company's position is that interest should not accrue as a result of the bulk mail delay.

Without a written agreement by the providers, the Prompt Pay Law tenets cannot be avoided. Bulk payments delay claims and may place them outside the acceptable 45-day limit. Bulk payment delays may also increase amounts of interest due and cause claims, not otherwise eligible for interest, to become qualified for said interest.

As a further issue, as noted elsewhere in this report, the calculation of interest, when due, is performed by claim adjudicators. These individuals calculate the interest when the claim is processed. They are not aware of when the claim payments will be mailed, and thus, their interest calculations cannot be correct.

It is recommended that interest be accrued during the period in which claims are withheld for the purpose of making bulk payments.

It is recommended that interest paid be calculated to include the date that the check is to be printed and mailed.

Subsequent to this finding, the Company developed a policy to comply with these recommendations.

E. Retroactive payment of claims

Certain prompt pay violations were found that were the result of the Company improperly denying claims because of the suspension of the group to which the subscriber belonged for non-payment of premiums. In other words, a middle market group (population from 50 to 250) that did not pay their premium when due was not terminated. Rather, the Company denied claims from the group using other reasons, then retroactively paid the claims when the policyholder paid the overdue premiums. This procedure unfairly transfers risk for unpaid premiums to the providers. Any "clean" claims so delayed are potential violations of Section 3224-a(a) and (c). If the policyholder never paid the premiums, the claims would never have been paid. Neither would the providers have been advised that the patient was no longer covered by the insurer.

It is recommended that the Company calculate and pay interest on claims pended while awaiting overdue premiums, where such claims are eligible for interest pursuant to Section 3224-a(c).

6. UTILIZATION REVIEW

A. Department of Insurance Complaints

New York Regulation 64 Part 216.4(d) and the Company's own written Policies and Procedures state that all complaints received from the Insurance Department are to go directly to the Consumer Affairs Department where they are to be logged in. Further, NY Circular Letter No. 11 (1978) mandates the items that are to be maintained in such a

log. Ten such complaints were sampled, and thirty percent of the sample tested were not properly logged.

It is recommended that the Company implement standards to ensure it adheres to Regulation 64 Part 216.4(d), Circular Letter No. 11 (1978) and its own Policy and Procedures by having the Consumer Affairs Department log all consumer complaints received through the Department of Insurance.

Regulation 64 Part 216.4(d) states in part that every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall within 10 business days, furnish the Department with information requested respecting the claim. The examiner tested a sample of thirty-four Insurance Department requests for information to determine the Company's compliance with this regulation. Twenty-one percent, or five, of the informational requests could either not be found or were not responded to in a timely manner.

It is recommended that the Insurance Company implement standards to ensure it adheres to Regulation 64 Part 216.4(d) by responding to the Department's complaint inquiries within the mandated ten-day time frame.

B. Grievances

United HealthCare Insurance Company of New York, Inc. has no managed care health insurance contracts as defined in §4801(c) of the New York Insurance Law.

Circular Letter No.5 (1999) states in part that insurers do not need to report grievance information to the Department in their annual statements if they do not have a product meeting §4801(c) of the New York Insurance Law definition. However, if those insurers have voluntarily implemented a grievance procedure not subject to the provisions of Chapter 705 of the laws of 1996, they are encouraged to report such grievance information in their annual statement. They should, however, note that such information comes from a voluntary program.

Although the Insurance Company does maintain such a grievance procedure, it did not report any grievances in the annual statement.

It is recommended that the Insurance Company agree to voluntarily report all grievance cases in its annual statement.

A review of the Plan's subscriber contract was conducted to verify if the grievance procedure was included in the contract and whether it complied with §4408-a of the New York Public Health Law. Said Section 4408-a (4) requires that grievances be resolved in an expeditious manner, and in any event, no more than:

(i) thirty days after the receipt of all necessary information in the case of requests for referral and

(ii) forty-five days after the receipt of all necessary information in all other instances.

The Plans' contract wording is not consistent with §4408-a (4), of the New York Public Health Law because said contract states that the Company will perform investigations and resolve complaints based on the following time frames:

(i) 30 business days after the receipt of all necessary information in the case of requests for referral; and

(ii) 45 business days after receipt of all necessary information in all other complaints in writing.

The use of business days, instead of calendar days gives the Company more time to resolve the grievances than the law intends.

It is recommended that the Plans comply with §4408-a (4) of the New York Public Health Law by amending their HMO contracts to state that grievances will be resolved within the appropriate number of "calendar" days as opposed to "business" days.

Grievance files from the two New York Public Health Law Article 44 HMOs were reviewed for compliance with the time parameters required by §4408-a of the New York Public Health Law. Results of that review indicate that thirty-seven percent, or thirty-five of the ninety-four files tested, were either missing acknowledgment letters or had those acknowledgement letters sent late. Additionally, eighteen percent, or seventeen

of the grievances were resolved outside of the required parameters. It should be noted that an additional five files could not be located by the Company.

It is recommended that the Plans adhere to §4408-a(4) of the New York Public Health Law by ensuring that subscribers submitting grievances have acknowledgment letters issued within the required fifteen-day time limit. Further, it is recommended that the grievances be resolved within the law's prescribed time frames.

Section 4408-a(6) of the New York Public Health Law requires that notice of determination of the grievance shall be made in writing to the insured or to the insured's designee. Additionally, the Company's own policy requires this. In twenty-one percent, or twenty of the ninety-four cases reviewed, there was no documentation in the file to indicate that any determination notice was sent to the insured or to the insured's designee.

It is recommended that the Plans comply with §4408-a(6) of the New York Public Health Law and its own policies by ensuring that determination notices are sent to the insured or to the insured's designee following the resolution of a grievance.

Section 4408-a (10) of the New York Public Health Law and the Plan's own policy requires that the determination of an appeal of a grievance on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination. In three

percent, or two of the ninety-four cases reviewed, the person who made the initial determination also reviewed the appeal of a grievance.

It is recommended that the Plans adhere to §4408-a(10) of the Public Health Law and their own policy by ensuring that only qualified personnel be permitted to review appeals of grievances.

C. Utilization Review Appeals

The only appeals that are subject to the utilization review appeals process are those denials for service based on the grounds that the service was not medically necessary.

The utilization review log supplied by the Downstate HMO included both grievances and utilization reviews. Letters were used to differentiate between the two; "G" for grievances, and "A" for utilization reviews. When the actual files were reviewed, however, it was noted that in some cases, the symbol "A" represented a grievance appeal and not a utilization review appeal.

It is recommended that the United HealthCare of New York, Inc. maintain separate logs for their grievance files and their utilization review files.

Section 4904(d) of the New York Insurance Law and §4904(b)(4) of the New York Public Health Law state that both expedited and standard utilization review appeals

shall be handled by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial determination. Additionally, the Company's own policy requires this. However, in eight percent, or four of the fifty-two cases tested, the same person who reviewed the appeal also rendered the initial adverse determination.

It is recommended that the Upstate Plan adhere to §4904(d) of the New York Insurance Law, §4904(b)(4) of the New York Public Health Law and their own policies by ensuring that in every case, utilization review appeals be handled by clinical peer reviewers other than the reviewer that issued the initial determination.

7. INTERNAL AUDIT

During the examination period, the Internal Audit department at United HealthCare was a division of the national office. There were no staff assigned specifically to the New York Companies.

The Company reported that no internal defalcations of any amounts greater than $500 occurred during the examination period. This seems unlikely in light of the fact that there were no audits directed specifically at the New York Companies.

It is recommended that the Company address the issue of security and internal controls at the New York Companies.

8. RECORDS RETENTION

One of the computer systems used by the Insurance Company (the IMCS system), overlaid the field "date received" within the claim processing system when a "dirty" claim was reprocessed. As a result, there was no way to determine the original received date for many of the claims within the system. This is a violation of Regulation 152, Section 243.2, which requires that the claim file shall show clearly the dates that forms and other documents were received. It is also a violation of Regulation 64 Part 216.11 which requires that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim. While this Regulation does not directly apply to the HMOs, good business practice dictates that the Regulation be applied similarly.

The Company maintains that as of January 1, 2000, the IMCS system is no longer used to initiate claim processing.

During examination of the timeliness of the Company's response to subscriber complaints received through the Department, as described in Section 3 herein, the Company was not able to locate two of the sample files requested. This is a violation of Regulation 152 Part 243.2(b)(6), as regards the Insurance Company, which requires that all complaint records be maintained for six years after the complaint has been closed.

It is recommended that the Company comply with all aspects of Regulation 152 regarding records retention.

9. FRAUD PREVENTION

Between the period January 1998 and September 1999, the Company received 470 fraud referrals. Of these 470, a total of 136 cases were opened; 30 in 1998, and 106 in 1999.

As of September 1999, 57% of the fraud cases opened during 1998 were unresolved. The longer the Company waits to resolve these issues, the less chance there is of recovering claim dollars paid out improperly due to fraud.

It is recommended that the Company attach a higher priority to the investigation and resolution of fraud allegations.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

document that was violative of New York Insurance Law §4318 was originally approved for distribution in order to prevent a reoccurrence.

G. It is recommended that the Company take steps to ensure that rates charged are approved and properly billed as required by New York Insurance Law §4308(b). 10

H. It is recommended that the Company comply with New York Insurance Law §4308(b) and utilize an experience-rating formula that has been approved by the Department. 11

I. It is recommended that the Companies maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York Insurance Law. 12

J. It is recommended that the Company initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate Plan formalize an agreement with its general agents. 13

K. It is recommended that United HealthCare license its internal agents to confirm compliance with NY Insurance Law §2114(a)(3). 14

L. It is recommended that United HealthCare of Upstate New York, Inc. file certificates of appointment for each of its agents as required by New York Insurance Law §2112(a). 14

M. It is recommended that the United HealthCare Companies improve their record keeping as regards agents and brokers. 15

CLAIM PROCESSING

N.	United HealthCare indicates that an independent auditor will be auditing certain of the EDI companies for compliance with the claim submission standards and it is recommended they do so.	16
O.	It is recommended that the Company develop a system that will permit it to determine the exact count and inventory of NY claims at any given point in time as required by the Department and in the case of the two HMOs as required by 10 NYCRR Part 98.11(a).	18
P.	It is recommended that the Company utilize its approved plan on a consistent basis or otherwise accurately report claim counts and values in its Schedule H filings in compliance with New York Insurance Law §308.	18
Q.	It is recommended that United HealthCare discontinue its use of a prepared list of emergency room diagnoses it declares ineligible for coverage. Instead, it is recommended that the Company consider each claim separately on its merits.	19
R.	It is recommended that the Company adhere to provisions within the contract setting forth a prudent lay person standard as defined in §3216(i), §3221(k)(4) and §4303(a)(2) of the New York State Insurance Law.	20
S.	It is recommended that the Company comply with the provisions of New York Insurance Law §2601(a)(4) in its the settlement of	20

all emergency room claims.

T. It is recommended that the Company reevaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment. 20

U. It is recommended that the Explanation of Benefits text on denied claims be amended to indicate to subscribers and providers that if additional information is provided, the denied claim will be reconsidered upon receipt of the information. Additionally, when the Company is aware that additional specific information is needed to allow the processing of a claim, said Explanation of Benefits form or system generated letter should indicate such clearly. 22

V. It is recommended that the Company display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes. 23

W. It is recommended that EOBs sent to subscribers include the address of the provider performing the services. 23

X. It is recommended that the Company modify their Explanation of Benefits statement form to include the date the claim was received in order to comply with the intent of the prompt pay laws. 24

Y. It is recommended that United HealthCare modify their 24

Explanations of Benefits statement form to comply with §3234(b) of the New York Insurance Law regarding rights of appeal.

Z. It is recommended that the Company retroactively calculate and pay the New York Health Law §2807-t Debt and Charity Pool on capitated groups it failed to properly account for. 25

AA. It is recommended that the Company retroactively determine any surcharge amounts due but not paid as a result of eligible providers not being listed in the system as so eligible. 25

PROMPT PAY

AB. It is recommended that the Company take steps to ensure that the provisions of §3224-a of the New York Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 29

AC. It is further recommended that the Company review all claims that may have been eligible for interest since January 23, 1998 to determine whether interest is due on such claims. Where the claims are found to be eligible for interest, such interest should be paid in compliance with New York Insurance Law §3224-a(c). 30

AD. It is recommended that the Company install an automated procedure to calculate and pay interest. 30

AE. It is recommended that the Company's Quality Assurance Department establish a procedure to test New York claims for the appropriate application of interest. 31

utilization review appeals be handled by clinical peer reviewers other than the reviewer that issued the initial determination.

INTERNAL AUDIT

AS. It is recommended that the Company address the issue of security and internal controls at the New York Companies. 39

RECORDS RETENTION

AT. It is recommended that the Company comply with all aspects of Regulation 152 regarding records retention. 40

FRAUD PREVENTION

AU. It is recommended that the Company attach a higher priority to the investigation and resolution of fraud allegations. 41

Respectfully submitted,

Bruce Borofsky

Bruce Borofsky

Senior Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Bruce Borofsky, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Bruce Borofsky

Bruce Borofsky

Subscribed and sworn to before me

This 30th day of January 2001

Charles T. Lovejoy

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4798952
Qualified in New York County
Commission Expires 1-25-02

Appointment No. 021360

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Bruce Borofsky

as a proper person to examine into the affairs of the

United HealthCare Insurance Company of New York

and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York,

this 16th *day of* February *1999*

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent