REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

UNITEDHEALTHCARE INSURANCE COMPANY

AS OF JUNE 30, 2013

Conducted from January 21, 2014

Through

September 15, 2015

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 36-2739571
NAIC: 79413

COMMONWEALTH OF VIRGINIA

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BUREAU OF INSURANCE

I, Greg Lee, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of UnitedHealthcare Insurance Company as of June 30, 2013, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2017-00002 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 9th day of March, 2017.

Greg Lee

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of UnitedHealthcare Insurance Company (hereinafter referred to as "UHIC") was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1809 and 38.2-3407.15 C of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

A Market Conduct Investigation covering the period of August 1, 2012 to May 31, 2013 concerning the issuance of non-approved student health policy forms and premium rates was concluded on July 21, 2014. As a result of that investigation, UHIC made a settlement offer that was accepted by the State Corporation Commission on September 12, 2014, in Case No. INS-2014-00173.

The period of time covered for the current examination was January 1, 2013, through June 30, 2013. The examination was initiated on January 21, 2014, at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia and completed on September 15, 2015. The violations cited and the comments included in this Report are the opinions of the examiners.

The examiners may not have discovered every non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether UHIC was in compliance with various provisions of the Code and regulations found in the Virginia

Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-100-10 et seq.	Rules Governing the Submission for Approval of Life, Accident and Sickness, Annuity, Credit Life and Credit Accident Sickness Policy Forms;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (Aids);
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices/Collections/Reinstatements
- Cancellations/Nonrenewals
- Complaints
- Claim Practices
- Internal Appeal and External Review

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to UHIC during the course of the examination.

II. COMPANY HISTORY

The UnitedHealthcare Insurance Company (UHIC) was originally incorporated as a stock life and health insurance company under the laws of the State of Illinois on April 11, 1972. The Company was licensed in the Commonwealth of Virginia on November 17, 1972.

UHIC is the primary insurance company within UnitedHealth Group. The company represents the merged, former health insurance operation of MetLife and Travelers, known as the MetraHealth Insurance Company and United Health and Life Insurance Company, the predecessor insurance operations of UnitedHealth Group, as more fully described below. In 1994, the name was changed to The MetraHealth Insurance Company and the Company re-domesticated to the State of Connecticut.

On January 3, 1995, Travelers and MetLife each contributed assets associated with their group medical insurance and managed care businesses to The MetraHealth Companies, Inc. (the company's then direct parent) or its subsidiaries. Travelers and MetLife also contributed to MetraHealth all of the capital stock of their wholly-owned subsidiaries, including The MetraHealth Insurance Company, constituting their group medical insurance and managed care businesses.

On October 2, 1995, 100% of The MetraHealth Companies Inc. was purchased by UnitedHealthcare Corporation. In May 1996, the MetraHealth Companies, Inc. and MetraHealth Pharmacy Management, Inc. were merged with and into The MetraHealth Insurance Company with the company as the survivor.

Due to the considered overlap of The MetraHealth Insurance Company's state licenses with those of UnitedHealthcare's original insurance subsidiary, United Health

and Life Insurance Company, a Minnesota insurance company, the companies were merged effective January 1, 1997. At the same time, the surviving entity, The MetraHealth Insurance Company, was renamed UnitedHealthcare Insurance Company.

In March of 2000, UnitedHealthcare Insurance Company's direct parent, UnitedHealthcare Corporation changed its name to UnitedHealth Group Incorporated ("UnitedHealth Group"). In June 2000, UnitedHealth Group contributed all the shares of UHIC to its wholly owned subsidiary UnitedHealthcare Services, Inc., who in turn contributed all the issued and outstanding shares of UnitedHealthcare Insurance Company to its wholly owned subsidiary, Unimerica, Inc., a Delaware corporation. As of June 30, 2000, UHIC became a direct wholly owned subsidiary of Unimerica, Inc. On March 31, 2004, Unimerica, Inc. changed its name to UHIC Holdings, Inc. On June 24, 2005, UHIC became licensed in the Commonwealth of the Mariana Islands and in November, 2005 it became licensed in American Samoa.

UHIC is licensed to write life and group accident and health business in the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Guam, and all states except New York. In addition to the medical business, UHIC markets life, dental, stop loss, vision, critical illness, accident only, short term disability, long-term disability and other insured and self insured plans.

UHIC provides Medicare supplement and other supplemental coverage to members of the American Association of Retired Persons (AARP), and other senior insureds, administrative services only (ASO) and stop loss coverage to regional and national large employer accounts, and small case and middle market segments (groups

defined by up to 50 and 5,000 employees, respectively). Two thirds of the middle market business and virtually the entire small case segment is insured business.

As of December 31, 2013, the net statutory admitted assets of UHIC totaled $14,512,561,082 and the total direct accident and health insurance premiums in the Commonwealth of Virginia totaled $1,047,748,625.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

COMPLAINT SYSTEM

The examiners requested a sample of 40 from the total population of 155 written complaints received during the examination time frame. However, 10 of the files provided were complaints related to an affiliate HMO, Optimum Choice, Inc. As a result, 30 UHIC complaint files were reviewed.

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner.

Administrative Letter 2011-05 stated that the Bureau of Insurance will provide carriers with an extension through January 1, 2012, to secure approval of their complaint system filings pursuant to § 38.2-5804 of the Code. Complaint system procedures revised or modified to address the requirements in the Law and the Rules must be filed with and approved by the Bureau on or before January 1, 2012.

As discussed in Review Sheet MC01, UHIC failed to comply with the directives of the Administrative Letter and to establish and maintain a complaint system approved by the Commission during the examination time frame, in violation of § 38.2-5804 A of the Code. UHIC disagreed with the examiners' observations and responded that:

> The VA Bureau of Insurance (BOI) issued Administrative Letter 2011-05, dated 7/14/11 that exempted insurers from compliance with the new appeal requirements until 12/31/11. United does have a complaint system in place and the original complaint system was filed with the Bureau timely in December 2011. Our records indicate that there have been numerous resubmissions requested and discussions with the Bureau on this subject. Our last communication from the Bureau is dated January 16, 2014 in which it was requested that revised letters from our appeal department be submitted. The revised letters were submitted on February 5, 2014. To date we still await approval or further guidance from the Bureau. UnitedHealthcare Insurance Company…will continue to work with the Bureau and to make best efforts to achieve approval of its compliant filing system.

The examiners maintained their findings and responded that "…a review of the Bureau's records indicates that UHIC failed to obtain approval of its complaint system procedures by January 1, 2012, as requested in Administrative Letter 2011-05."

The examiners reviewed the sample of UHIC's complaints for compliance with its established procedures and the requirements of the Code.

TIMELINESS

UHIC's complaint and appeal procedures indicate that the company will advise its decision regarding a complaint within 60 days after receiving it; a decision will be provided within 15 days after receipt for appeal of a pre-service request; and a decision regarding a post-service appeal will be provided within 30 days after receipt.

A review of the sample selected revealed that UHIC was in substantial compliance with its procedures regarding the timely handling of complaints and appeals.

HANDLING

Subsection 1 of § 38.2-502 of the Code states that no person shall make, circulate, cause or knowingly allow to be made, issued or circulated any statement that: misrepresents the benefits, advantages, conditions or terms of any insurance policy.

Section 38.2-503 of the Code states that no person shall disseminate, circulate, or place before the public a statement relating to the business of insurance that is untrue or misleading.

The review revealed 2 instances in which UHIC included misinformation in its response letters to insureds who had filed a complaint or submitted an appeal. As discussed in Review Sheet CP02, the response letter stated, "I understand the appeal to state that the facility should be paid at the network benefit level because the service was performed by a network physician." This statement was incorrect. The appeal was related to out-of-network physician charges for services provided at an in-network facility. The facility charges were not at issue. The response letter further stated, "...I determined the service(s) is covered under your health plan." This response does not explain why the claim was reprocessed. The service was covered initially; however, it was reprocessed following the appeal and paid at a higher level. Although the explanation provided in the appeal response letter was a true statement, it was incomplete and unclear and, as a result, misleading.

Review Sheet CP03 involved another complaint response letter that provided the same incomplete and misleading explanation for the reprocessing of a claim. The services were covered initially, but fewer units were initially covered than the number indicated on the claim submission. The claim was reprocessed with the additional units

being covered; however, the explanation stated only that “...I determined the service(s) is covered under your health plan.”

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

PROVIDER CONTRACTS

The examiners reviewed a sample of 54 from an unknown population of provider contracts in-force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed that in 253 instances, UHIC's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular Code Section, Number of Violations, and a Review Sheet Example are referred to in the table below.

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	6	EF49
§ 38.2-3407.15 B 1 b	34	EF08
§ 38.2-3407.15 B 2	40	EF01
§ 38.2-3407.15 B 3	6	EF47
§ 38.2-3407.15 B 4	6	EF47
§ 38.2-3407.15 B 4 a (i)	5	EF39
§ 38.2-3407.15 B 5	6	EF45
§ 38.2-3407.15 B 5 a	34	EF06
§ 38.2-3407.15 B 6	6	EF49
§ 38.2-3407.15 B 7	6	EF50
§ 38.2-3407.15 B 8	46	EF08
§ 38.2-3407.15 B 9	6	EF48
§ 38.2-3407.15 B 10	45	EF19
§ 38.2-3407.15 B 11	7	EF44

An example of some of the violations cited were discussed in Review Sheet EF06, where the examiners' initial observations stated, in part, that:

> A review of the file reveals that the Virginia Regulatory Requirements Appendix included with this Agreement does not include all of the provisions as required by § 38.2-3407.15 B of the Code of Virginia.
>
> Section 38.2-3407.15 B 1 b of the Code requires the carrier to maintain a written or electronic record of the receipt of a claim and states that the **person submitting the claim** [emphasis added] shall be entitled to inspect such record on request. "Person submitting the claim" includes the Provider, but Provision 4 (c) of the Appendix entitles only the "Customer" submitting the claim to inspect such record.
>
> Section 38.2-3407.15 B 2 of the Code requires the carrier to request required information from the **person submitting the claim** [emphasis added] and states that the carrier may not refuse to pay a claim if the carrier has failed to timely notify the **person submitting the claim** [emphasis added] of the required information. Provision 4 (d) in the Agreement's Appendix excludes the Provider from this process by its use of "Customer submitting the claim."…
>
> …Section 38.2-3407.15 B 5 a. of the Code allows the carrier to refuse to pay a claim for a previously authorized service if documentation provided by the **person submitting the claim** [emphasis added] clearly fails to support the claim as originally authorized. The use of "Customer submitting the claim" in Provision 4 (h) (i) of the Appendix includes no such allowance when documentation provided by the Provider fails to support the claim as originally authorized.
>
> Section 38.2-3407.15 B 8 of the Code **requires the provider contract** [emphasis added] to include or attach, at the time it is presented, the fee schedule and all applicable material addenda, schedules and exhibits. This Code provision places no requirements on the provider. However, Provision 4 (j) of the Appendix requires the Provider to agree that all required documents and information have been provided. This language fails to set forth the requirement that the Agreement include these documents and information…

UHIC disagreed with the examiners' observations and stated that:

> In the Virginia Regulatory Requirements Appendix, the term "Customer," has the same meaning as "member," "enrollee," or "covered person". The position of the health plan is, the rights to claim information and the ability to view, access or control that information resides with the "member,"

> "enrollee," or "covered person". The provider only acts as a proxy for the "member," "enrollee," or "covered person" and does not assume or obtain the "member's," "enrollee's," or "covered person's" rights when submitting claims on behalf of such parties…The only provider requirement in section 8(j) is to acknowledge that United is complying with its obligations and requirements as set-forth in Section 38.2-3407.15 B 8 of the Code.

The examiners maintained their observations and responded that:

> Provisions 4 (c), 4 (d), and 4 (h) (i) of the Appendix exclude reference to the provider by referring to the "customer" submitting the claim rather than satisfying the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, and 38.2-3407.15 B 5 a of the Code of Virginia by referencing the "person" submitting the claim. "Customer" is stated to have the same meaning as "member," "enrollee," or "covered person," none of which could be interpreted to include the health care provider…
>
> …Provision 4 (j) places the requirement on the provider to agree that all required documents and information have been provided, while § 38.2-3407.15 B 8 of the Code requires the provider contract to include or attach, at the time it is presented, the fee schedule and all applicable material addenda, schedules and exhibits.

UHIC failed to amend its provider contracts to comply with § 38.2-3407.15 B of the Code with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code, which prohibits as a general business practice failing to comply with § 38.2-3407.15 of the Code.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions, requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for

claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The examiners reviewed a sample of 573 claims from a population of 1,667 claims processed under 50 of the sample provider contracts during the examination time frame.

Section 38.2-3407.15 B 1 of the Code states that a carrier shall pay any clean claim within 40 days of receipt of the claim. The review revealed 4 instances where UHIC failed to pay a clean claim within 40 days, in violation of § 38.2-3407.15 B 1 of the Code. An example is discussed in Review Sheet EF26A. UHIC agreed with the examiners' observations.

Section 38.2-3407.15 B 2 of the Code requires a carrier, within 30 days after receipt of a claim, to request electronically or in writing the information and documentation that the carrier reasonably believes will be required to process and pay the claim. As discussed in Review Sheet EF21A, the review revealed 1 violation of this section. UHIC agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code requires that any interest owing or accruing on a claim under § 38.2-3407.1, shall be paid at the time the claim is paid or within 60 days thereafter. The review revealed 5 instances where UHIC failed to pay interest as required by this section, in violation of §§ 38.2-3407.15 B 3 and 38.2-3407.1 B of the Code. An example is discussed in Review Sheet EF12A, where UHIC took 20 working days to pay a claim and failed to pay the statutory interest required. UHIC agreed with the examiners' observations.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

The review of the sample claims revealed that UHIC underpaid the fee schedule amount specified for the health care service provided in 8 instances, in violation of § 38.2-3407.15 B 8 of the Code in each instance. Examples are discussed in Review Sheet EF30A. UHIC agreed with the examiners' observations.

UHIC's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.

V. ADVERTISING

A review was conducted of UHIC's advertising materials to determine compliance with the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503 and 38.2-504 of the Code, as well as § 38.2-3609 of the Code, 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-170-10 et seq., Rules Governing Minimum Standards for Medicare Supplement Policies.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed (14 VAC 5-90-50).

A sample of 225 was selected from a population of 502 advertisements distributed in Virginia during the examination time frame. The review revealed that 44 of the advertisements contained violations. In the aggregate, there were 152 violations, which are discussed in the following paragraphs.

14 VAC 5-90-170 A requires an insurer to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed that UHIC failed to include a notation in the file of the manner and extent of distribution for 31 of the 225 sample advertisements reviewed, in violation of

this section. An example is discussed in Review Sheet AD27. UHIC agreed with the examiners' observation.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]." The review revealed 38 violations of this section. An example is discussed in Review Sheet AD10, where the invitation to inquire failed to contain the required disclosure. UHIC agreed with the examiners' observations and stated that "This weakness in our process has been addressed and we do not anticipate this oversight in the future."

14 VAC 5-90-60 A 1 states that an advertisement shall not use words, phrases, or statements if the use of the words, phrases or statements have the capacity, tendency or effect of misleading prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The review revealed 4 violations of this section. An example is discussed in Review Sheet AD34, where the advertisement stated that, "Accident insurance can **pay for itself**…" UHIC agreed with the examiners' observations.

14 VAC 5-90-60 A 2 states that an advertisement shall not contain or use words or phrases such as "this policy will help to replace your income" or similar words and phrases in a manner that exaggerates a benefit beyond the terms of the policy, but may be used only in such manner as to fairly describe the benefit. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD01A, where the

advertisement stated that the critical illness coverage offered will “Continue to pay your rent or mortgage and other daily living expenses, such as childcare and groceries.” UHIC agreed with the examiners’ observations.

14 VAC 5-90-60 B 3 states that when an advertisement refers to a dollar amount, a period of time for which any benefit is payable, a specific policy benefit, or the loss for which a benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead. The review revealed 41 violations of this section. An example is discussed in Review Sheet AD38, where UHIC agreed with the examiners’ observations and stated that, “UHIC is currently working on a plan to bring the materials into full compliance.”

14 VAC 5-90-60 B 4 states that when a policy contains a waiting or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, the advertisement shall disclose the existence of these periods. The review revealed 34 violations of this section. An example is discussed in Review Sheet AD43, where UHIC agreed with the examiners’ observations and stated that, “UHIC is currently working on a plan to bring the materials into full compliance.”

14 VAC 5-90-60 B 6 states that an advertisement for a policy providing benefits for specified illnesses only shall clearly and conspicuously state in boldface type and all capital letters the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to, the following: "THIS IS A LIMITED POLICY". The review revealed 25 violations of this section. An example is discussed in Review Sheet

AD23, where UHIC agreed with the examiners' observations and stated that, "This invitation to inquire failed to contain the disclosures required by…14 VAC 5-90-60 B 6."

14 VAC 5-90-90 A states that statistical information relating to any insurer shall not be used unless it accurately reflects all current and relevant facts. The review revealed 3 violations of this section. An example is discussed in Review Sheet AD17, where an email advertisement stated that UHIC has the "Largest single proprietary network of doctors and hospitals in the nation including more [sic] 33,000 providers in Maryland, Virginia, and Washington, D.C." UHIC disagreed with the examiners' observations and stated that:

> The statement in the email is intended to convey that UnitedHealthcare has products that can get them access to the largest proprietary network of doctors and hospital in the nation. It is not intended to be specific to UHIC.
>
> And while some other plans may have large national access, it is commonly patched together from rented networks throughout the country. From our internal analysis, we are confident in the accuracy of the statement that UnitedHealthcare does have the nation's largest proprietary network of doctors and hospitals.

The examiners would refer UHIC to the notation at the bottom of the first page of the advertisement, which states that insurance coverage was "…*provided by or through UnitedHealthcare Insurance Company or its affiliates".* This comment would indicate that the advertisement was referring primarily to UHIC. Additionally, in the examiners Review Sheet response, we requested copies of the "internal analysis" documenting the accuracy of the statement cited, which UHIC provided to the examiners on June 9, 2014. The documentation consisted of 2 spreadsheets listing the number of "access points" of UHIC's dental network as compared to its competitors. The documentation did not

support the assertion that UHIC has the “Largest single proprietary network of doctors and hospitals in the nation…”

14 VAC 5-90-90 C states that the source of any statistics used in an advertisement shall be identified in the advertisement. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD06, where the advertisement stated that a key feature of the dental coverage offered was that it had “Some of the nation’s largest network/discounts up to 35%” and that one of the Key Features of the STD and LTD coverage offered is that “Staff members have an average of 15 years of experience working with disability claims.” UHIC was unable to provide the examiners with the source of these statistics. UHIC did not indicate whether it agreed or disagreed with the examiners’ observations and made the following statement:

> Regarding the statement “Average of 15 years experience for customer service”:
>
> At the time that our marketing materials were produced, due diligence was performed of the claims staff to ensure the accuracy of the statements that staff had an average of 15 years’ experience in the disability industry. At this time, we are not able to locate the written documentation in support of this statement.
>
> UHIC will be performing additional due diligence to ensure compliance with this statement. If the staff still has an average of 15 years of experience or more, UHIC will forward that documentation to the Department. If the average level of staff service in the industry is now below 15 years, we will update the marketing materials and advise the Department accordingly. UHIC will be retaining all supporting documentation.
>
> Regarding the statement “some of the nation’s largest Networks/Discounts up to 35%.”
>
> Quarterly the status of the UHC discounts and Networks are evaluated and referred to the actuarial function. Supporting documentation is attached.

The supporting documentation referred to in UHIC's response consisted of a spreadsheet listing the number of "access points" of UHIC's dental network as compared to its competitors and did not constitute the source of the statistic used.

14 VAC 5-90-100 A states that when a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected. As discussed in Review Sheets AD06 and AD07, the review revealed 2 violations of this section. UHIC failed to respond to the examiners' observations concerning these violations.

Standards for Marketing – Medicare Supplement Insurance

14 VAC 5-170-180 sets forth the standards for marketing applicable to Medicare Supplement Insurance. The examiners review of the 100 Medicare Supplement advertisements in the sample selected revealed that UHIC was in substantial compliance.

SUMMARY

UHIC violated 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-60 B 6, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-100 A and 14 VAC 5-90-170 A, which placed it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

A review was conducted to determine if UHIC complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

14 VAC 5-100-10 et seq. and § 38.2-316 of the Code set forth the filing and approval requirements for forms that are to be issued or issued for delivery in Virginia.

Sections 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code set forth the filing and approval requirements for group policies, certificates of insurance, amendments, riders and application/enrollment forms used in connection with any group accident and sickness insurance policy issued in Virginia.

The scope of the policy forms review was limited to group policies of accident and sickness insurance issued in Virginia and Medicare supplement certificates issued in Virginia under a master group policy issued in the District of Columbia.

Student Health

During the course of the policy forms review, it was revealed that the certain policies, certificates of coverage and other coverage documents were issued to several colleges and universities renewing student health coverage in the Commonwealth of Virginia for the 2012-2013 academic year, prior to the policy forms and premium rates being filed with and approved by the Commission, as required. It was also revealed that non-approved enrollment and application forms were used by UHIC to issue student health medical, dental and vision coverage.

Due to the immediate nature of these violations, the Bureau of Insurance initiated a market conduct investigation. This investigation resulted in a Settlement Order requiring UHIC to cease and desist from future violations of §§ 38.2-316 A, 38.2-316 B,

38.2-316 C 1, 38.2-3405 A and 38.2-3405 B of the Code. The order was issued on September 12, 2014, in Case No. INS-2014-00173.

Comprehensive Major Medical

The examiners reviewed a sample of 58 from the total population of 421 group comprehensive major medical policies issued during the examination time frame.

The review revealed 53 instances where a revised version of an amendment was issued to a group policyholder prior to the revised form being filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. As discussed in Review Sheet PF15, UHIC deleted the phrase "...and state law" from the first sentence on Page 1 of the Appeals Amendment APPEALSAMD.I.VA, and failed to file the altered form with the Commission for approval. UHIC indicated in its response to the Review Sheet that it agreed with the examiners' observations and stated that "We agree with the finding that the group contracts identified had a clerical error within the first sentence of the cited Appeals Amendment." The examiners responded that the "…observations did not concern a 'clerical error' but UHIC's failure to file the revised amendment to the Commission for approval."

As discussed in Review Sheets PF17 and PF19, the review revealed that UHIC issued the rider titled "Outpatient Prescription Drug Rider RDR.RXSBN.PLS.I.09.VA" prior to the form being filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code in 2 instances. UHIC disagreed with the examiners' observations and stated that:

> The 2009 INS series for VA, which included this Rx SBN, was approved on 10/5/10 (SERFF File No. UHLC-126226391). The person filing the form inadvertently changed part of the standard form numbering convention. The approved form number is "RDR.RXSB.PL.I.09.VA". Had

she followed standard naming convention, the only variation for the VA form would be the ".VA" at the end of the form, so the form would have read "RDR.RXSB**N**.PL**S**.I.09.VA" (emphasis added).

The examiners responded that "…any change to the form number would require the amended form to be filed with and approved by the Commission."

Other Group Accident & Sickness Policies

The examiners selected samples from the populations listed in the table below.

Line of Business	Population	Sample
Short-Term Disability Income	13	6
Long-Term Disability Income	16	6
Dental	138	15
Vision	245	27
Critical Illness	2	2

The review revealed that the policy forms issued during the examination time frame for the above lines-of-business were filed with and approved by the Commission.

Medicare Supplement Certificates

The examiners reviewed a sample of 100 from the total population of 9,027 Medicare supplement certificates issued during the examination time frame.

The review revealed that the policy forms issued during the examination time frame were filed with and approved by the Commission.

ACCIDENT AND SICKNESS RATE FILING

Section 38.2-316 A of the Code sets forth the requirements for the filing of rates and rate changes. 14 VAC 5-170-130 B sets forth the requirements for the filing of rates or rate changes for Medicare Supplement policies.

With the exception of the Student Health line-of-business, the review revealed that UHIC was in substantial compliance.

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and enrollment forms prior to use.

The review revealed that in 3 instances, UHIC used a group application form that had not been filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. The Form Number and the Review Sheet documenting the violations are listed in the following table.

Form Number	# of Violations	Review Sheet
UNITEDHEALTHCARE - KEY ACCOUNTS ATLAS Proposal Request Form	**1**	**PF16**
Insured Employer Application LG.ER.10.IL 6/10	**2**	**PF18, PF27**

UHIC agreed with the examiners' observations concerning the above forms.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval.

As discussed in Review Sheet PF28, the review revealed that the Dental EOB (no form#) used by UHIC in the processing of paid and denied dental claims during the

examination time frame had not been filed with or approved by the Commission, in violation of § 38.2-3407.4 A of the Code.

Additionally, as discussed in Review Sheet PF29, Explanation of Benefit form numbers EOB (9/12) and EOB (8/05), used for Student Health claims, were not filed with and approved by the Commission prior to use, in violation of § 38.2-3407.4 A of the Code in 2 instances.

VII. AGENTS

The purpose of this review was to determine compliance with various Sections of Title 38.2, Chapter 18 of the Code. The 102 agents and 61 agencies designated in the sample of 114 group accident and sickness new business files were reviewed. Additionally, the 74 agents and 5 agencies designated in the 100 Medicare supplement certificate issued files were reviewed.

LICENSED AGENT REVIEW

Section 38.2 1822 A of the Code requires that a person be licensed prior to soliciting contracts or acting as an agent in the Commonwealth.

The review revealed 34 violations of this section. An example is discussed in Review Sheet AG63, where an internal account executive acted as an agent in the Commonwealth prior to obtaining a license. UHIC agreed with the examiners' observations.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer, within 30 calendar days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 29 violations of this section. An example is discussed in Review Sheet AG36, where UHIC failed to reject a group application submitted by an agent that was not appointed. UHIC agreed with the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency which was not appointed or which was not licensed at the time of the transaction.

The review revealed 39 violations of this section. An example is discussed in Review Sheet AG38, where UHIC paid commission or other valuable consideration to an account executive that was not licensed or appointed. UHIC agreed with the examiners' observations.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment. A sample of 40 was selected from the total population of 1,376 agents whose appointments terminated during the examination time frame.

As discussed in Review Sheet AG16, the review revealed that UHIC failed to notify 1 agency and 7 agents of termination of appointment within 5 calendar days, in violation of § 38.2-1834 D of the Code in 8 instances. UHIC disagreed with the examiners' observations but was unable to provide the examiners with documentation that it had notified the agents in accordance with this section.

VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of UHIC's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620 and 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine whether UHIC's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with UHIC's procedures and correct premiums were being charged. The scope of the review was limited to UHIC's group accident and sickness lines-of-business.

UNDERWRITING REVIEW

The examiners reviewed a sample of 114 from the total population of 835 group accident and sickness insurance policies issued during the examination time frame.

The review revealed no evidence of unfair discrimination.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that UHIC was in substantial compliance.

MECHANICAL RATING REVIEW

The review revealed that UHIC calculated premium amounts in accordance with its established guidelines.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use and disclosure of personal/privileged information gathered in connection with insurance transactions.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The review revealed that the disclosure authorizations used by UHIC in the underwriting of its group business were in substantial compliance.

ADMINISTRATIVE LETTER 2010-12

The purpose of this Administrative Letter is to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association,* was approved effective November 1, 2010.

As discussed in Review Sheet UN01, the review revealed that UHIC failed to deliver the summary document to the policy or contract owner in 835 instances, in violation of § 38.2-1715 B of the Code in each instance. UHIC agreed with the examiners' observations.

IX. PREMIUM NOTICES/COLLECTIONS/REINSTATEMENTS

UHIC's procedures for processing premium notices, collections and reinstatements were reviewed for compliance with its established procedures.

UHIC's practices for notifying policy holders of the intent to increase premium by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM NOTICES

Premium invoices are generated approximately two weeks prior to the due date. Invoices may contain charges for current and prior months not previously billed (retroactivity) and future months. In order to create an invoice, the group's demographic information is needed; there must be charges to create the invoice; and a contractual policy must exist. Invoices are generated through a nightly batch process. The invoices created are available to group policyholders to view.

The review revealed that UHIC's premium notices were generated in accordance with its established procedures.

UHIC's practices for notifying policy holders of the intent to increase premium by more than 35% were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

The total population of 4 groups whose premiums increased by more than 35% was reviewed. The review revealed that UHIC was in substantial compliance with the notification requirements.

COLLECTIONS

Once the due date of the invoice has passed the group policyholder may receive a statement with the past due balance or a phone call requesting the status of the payment. Smaller groups receive a statement, generated on the 12th-14th day after the due date of the invoice, alerting the customer they may be at risk for termination due to non-payment of premiums. If the balance is not paid by the end of the grace period, the policy is cancelled for non-payment. Larger groups may receive a phone call or email requesting the status of their payment from the billing area. If the group remains delinquent, the group is escalated to an analyst for an additional call to be made. If a payment is not received for a second month, the analyst will make one attempt to obtain payment confirmation. If confirmation is not received, the group may be escalated to the market Chief Financial Officer to pursue payment confirmation. If a larger group pays outside their grace period for 3 of the last 6 months and has paid 2 consecutive months outside the grace period, they qualify to receive a demand or severe payment letter.

The review revealed that UHIC was in substantial compliance with its established procedures for collections.

REINSTATEMENTS

Groups seeking reinstatement as a result of termination for non-payment of premiums are required to pay all past due premiums and the current month's premium in full. Reinstatement requests must be received within 30 days of the termination statement date. Groups are allowed three reinstatements in a rolling 12 month period. At the time of the second reinstatement, a reinstatement letter is sent out to the group.

At the time of the third reinstatement a final reinstatement letter is sent. There is an exception process in place for reinstatements outside of the guidelines listed.

A sample of 10 was selected from the total population of 46 groups whose coverage was reinstated during the examination time frame. The review revealed that UHIC was in substantial compliance with its established procedures for reinstatement.

X. CANCELLATIONS/NONRENEWALS

The examination included a review of UHIC's cancellation/nonrenewal practices and procedures to determine compliance with the policy provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; and the notification requirements of § 38.2-3542 C of the Code.

A sample of 24 was selected from a total population of 77 group accident and sickness policies that were cancelled, non-renewed, or terminated during the examination time frame.

The review revealed that UHIC was in substantial compliance with its established procedures, the policy provisions, and the notification requirements of § 38.2-3542 C of the Code.

Additionally, there was no evidence of unfair discrimination in the sample files reviewed.

XI. COMPLAINTS

UHIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 30 was selected from a total population of 155 written complaints. The review revealed that UHIC was in substantial compliance.

XII. CLAIM PRACTICES

The examination included a review of UHIC's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims processed under student health, group major medical, group dental and group vision policies. Student health pharmacy claims were processed internally by UHIC. OptumRx, Inc., an affiliate company, processed all other pharmacy claims.

PAID CLAIM REVIEW

Student Health

A sample of 125 was selected from a population of 4,276 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Major Medical

A sample of 383 was selected from a population of 211,271 claims paid during the examination time frame.

Subsection 2 (ii) of § 38.2-508 of the Code states that no person shall unfairly discriminate or permit any unfair discrimination in the benefits payable under a health insurance policy. The review revealed 1 violation of this section. As discussed in Review Sheet CL32, the violation concerned UHIC's decision to waive its Professional/Technical Component Policy (Policy Number 2013R0012A) in regard to a

claim received on behalf of an insured from a non-participating pathologist.

The Professional/Technical Component Policy stated the following:

> When a physician or other health care professional provides the equipment to perform the service or procedure in a facility POS 21, 22, 23, 26, 34, 51, 52, 56, or 61, only the facility may be reimbursed for the technical component of the service or procedure.

In Review Sheet CL32, the examiners observed that:

> UHIC unfairly waived its "Professional/Technical Component Policy" applicable to the health care services billed on this claim due to an "EE (eligible employee?) Broker Issue." This covered employee was reimbursed directly for the interpretation of laboratory results while other members of her group and other persons covered under UHIC's group major medical policies issued in Virginia were held liable for the cost of non-reimbursable laboratory interpretations received from non-contracted pathologists.

UHIC disagreed with the examiners' observations and responded that:

> The Company respectfully disagrees with all citations listed pertaining to this claim sample. The claim originally processed correctly; however, we processed the claim to remove the member from the balance billing situation. In general, physicians reporting these laboratory tests on a claim with a facility place of service are indicating they are billing for the supervision of a hospital laboratory. There is almost never any direct patient care involved in these situations, no face to face encounter with a patient, and the physician is not actually reading the test or writing a separate written report. In the situations where this denial code is used, pathologists merely oversee the laboratory and the technical staff for quality control purposes. They do not render any professional services to individual members, and given that no specific, identifiable services are provided to individual members, we do not feel that separate charges from such a provider are warranted or legitimate…
>
> As we do not feel that separate charges from such a provider are warranted or legitimate, the Company does not believe that a provider should balance bill the member for these services. In this instance, the member alerted us via a phone call that they were being balance billed and the company removed the member from that situation. Any member who notifies us that they are going through the same situation would receive the same assistance. The Company agrees that the remark code

> verbiage could be more clear in alerting members of the option to contact us if they are being balance billed. Remark code verbiage modifications will be implemented.

The examiners maintained their findings and responded that the notations in the claim file did not support UHIC's statement that "Any member who notifies us that they are going through the same situation would receive the same assistance." The file documentation indicated that the member had contacted UHIC customer service on August 13, 2013 and requested that the claim be adjusted. No action was taken by UHIC to adjust the claim until an insurance broker intervened on the insured's behalf in January of 2014.

Group Dental

A sample of 75 was selected from a population of 15,936 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Vision

A sample of 60 was selected from a population of 5,854 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Pharmacy

A sample of 125 was selected from a population of 650,961 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

INTEREST

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

All of the claims in the paid claims sample were reviewed for compliance with this section in addition to any claims in the denied claims sample that were adjusted to pay during, or subsequent to, the examination time frame.

Student Health

The review revealed 3 violations of § 38.2-3407.1 B of the Code. In each instance, statutory interest was due and UHIC failed to pay interest. An example is discussed in Review Sheet CL03, where UHIC took 23 working days to pay the claim and failed to pay interest. UHIC disagreed with the examiners' observations stating that:

> …Section 38.2-3537 of the Code of Virginia states: "Each group accident and sickness insurance policy shall contain a provision that all benefits payable under the policy other than benefits for loss of time shall be payable within sixty days after receipt of proof of loss."
>
> This claim was received on January 23, 2013. A letter acknowledging receipt of the claim was sent on January 29, 2013. The claim was processed and benefits were paid on February 19, 2013. Thus, no interest was due or payable.

The examiners responded that there was "…no conflict with these statutes {§ 38.2-3407.1 B} and the policy form provision required by § 38.2-3537 of the Code of Virginia" and that "UHIC took more than 15 working days to affirm the claim and failed to pay the statutory interest due."

Group Major Medical

The review revealed 13 violations of § 38.2-3407.1 B of the Code. In 5 instances, the amount of statutory interest due was underpaid. In 8 instances, no interest was paid. An example is discussed in Review Sheet CL19, where UHIC disagreed with the examiners' observations, and stated that:

> The company respectfully disagrees with the criticism. Documentation attached shows that the claim was received on 06/04/13 & was processed on 06/05/13 closing the claim for medical records. A letter was sent to provider on 06/08/13.

The examiners responded that "…a review of the file indicates that the claim was paid on August 9, 2013 without the additional proof of loss requested by UHIC on June 8, 2013 (Medical Records) being received."

Additionally, as discussed in Review Sheet CL33, notations in the claim file from UHIC's "Online Routing System" stated that:

> Payment goes to member and per the Prompt Pay Sharepoint we do not pay interest to the member…Per the Prompt Pay At a Glance we should not pay interest when paying member.

Based on these comments, UHIC had a policy in place during the examination time frame of not paying interest on claims that were paid directly to insureds. UHIC agreed in its response to Review Sheet CL33, that it had failed to pay the required interest.

Group Dental

The review revealed 2 violations of § 38.2-3407.1 B of the Code. In both instances, the amount of statutory interest due was underpaid. An example is discussed in Review Sheet CL43, where UHIC agreed with the examiners' observations.

Group Vision

The review revealed 5 violations of § 38.2-3407.1 B of the Code. In every instance, the amount of statutory interest due was underpaid. An example is discussed in Review Sheet CL54.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took UHIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the sample of 768 paid accident and sickness claims.

PAID CLAIMS			
Claim Type	Working Days to Settle	Number of Claims	Percentage
Group Accident & Sickness	0 – 15	741	96.48%
	16 – 20	7	0.92%
	Over 20	20	2.60%

Of the 768 claims reviewed for the time study, 3.5% of claims were not settled within 15 working days.

Shared Savings Program (SSP)

During the course of the review of complaints and paid claims, the presence of certain remark codes printed on the Explanation of Benefits forms (EOBs) sent to insureds was noted by the examiners. These remark codes stated:

> The physician or health care provider is not a network provider. However, they have accepted a discount on this service in accordance with their {Beech Street Supplemental or PMCS} network agreement. The member is responsible for the total amount indicated in the area of this statement showing what the patient owes. If you have already paid the entire bill, please contact the physician or health care provider for a refund.
>
> The physician or health care provider is not a network provider but has accepted a discount on this service in accordance with his or her MultiPlan agreement. The member is responsible for the total amount indicated in the area of this statement showing what the patient owes. You are not responsible for the difference between the amount charged and the amount allowed. If you already paid the entire bill, please contact the physician or health care provider for a refund.

In its response to Review Sheets CL101, CL102 and CL103, UHIC described these discount arrangements as follows:

> The Shared Savings Program (SSP) is a discount program applied to services billed by out-of-network (OON) providers. Outside vendors arrange a pre-negotiated discount with the physician or other health care providers, and pass the lower rates to UHIC. There is a hierarchy for fully-insured plans in VA. A physician claim will first route to Primary SSP Vendor then if that vendor does not have an active discount agreement with the provider, then the claim is automatically routed to the Secondary SSP Vendor, then if that vendor does not have an active discount agreement with the provider it will move on to the next vendor until all vendors are exhausted.

The examiners extracted the 4,941 claims from the paid claims population containing the EOB remark codes listed above and compared the provider names in the claims data with the on-line listing of preferred (PPO) and point-of-service (POS) on UHIC's website.

As discussed in Review Sheets CL101, CL102 and CL103, the review revealed 53 instances where UHIC paid claims as out-of-network under the SSP arrangement when it had a direct contract with the provider in question. The examiners observed that UHIC's actions in these 53 instances constituted non-compliance with 14 VAC 5-400-40 A, which prohibits knowingly obscuring or concealing from claimants, benefits, coverages or other provisions of any insurance policy when such benefits, coverages or other provisions are pertinent to a claim and 14 VAC 5-400-70 D, which requires an insurer to offer a claimant an amount that is fair and reasonable.

In its response to Review Sheet CL102, UHIC partially agreed with the examiners' observations and stated that "Claims…should have been paid as Par as the provider had an existing contract on the Date of Service."

Out-of-Pocket Maximum

A sample of 21 was selected from a population of 371 insureds that met their out-of-pocket (OOP) maximum during the examination time frame.

As discussed in Review Sheet CL01BW, the review revealed 1 instance in which the insured exceeded the OOP maximum, but UHIC failed to provide the insured with a refund. Therefore, UHIC failed to comply with the requirements of 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices and the terms of the certificate of coverage. This example is referenced in the *Unfair Claims Settlement Practices Review* subsection. UHIC agreed with the examiners' observations.

DENIED CLAIM REVIEW

Student Health

A sample of 75 was selected from a population of 1,723 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Major Medical

A sample of 184 was selected from a population of 22,455 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with UHIC's established procedures.

Group Dental

A sample of 35 was selected from a population of 3,650 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Vision

A sample of 30 was selected from a population of 4,137 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Group Pharmacy

A sample of 50 was selected from a population of 58,919 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 768 paid claims and 374 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-40 A requires that no insurer knowingly obscure or conceal from claimants, benefits, coverages or other provisions of an insurance policy when such benefits, coverages or other provisions are pertinent to a claim.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer.

14 VAC 5-400-60 B requires that if the investigation of a claim has not been completed, every insurer shall, within 45 days from the date of the notification of the claim and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

14 VAC 5-400-70 A requires that any denial must be given to the claimant in writing and that the claim file shall contain a copy of the denial.

14 VAC 5-400-70 B requires an insurer to include a reasonable explanation of the basis for the denial of a claim in the written denial.

14 VAC 5-400-70 D requires an insurer to offer a claimant an amount that is fair and reasonable.

Additionally, the 4,941 claims extracted from the paid claims population that were paid under the SSP discount program were reviewed for compliance with 14 VAC 5-400-40 A and 14 VAC 5-400-70 D.

The review was conducted using the date the letter or check was mailed as the settlement date.

14 VAC 5-400-40 A – in 54 instances, benefits of an insurance policy were knowingly obscured from claimants when such benefits were pertinent to a claim. Examples are discussed in Review Sheets CL101, CL102, CL103 and CL01BW.

14 VAC 5-400-50 A – in 53 instances, a claim was not acknowledged within 10 working days upon receipt of notification. An example is discussed in Review Sheet CL100, where UHIC agreed that it failed to acknowledge the receipt of 53 vision claims within 10 working days upon receipt of notification. UHIC agreed with the examiners' observations.

14 VAC 5-400-60 A – in 46 instances, a claimant was not advised of the acceptance or denial of a claim within 15 working days after proof of loss was received. An example is discussed in Review Sheet CL25, where UHIC took 45 working days to affirm the claim after receipt of proof of loss. UHIC agreed with the examiners' observations.

14 VAC 5-400-60 B – in 10 instances, within 45 days from the date of notification of a claim, UHIC failed to send the claimant a letter setting forth the reasons additional time was needed for investigation. Review Sheet CL20 provides an example. UHIC agreed with the examiners' observations.

14 VAC 5-400-70 A – in 31 instances, a denial was not made in writing. An example is discussed in Review Sheet CL28, where the EOB failed to provide the claimant with a written reason for the claim denial. UHIC agreed with the examiners' observations.

14 VAC 5-400-70 B - in 31 instances, a claim was denied without a written reasonable explanation of the basis for such denial. Examples are discussed in Review Sheet CL100, where in 29 instances, UHIC failed to provide written EOBs to insureds for denied vision claims. UHIC agreed with the examiners' observations.

14 VAC 5-400-70 D – in 54 instances, UHIC failed to offer a claimant an amount that was fair and reasonable. Examples are discussed in Review Sheets CL101, CL102, CL103, CL104 and CL01BW.

UHIC's failure to comply with certain sections of the above regulations in regard to the handling of its paid and denied vision claims occurred with such frequency as to indicate a general business practice, and placed UHIC in violation of 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 4 VAC 5-400-70 A and 14 VAC 5-400-70 B.

THREATENED LITIGATION

UHIC informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

XIII. INTERNAL APPEAL AND EXTERNAL REVIEW

Chapter 35.1 of Title 38.2 of the Code and 14 VAC 5-216-10 et seq. set forth the requirements for the establishment of a health carrier's internal appeal process and a process for appeals to be made to the Bureau of Insurance to obtain an external review of final adverse decisions.

On July 14, 2011, the Bureau of Insurance issued Administrative Letter 2011-05, the purpose of which was to provide a summary of the new internal appeals and external review process under Virginia law, and to provide guidance for the submission of complaint system filings revised to comply with these new requirements.

The examiners reviewed the entire population of 1 appeal to obtain an independent external review of a final adverse decision that occurred during the examination time frame. In addition, the 30 sample complaint files were reviewed for compliance with the notice requirements for external review.

Section 38.2-503 of the Code states that no person shall disseminate, circulate, or place before the public a statement relating to the business of insurance that is untrue or misleading. Administrative Letter 2011-05 states, in part, that "The Commissioner of Insurance will no longer render an order; instead, the decision that results from the review by the Independent Review Organization (IRO) is final and binding on the health carrier and the covered person (except to the extent that the covered person has remedies available under federal or state law). The IRO will communicate its decision to the covered person, the health carrier and the Bureau."

The review revealed 2 violations of the Code and non-compliance with the directives of the Administrative Letter. An example is discussed in Review Sheet EX01,

where the adverse determination letter incorrectly advised the covered person that "The review organization will make a written recommendation to the Commissioner of Insurance. The Commissioner will then issue a written ruling that will uphold, reverse, or modify the decision made by UnitedHealthcare." UHIC agreed with the examiners' observations.

14 VAC 5-216-30 B requires any adverse benefit determination to provide contact information for the Bureau of Insurance, and if the plan is a managed care health insurance plan (MCHIP), the mailing address, telephone number, and mailing address for the Office of the Managed Care Ombudsman shall also be included.

The review revealed 2 violations of this section. An example is discussed in Review Sheet EX02, where an adverse determination sent by UHIC's Pharmacy Benefit Manager failed to provide contact information for the Office of the Managed Care Ombudsman, as required. UHIC disagreed, stating that contact information was provided for Virginia's Consumer Assistance Program as posted by the United States Department of Labor and that the UHC Pharmacy plan monitors the Department's web page for updates. The examiners maintained their findings and responded that, although the adverse determination letter included contact information for the Bureau of Insurance as required by 14 VAC 5-216-30 B, it failed to include the mailing address, telephone number, and email address for the Office of the Managed Care Ombudsman which the regulation also requires for managed care health insurance plans.

Section 38.2-5804 A 2 of the Code requires a health carrier to provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone

number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions.

The review revealed 1 violation of this section. As discussed in Review Sheet EX04, UHIC's appeal acknowledgement letter provided contact information for the Office of the Managed Care Ombudsman, but it also referenced the "California Language Assistance Program" and referred the covered person to the California Department of Insurance. In addition, the letter included external review request forms for the California Department of Insurance although the plan was situsedin Virginia. The letter further included a "Special Note" regarding self-funded employee benefit plans although the company's Escalation Tracking System indicated that the appellant was covered under a fully insured plan. UHIC agreed with the examiners' observations and advised that the record was misclassified as fully insured and that the plan was self-funded. The examiners noted that self-insured plans are not eligible for external review, and external review rights and forms should not be provided, unless the plan has opted in to the state external review process.

Section 38.2-3559 D of the Code states that the health carrier shall include the standard and expedited external review procedures and any forms with the notice of the right to an external review.

As discussed in Review Sheet EX03, the review revealed 1 instance in which the final adverse determination provided notice of the right to external review but forms were not included, as required. UHIC agreed with the examiners' observations.

XIV. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, the examiners recommend that UHIC implement the following corrective actions. UHIC shall:

1. Establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;
2. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code contains the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a (i), 38.2-3407.15 B 5, 38.2-3407.15 B 5 a, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code, and does not contain provisions that are more burdensome upon the provider than the specific provisions;
3. Establish and maintain procedures to ensure that claims processed under a "provider contract" as defined in § 38.2-3407.15 A of the Code are processed in accordance with the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 of the Code;
4. Establish and maintain procedures to include in the advertising file a notation of the manner and extent of distribution of each advertisement and the form number of the policy advertised, as required by 14 VAC 5-90-170 A;
5. Establish and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A;

6. Establish and maintain procedures to ensure that an advertisement does not use words, phrases, or statements that have the capacity or tendency to mislead prospective purchasers as to the nature and extent of any policy benefit payable, loss covered, or premium payable, as required by 14 VAC 5-90-60 A 1;

7. Establish and maintain procedures to ensure that an advertisement does not contain or use words or phrases in a manner that exaggerates the benefits beyond the terms of the policy, as required by 14 VAC 5-90-60 A 2;

8. Establish and maintain procedures to ensure that when an advertisement refers to a dollar amount; a period of time for which any benefit is payable, a specific policy benefit, or the loss for which a benefit is payable, it also discloses those exceptions, reductions, and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B 3;

9. Establish and maintain procedures to ensure that an advertisement discloses the existence of any waiting or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for a loss, as required by 14 VAC 5-90-60 B 4;

10. Establish and maintain procedures to ensure that an advertisement for a policy providing benefits for specified illnesses clearly and conspicuously states in boldface type and all capital letters, the limited nature of the policy in language identical to or substantially similar to “THIS IS A LIMITED POLICY”, as required by 14 VAC 5-90-60 B 6;

11. Establish and maintain procedures to ensure that statistical information used in an advertisement is accurate and reflects all of the current and relevant facts, as required by 14 VAC 5-90-90 A;
12. Establish and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C;
13. Establish and maintain procedures to ensure that when a choice of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of benefits selected, as required by 14 VAC 5-90-100 A;
14. Establish and maintain procedures to ensure that all amendments, riders and group application forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
15. Establish and maintain procedures to ensure that all EOB forms are filed with the Commission for approval, as required by § 38.2-3407.4 A of the Code;
16. Establish and maintain procedures for compliance with §§ 38.2-1812 A, 38.2-1822 A and 38.2-1833 A 1 of the Code concerning the licensing of, appointment of, and payment of commission to, agents and agencies;
17. Strengthen its procedures for notifying agents and agencies of appointment termination within 5 calendar days, as required by § 38.2-1834 D of the Code;
18. Establish and maintain procedures to ensure that the notice and disclaimer contained in the Guaranty Association summary document approved by the Commission is attached to all policies or contracts delivered in Virginia, as required by Administrative Letter 2014-05 and § 38.2-1715 B of the Code;

19. Establish and maintain procedures to ensure that no insured person is unfairly discriminated against in the benefits payable under a health insurance policy, in order to maintain compliance with subsection 2 (ii) of § 38.2-508 of the Code;

20. Establish and maintain procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;

21. Review and consider for re-adjudication all paid student health, group major medical, group dental and group vision claims that took greater than 15 working days to pay for the years of 2013, 2014, 2015 and the current year and make interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

22. Establish and maintain procedures to ensure that it administers its Shared Savings Program (SSP) in accordance with the requirements of 14 VAC 5-400-40 A and 14 VAC 5-400-70 D;

23. Re-open all claims that were paid at the out-of-network level of benefits under the Shared Savings Program (SSP) that should have been paid as in-network under direct UHIC provider contracts accepting reimbursement for UHIC's Choice Plus, Options and Non-Differential products for the years of 2013,

2014, 2015 and the current year and adjust the claims to pay under the "Network Benefits" level. Include the statutory interest required by § 38.2-3407.1 B of the Code with all payments. Include verbiage on the EOB sent to the covered person and provider stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was paid under the Non-Network level of benefits in error. Please accept this additional payment amount." After which, furnish the examiners with documentation that the additional amounts with interest have been paid within 180 days of this Report being finalized;

24. Review its established procedures to ensure that, when an insured meets the out-of-pocket maximum, UHIC complies with the terms of the certificate of coverage and the requirements of 14 VAC 5-400-40 A and 14 VAC 5-400-70 D;

25. Review its established procedures to ensure that it acknowledges the receipt of notification of all vision claims within 10 working days, as required by 14 VAC 5-400-50 A;

26. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;

27. Review its established procedures to ensure that written notification of a claim under investigation is sent to the claimant every 45 days from the date of

notification of the claim, and every 45 days thereafter, as required by 14 VAC 5-400-60 B;

28. Establish and maintain procedures to ensure that a denial of a claim is given to a claimant in writing, as required by 14 VAC 5-400-70 A;
29. Establish and maintain procedures to ensure that the claimant is provided a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B;
30. Establish and maintain procedures to ensure that complaint and appeal response letters provide complete, clear, and accurate information as required by subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
31. Establish and maintain procedures to ensure that forms are included with the notice of the right to external review in applicable final adverse determination letters, as required by § 38.2-3559 D of the Code;
32. Establish and maintain procedures to ensure that contact information for the Bureau of Insurance and the Office of the Managed Care Ombudsman is included in all adverse determination letters, as required by 14 VAC 5-216-30 B;
33. Establish and maintain procedures to ensure that appeal and complaint response correspondence includes correct information regarding consumer assistance and external review based upon the funding and situs of the policy, as required by § 38.2-5804 A 2 and Administrative Letter 2011-05; and
34. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XV. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by UHIC's officers and employees during the course of this examination is gratefully acknowledged.

Gregory Lee, FLMI, CIE, MCM, Laura Wilson, MCM, Bryan Wachter, FLMI, AIE, AIRC, MCM, and Melissa Gerachis, FLMI, AIRC, AMCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

Julie Fairbanks, ACS, AIRC, FLMI, MCM
Supervisor, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XVI. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
§ 38.2-5804 A, 1 violation, MC01
Subsection 1 of § 38.2-502, 2 violations, CP02, CP03
§ 38.2-503, 2 violations, CP02, CP03
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 1 b, **34 violations**, EF01, EF02, EF03, EF05, EF06, EF07, EF08, EF09, EF10, EF12, EF13, EF14, EF15, EF17, EF18, EF19, EF20, EF21, EF22, EF23, EF25, EF26, EF27, EF28, EF30, EF31, EF32, EF33, EF34, EF36, EF39, EF41, EF42, EF44
§ 38.2-3407.15 B 2, 40 violations, EF01, EF02, EF03, EF05, EF06, EF07, EF08, EF09, EF10, EF12, EF13, EF14, EF15, EF17, EF18, EF19, EF20, EF21, EF22, EF23, EF25, EF26, EF27, EF28, EF30, EF31, EF32, EF33, EF34, EF36, EF39, EF41, EF42, EF44, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 3, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 4, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 4 a (i), 5 violations, EF36 EF39, EF41, EF42, EF44
§ 38.2-3407.15 B 5, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 5 a, 34 violations, EF01, EF02, EF03, EF05, EF06, EF07, EF08, EF09, EF10, EF12, EF13, EF14, EF15, EF17, EF18, EF19, EF20, EF21, EF22, EF23, EF25, EF26, EF27, EF28, EF30, EF31, EF32, EF33, EF34, EF36, EF39, EF41, EF42, EF44
§ 38.2-3407.15 B 6, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 7, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50

§ 38.2-3407.15 B 8, 46 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23, EF24, EF25, EF26, EF27, EF28, EF29, EF30, EF31, EF32, EF33, EF34, EF35, EF36, EF39, EF41, EF42, EF44, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 9, 6 violations, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 10, 45 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23, EF25, EF26, EF27, EF28, EF29, EF30, EF31, EF32, EF33, EF34, EF35, EF36, EF39, EF41, EF42, EF44, EF45, EF46, EF47, EF48, EF49, EF50
§ 38.2-3407.15 B 11, 7 violations, EF44, EF45, EF46, EF47, EF48, EF49, EF50
Provider Claims
§ 38.2-3407.15 B 1, 4 violations, EF04A, EF21A, EF26A, EF32A
§ 38.2-3407.15 B 2, 1 violation, EF21A
§ 38.2-3407.15 B 3, 5 violations, EF03A, EF05A, EF12A, EF25A, EF32A
§ 38.2-3407.15 B 8, 8 violations, EF30A
ADVERTISING
14 VAC 5-90-55 A, 38 violations, AD01A, AD02A, AD03A, AD04A, AD05, AD06, AD07, AD08, AD09, AD10, AD12, AD13, AD14, AD15, AD16, AD17, AD18, AD19, AD20, AD21, AD22, AD23, AD24, AD25, AD26, AD27, AD28, AD29, AD34, AD35, AD36, AD37, AD38, AD39, AD40, AD41, AD42, AD43
14 VAC 5-90-60 A 1, 4 violations, AD04A, AD34, AD35, AD36
14 VAC 5-90-60 A 2, 2 violations, AD01A, AD03A
14 VAC 5-90-60 B 3, 41 violations, AD01A, AD02A, AD03A, AD04A, AD06, AD07, AD08, AD09, AD10, AD12, AD13, AD14, AD15, AD16, AD18, AD19, AD20, AD21, AD22, AD23, AD24, AD25, AD26, AD27, AD28, AD29, AD30, AD31, AD32, AD33, AD34, AD35, AD36, AD37, AD38, AD39, AD40, AD41, AD42, AD43, AD44
14 VAC 5-90-60 B 4, 34 violations, AD01A, AD02A, AD03A, AD04A, AD06, AD07,

AD08, AD09, AD10, AD12, AD13, AD14, AD15, AD16, AD18, AD19, AD20, AD23, AD24, AD25, AD26, AD27, AD28, AD29, AD34, AD35, AD36, AD37, AD38, AD39, AD40, AD41, AD42, AD43
14 VAC 5-90-60 B 6, 25 violations, AD01A, AD06, AD07, AD08, AD12, AD13, AD18, AD21, AD22, AD23, AD24, AD25, AD27, AD28, AD29, AD34, AD35, AD36, AD37, AD38, AD39, AD40, AD41, AD42, AD43
14 VAC 5-90-90 A, 3 violations, AD06, AD07, AD17
14 VAC 5-90-90 C, 2 violations, AD06, AD07
14 VAC 5-90-100 A, 2 violations, AD06, AD07
14 VAC 5-90-170 A, 1 violation, AD27
POLICY FORMS
§ 38.2-316 B, 58 violations, PF10, PF11, PF12, PF13, PF15 (49), PF16, PF17, PF18, PF19, PF27
§ 38.2-316 C 1, 58 violations, PF10, PF11, PF12, PF13, PF15 (49), PF16, PF17, PF18, PF19, PF27
§ 38.2-3407.4 A, 3 violations, PF28, PF29 (2)
AGENTS
§ 38.2-1812 A, 39 violations, AG09, AG10, AG11, AG12, AG13, AG14, AG17, AG18, AG19, AG20, AG21, AG22, AG23, AG24, AG25, AG26, AG27, AG28, AG30, AG31, AG32, AG34, AG35, AG38, AG39, AG41, AG43, AG49, AG51, AG53. AG54, AG55, AG58, AG59, AG60, AG61, AG62, AG63, AG65
§ 38.2-1822 A, 34 violations, AG09, AG10, AG11, AG12, AG13, AG14, AG19, AG20, AG21, AG22, AG24, AG25, AG26, AG27, AG31, AG32, AG34, AG35, AG38, AG39, AG41, AG43, AG49, AG51, AG53, AG54, AG55, AG56, AG58, AG59, AG61, AG62, AG63, AG65
§ 38.2-1833 A 1, 29 violations, AG09, AG17, AG18, AG19, AG20, AG21, AG22, AG23, AG24, AG28, AG30, AG33, AG34, AG35, AG36, AG37, AG38, AG40, AG42, AG44,

AG48, AG52, AG53, AG55, AG56, AG57, AG60, AG64, AG65
§ 38.2-1834 D, 8 violations, AG16
UNDERWRITING/UNFAIR DISCRIMINATION / INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-1715 B, 835 violations, UN01
CLAIM PRACTICES
Subsection 2 (ii) of § 38.2-508, 1 violation, CL32
§ 38.2-3407.1 B, 23 violations, CL01, CL03, CL04, CL14, CL15, CL16, CL18, CL19, CL21, CL22, CL25, CL26, CL31, CL32, CL33, CL34, CL43, CL44, CL46, CL54, CL55, CL56, CL58
14 VAC 5-400-40 A, 54 instances of non-compliance, CL01BW, CL101 (5), CL102 (40), CL103 (8)
14 VAC 5-400-50 A, violated in 53 instances, CL100
14 VAC 5-400-60 A, violated in 46 instances , CL01, CL03, CL04, CL05, CL06, CL08, CL09, CL10, CL11, CL14, CL15, CL16, CL18, CL19, CL20, CL21, CL22, CL24, CL25, CL29, CL31, CL32, CL33, CL34, CL35, CL36, CL37, CL39, CL41, CL42, CL43, CL44, CL45, CL46, CL47, CL48, CL49, CL51, CL52, CL53, CL54, CL55, CL56, CL57, CL58, CL60
14 VAC 5-400-60 B, 10 instances of non-compliance, CL01, CL04, CL08, CL10, CL11, CL20, CL25, CL32, CL41, CL45

14 VAC 5-400-70 A, violated in 31 instances, CL28, CL29, CL100 (29)
14 VAC 5-400-70 B, violated in 31 instances , CL28, CL29, CL100 (29)
14 VAC 5-400-70 D, 54 instances of non-compliance, CL01BW, CL101 (19), CL102 (84), CL103 (8)
INTERNAL APPEAL AND EXTERNAL REVIEW
§38.2-503, 2 violations, EX01, EX04
§ 38.2-3559 D, 1 violation, EX03
§ 38.2-5804 A 2, 1 violation, EX04
14 VAC 5-216-30 B, 2 violations, EX02, EX04

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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December 4, 2015

CERTIFIED MAIL 7014 1200 0001 3578 7965
RETURN RECEIPT REQUESTED

Mr. Joseph Stangl
Director, Regulatory Affairs Northeast & Mid-Atlantic
UnitedHealthcare Insurance Company
4 Research Drive, 5th Floor
Shelton, CT 06484

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Stangl:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of UnitedHealthcare Insurance Company (UHIC) for the period of January 1, 2015 through June 30, 2013. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of UHIC, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. UHIC's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R Fairbanks

Julie Fairbanks, ACS, AIRC, FLMI, MCM
Supervisor, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

UnitedHealthcare®
A UnitedHealth Group Company

April 8, 2016

Ms. Julie R. Fairbanks
Principal Insurance Market Examiner
Market Conduct, Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: UnitedHealthcare Insurance Company Draft Market Conduct Examination Report as of June 30, 2013

Dear Ms. Fairbanks:

UnitedHealthcare Insurance Company (UHIC) would first like to thank the Bureau for allowing us an extension in providing this response.

I write to you today to provide you with UHIC's response and proposed corrective action measures to the recommendations made by the Bureau in the draft report. Upon receipt of your approval, UHIC will move forward with its proposed corrective measures.

UHIC respectfully requests that any enclosed Exhibits and Attachments be maintained as proprietary and confidential.

Thank you for your time and consideration.

Sincerely,

Joseph Stangl
Director, Regulatory Affairs
UnitedHealthcare
4 Research Drive
Shelton, CT 06484
203-447-4474
Joseph_stangl@uhc.com

Commonwealth of Virginia
State Corporation of Insurance, Bureau of Insurance
Market Conduct Exam of
UnitedHealthcare Insurance Company
January 1, 2013 – June 30, 2013

Corrective Action Plan of April 8, 2016

1. Establish and maintain procedures to notify the Commission of any operations materially at variance with the information pursuant to this section, particularly operations that influence the cost or level of health care services between the health carrier or one or more providers with respect to the delivery of health care services through its MCHIPs, in order to comply with §§ 38.2-5802 A and 38.2-5802 D of the Code.

   Company Response: UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. A detailed response on this matter is included in Exhibit 1.

2. Establish and maintain procedures to ensure that a list of the names and locations of all affiliated providers are provided to covered persons at the time of enrollment or at the time the evidence of coverage is issued and made available upon request or at least annually, as required by § 38.2-5803 A 1 of the Code.

   Company Response: UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. A detailed response on this matter is included in Exhibit 1.

3. Establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code.

   Company Response: UHIC currently has in place a filing team responsible for state required filing such as the Virginia required complaint system. The compliant system is currently filed and approved as of April 11, 2014.

4. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code contains the provisions required by 38.2-3407.15B1, 38.2-3407.15B1b, 38.2-3407.15B2, 38.2-3407.15 B 3, 38.2-3407.15B4, 38.2-3407.15B4a(i),38.2-3407.15 B 5, 38.2-3407.15 B 5 a, 38.2-3407.15 B 6, 38.2-3407.15 B 7,38.2-3407.158 8,38.2-3407.158 9, 38.2-3407.158 10 and 38.2-3407.15 B 11 of the Code, and does not contain provisions that are more burdensome upon the provider than the specific provisions.

   Company Response:
   In regard to 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, and 38.2-3407.15 B 5a, UHIC will update its Regulatory Appendix to include language referring to the provider.

In regard to 38.2-3407.15 B 8, UHIC will update its Regulatory Appendix to change "provider agrees" to "provider acknowledges."

In regard to 38.2-3407.15 B 4 a (i) and 38.2-3407.15B 9, in 2010 UHIC updated its Regulatory Appendix in 2010 which included updating the language pertaining to both these sections of the Virginia Code. A mass mailing of the Regulatory Appendix was made to all Virginia contracted providers. The updated Regulatory Appendix should have been provided to the exam team as part of the contract review; we apologize for the oversight and are attaching the 2010 Appendix herein. Please see sections 8j and 8k respectively. As such, UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to 38.2-3407 .15 B 10, the language requirements of 38.2-3407.15 B 10 can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8g of both Regulatory Appendices (attached). As such, UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to 38.2-3407.15 B 7, the language requirements of 38.2-3407.15 B 7 can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8i of both Regulatory Appendices (attached). UHIC would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

Specifically as it pertains to Optum Rx and in regard to 38.2-3407.15 B 1, 38.2-3407 .15 B 2, 38.2-3407 .15 B 3, 38.2-3407.15 B4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407 .15 B 7, 38.2-3407 .15 B 8, 38.2-3407 .15 B 9 38.2-3407 .15 B 10 and 38.2-3407.15 B 11. Optum Rx is in process of updating its Regulatory Appendix to comply with Virginia codes noted.

Please see Exhibit 2.

5. Establish and maintain procedures to ensure that claims processed under a "provider contract" as defined in § 38.2-3407.15 A of the Code are processed in accordance with the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 of the Code.

Company Response: UHIC continues to disagree with Review Sheet EF05A. We maintain our position that the claim was paid timely. Please see Exhibit 3. None the less, UHIC has reviewed and confirmed policies are in effect and compliant pertaining to timely payment, interest, and reimbursing per fee schedules. UHIC will distribute an educational memo to all claims staff in regard to these requirements.

6. Establish and maintain procedures to include in the advertising file a notation of the manner and extent of distribution of each advertisement and the form number of the policy advertised, as required by 14VAC 5-90-170 A.

Company Response: UHIC is in the process of implementing a revised advertising review

process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-170 A.

7. Establish and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A.

   Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-55 A.

8. Establish and maintain procedures to ensure that an advertisement does not use words, phrases, or statements that have the capacity or tendency to mislead prospective purchasers as to the nature and extent of any policy benefit payable, loss covered, or premium payable, as required by 14 VAC 5-90-60 A 1.

   Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 A 1.

9. Establish and maintain procedures to ensure that an advertisement does not contain or use words or phrases in a manner that exaggerates the benefits beyond the terms of the policy, as required by 14 VAC 5-90-60 A 2.

   Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 A 2.

10. Establish and maintain procedures to ensure that when an advertisement refers to a dollar amount; a period of time for which any benefit is payable, a specific policy benefit, or the loss for which a benefit is payable, it also discloses those exceptions, reductions, and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B 3.

    Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 B 3.

11. Establish and maintain procedures to ensure that an advertisement discloses the existence of any waiting or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for a loss, as required by 14 VAC 5-90-60 B 4.

    Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 B 4.

12. Establish and maintain procedures to ensure that an advertisement for a policy providing benefits for specified illnesses clearly and conspicuously states in boldface type and all

capital letters, the limited nature of the policy in language identical to or substantially similar to "THIS IS A LIMITED POLICY", as required by 14 VAC 5-90-60 B 6.

13. **Company Response:** UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 B 6.

14. Establish and maintain procedures to ensure that statistical information used in an advertisement is accurate and reflects all of the current and relevant facts, as required by 14 VAC 5-90-90 A.

    Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-90 A.

15. Establish and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C.

    Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-90 C.

16. Establish and maintain procedures to ensure that when a choice of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of benefits selected, as required by 14 VAC 5-90-100 A.

    Company Response: UHIC is in the process of implementing a revised advertising review process that will ensure that UHIC advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-100 A.

17. Establish and maintain procedures to ensure that all amendments, riders and group application forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code.

    Company Response: UHIC has a dedicated filing team in place with a dedicated individual responsible for Virginia. The three large group cases identified by the exam team are believed to be anomalies. In one case an incorrect group application form was used and in the other two the group application forms could not be provided and copy of the internal proposal request was provided to the exam team instead. UHIC has confirmed that the correct filed and approved group application form is in use and readily available to sales staff. Additionally, UHIC sales staff is aware that completion of the application is required in the commercial market (LG.ER.13.VA 5/13. approved 5/27/2014. SERFF# UHLC-129129222).

18. Establish and maintain procedures to ensure that all EOB forms are filed with the Commission for approval, as required by § 38.2-3407.4 A of the Code.

Company Response: As it pertains to the Student Resources EOB, the Explanation of Benefits with form number EOB (8/05) was filed and approved with the Virginia Bureau of Insurance. It was originally filed under The MEGA Life and Health Insurance Company and was approved on December 19, 2005. "MEGA" was obtained by UnitedHealthcare and a letter with the notice of name change for the previously approved forms was sent to the Commissioner on November 27, 2006. Enclosed is a copy of the original filing letter, the approval documents, a letter to the Commissioner with notice of the name change and UnitedHealthcare's authorization regarding the name change. UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

As it pertains to the dental EOB, UHIC filed its EOB form on April 29, 2015. The Bureau had objections which required major programing in order to make the changes. The programming is scheduled to be completed in June 2016. At that time UHIC will refile the revised EOB for the Bureau's approval.

19. Establish and maintain procedures for compliance with §§ 38.2-1812 A, 38.2-1822 A and 38.2-1833 A 1 of the Code concerning the licensing of, appointment of, and payment of commission to, agents and agencies.

Company Response: UHIC has completed a project that involved reviewing and updating its Policy & Procedures (P&P) for the licensing, appointment and commission payments of internal and external agents. The P&P is compliant with the Virginia regulations cited above. Management has also provided guidance and training to the nationwide sales staff on internal employee licensing and appointment. Tighter controls have also been put into place to ensure payments of commissions are only made to appropriately licensed agents and brokers.

20. Strengthen its procedures for notifying agents and agencies of appointment termination within 5 calendar days, as required by § 38.2-1834 D of the Code.

Company Response: As noted above in response 18, UHIC has completed a project that involved reviewing and updating its Policy & Procedures (P&P) for the licensing, appointment and commission payments of internal and external agents. The updated P&P also discusses requirements on timely termination of appointment. Additionally, terminations are now system generated which will further assist in managing to the 5 calendar requirement.

21. Establish and maintain procedures to ensure that the notice and disclaimer contained in the Guaranty Association summary document approved by the Commission is attached to all policies or contracts delivered in Virginia, as required by Administrative Letter 2014-05 and § 38.2-1715 B of the Code.

Company Response: UHIC has confirmed the Notice is in place across all lines of business.

22. Establish and maintain procedures to ensure that no insured person is unfairly discriminated against in the benefits payable under a health insurance policy, in order to maintain compliance with subsection 2 (ii) of § 38.2-508 of the Code.

Company Response: UHIC continues to disagree with Review Sheet CL32, and we refer you to Exhibit 4 for our position on this matter. UHIC respectfully request this be taken into consideration and the alleged violation be removed. None the less, in June 2016 UHIC updated the language for remark code IA to ensure consistency for members. The remark now reads as follows: "The claim for this service is denied because it was billed by a Physician or health care professional. The service is included in the facility (hospital or ambulatory surgery center) payment. If you used a network provider, you don't owe anything. If you receive a bill from an out-of-network provider for these services for any amount over your co-insurance, copay or deductible, please call the number on your health plan id card."

23. Establish and maintain procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code.

Company Response: UHIC has reviewed and confirmed policies are in effect and compliant pertaining to the payment of interest. UHIC will distribute an educational memo to all claims staff in regard to these requirements. As it pertains to vision review sheets CL46, CL47, and CL48, UHIC disagree that the claims are in violation of 38.2-3407.1 B. Further review has indicated the correct interest was indeed paid and documentation is included in response to item 23, please see Exhibit 5. UHIC respectfully request this be taken into consideration and the alleged violations be removed.

24. Review and consider for re-adjudication all paid student health, group major medical, group dental and group vision claims that took greater than 15 working days to pay for the years of 2011, 2012, 2013 , 2014 and the current year and make interest payments where necessary as required by§ 38.2-3407 .1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized.

Company Response: UHIC has procedures in place and closely monitors timely acknowledgement and payment for all claims and follows strict guidelines to ensure compliance with Virginia's mandated reimbursement timeframes and interest payment requirements. The agreed upon errors noted in the report were human processor errors and not systemic in nature. The paid claim review performed by the Bureau revealed the following:
Medical - 13 out of 383 claims or .03% where interest was not paid or under paid. UHIC agrees with 10 of the findings and attribute each to a manual processing error. UHIC continues to disagree in three instances: CL16, CL31, and CL32. We have included detail of each within Exhibit 4. With an error ratio of .03%, UHIC believes that requesting a review of claims for a five plus year period is excessive, simply based on the findings noted in the draft report. UHIC proposes for a corrective action measure, management coaching to the individuals responsible for the errors.

Student – 3 out of 125 claims or .02% where interest was not paid. Student Resources did agree to each of these errors and have confirmed each to be a human error. With an error ratio of .02%, UHIC believes that requesting a review of claims for a five plus year period is excessive, simply based on the findings noted in the draft report. UHIC proposes for a corrective action measure, management coaching to the individuals responsible for the errors.
Dental – 2 out of 110 claims or .01% where interest was under paid. UHIC agreed with one instance of human error and continues to disagree with the other. With an error ratio of .01%, UHIC believes that requesting a review of claims for a five plus year period is excessive, simply based on the findings noted in the draft report. UHIC proposes for a corrective action measure, management coaching to the individuals responsible for the errors.
Vision – The vision paid claim review yielded 13 errors in which a claim was paid beyond the statutory timeframe and it underpaid the interest amount. At the time UHIC agreed with these findings. Upon further review of these claims it has been determined that in each instance for which interest was owed, the correct 6% interest rate was applied. We are attaching for your review Exhibit 5, a detailed interest calculation for each claim along with a screen print demonstrating the correct interest was paid. Additionally, for claims A4802128 (CL55), A5541121 (CL50) and A5795248 (CL59) interest was not owed and we explain in detail why in the attachment. UHIC is of the position that each of these claims was processed according to Virginia prompt pay statues. At this time, UHIC disagrees that the claims in Review Sheets CL 46-49, 51-58 & 60 are in violation of 38.2-3407.1 B. and respectfully request this be taken into consideration and the alleged violations be removed.

25. Establish and maintain procedures to ensure that it administers its Shared Savings Program (SSP) in accordance with the requirements of 14 VAC 5-400-40 A, 14 VAC 5-400-70 D, §§ 38.2-510 A 1 and 38 .2-510 A 6 of the Code.

Company Response: UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. Detailed response on this matter is included in Exhibit 1.

26. Re-open all claims paid under its Shared Savings Program (SSP) for the years of 2011, 2012 , 2013 , 2014 and the current year that were initially paid under the "Non-Network Benefits" level and adjust the claims to pay under the "Network Benefits" level. Include the statutory interest required by § 38.2-3407.1 B of the Code with all payments. Include verbiage on the EOB sent to the covered person and provider stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was paid under the Non-Network level of benefits in error. Please accept this additional payment amount." After which, furnish the examiners with documentation that the additional amounts with interest have been paid within 180 days of this Report being finalized.

Company Response: UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. A detailed response on this matter is included in Exhibit 1.

As it pertains to the 111 claims noted in the draft report, we have done an in depth review and our results are as follows:

CL101 The providers of concern for the examiner are [redacted]. We have confirmed that none of these providers had an executed contract with UHIC on the dates of service for the claims. Dr. [redacted]'s contract was effective 11/7/2012 (please see [redacted]), Dr. [redacted]'s contract was effective 5/2/2014 (please see [redacted]) and Dr. [redacted]s contract was effective 7/1/2013. Claims in question preceded these dates. Dr. [redacted]'s contract terminated in 2006, and Dr. [redacted] was never contracted with UHIC for medical services. UHIC's position continues to be that these claims were all processed out-of-network appropriately. We are attaching applicable contracts, Exhibit 6.

CL102 - Our review has determined that the following providers did not have contracts in effect with UHIC for the dates of service in question: [redacted], with contract effective date 11/1/2014, [redacted], with contract effective date 7/25/2014, [redacted] with contract effective date 7/1/2013, [redacted] with contract effective date 4/16/2014, [redacted], with contract effective date 6/22/2013, and [redacted], with contract effective date 3/30/2013. UHIC maintains its position that these claims were all processed out-of-network appropriately. We are attaching applicable contracts within Exhibit 6.

For the following providers we have no record of them being contracted with UHIC: Dr. [redacted] and Dr. [redacted] UHIC maintains its position that these claims were processed out-of-network appropriately.

For provider, [redacted] there was a par ID on file, but the selection of the non-par provider ID was based on information on the claim billed by the provider, UHIC cannot alter information submitted by a provider. And as such UHIC maintains its position that these claims were processed out-of-network appropriately: . Additionally, although previously agreed to on Review Sheet CL102, UHIC respectfully disagrees with the citations for [redacted] for the same reason; it was processed out-of-network appropriately.

During the exam, UHIC agreed that the following providers were processed out-of-network incorrectly. Our review has confirmed that for the dates of service there was a participating contract in effect. A non-par ID was incorrectly selected at the time of processing. These providers are: [redacted] and [redacted]

For the following providers our review has determined that for the dates of service there was a participating contract in effect: [redacted] and [redacted] A non-par ID was incorrectly selected at the time of processing or there was a retroactive change made to the contract after the initial processing.

CL103 - The provider referenced in CL103 is [redacted] Our review has determined that for the dates of service there was a participating contract in effect. A non-par ID was incorrectly selected at the time of processing.

The draft report noted 111 claims of concern in regards to the SSP; based on our review of CL101, CL102, and CL103 we believe that number is actually 114.

The draft reports also notes the 111 (114) are the errors identified out of a population of 4941 claims. Based on our review of the data provided during the exam, we believe the correct population is 4853 not 4941.

Our review of the 114 claims found 43 to be in error and should have paid to a par ID. Of the 43 claims, 16 providers were affected. The below depicts the error rate.

Total Providers	Providers in error	Error Rate
500	16	3%
Total Claims	**Claims in Error**	**Error rate**
4853	43	(under) 1%

As corrective action measures UHIC proposes a review of the 16 providers whose claims were noted to be paid incorrectly and UHIC will correct claims as applicable and pay interest accordingly.

27. Review its established procedures to ensure that, when an insured meets the out-of-pocket maximum, UHIC complies with the terms of the certificate of coverage and the requirements of 14 VAC 5-400-40 A, 14 VAC 5-400-70 D, §§ 38.2-510 A 1 and 38.2-510 A 6 of the Code. UHIC shall provide the examiners with documentation substantiating that a refund was made to the insured discussed in Review Sheet CL01B.

Company Response: As it pertains to claims involving the SSP, UHIC disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. Detailed response on this matter is included in Exhibit 1. Outside of the SSP claims, the examiners identified only one instance where the member had exceeded their max out of pocket. In 2010, UHIC initiated processes to ensure that member's do not exceed their out-of-pocket maximum. Please see Exhibit 7 for requested documentation for CL01B.

28. Review its established procedures to ensure that it acknowledges the receipt of notification of all vision claims within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code.

Company Response: UHIC's Vision Department migrated to a new claims processing system March 31, 2014. With the new system, VAS, these issues have been rectified. Additionally, an educational memo will be distributed to all claims staff in regards these requirements.

29. Establish and maintain procedures to advise a claimant of acceptance or denial of a

claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code.

Company Response: UHIC has reviewed and confirmed policies are in effect and compliant pertaining to timely denial of a claim. UHIC will distribute an educational memo to all claims staff in regards these requirements. Specifically applicable to vision, UHIC's Vision Department migrated to a new claims processing system March 31, 2014. With the new system, VAS, these issues have been rectified.

30. Review its established procedures to ensure that written notification of a claim under investigation is sent to the claimant every 45 days from the date of notification of the claim, and every 45 days thereafter, as required by 14 VAC 5-400-60 B.

Company Response: UHIC has reviewed and confirmed policies are in effect and compliant pertaining to providing claimant with notification that a claim is under investigation. UHIC will distribute an educational memo to all claims staff in regard to these requirements.

31. Establish and maintain procedures to ensure that a denial of a claim is given to a claimant in writing, as required by 14 VAC 5-400-70 A.

Company Response: UHIC has reviewed and confirmed policies are in effect and compliant pertaining to the requirement that denials must be in writing. UHIC will distribute an educational memo to all claims staff in regards these requirements. Specifically applicable to vision, UHIC's Vision Department migrated to a new claims processing system March 31, 2014. With the new system, VAS, these issues have been rectified.

32. Establish and maintain procedures to ensure that the claimant is provided a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code.

Company Response: UHIC has reviewed and confirmed policies are in effect and compliant with the requirement that the basis of a denial must contain a reasonable explanation. UHIC will distribute an educational memo to all claims staff in regards these requirements. Specifically applicable to vision, UHIC's Vision Department migrated to a new claims processing system March 31, 2014. With the new system, VAS, these issues have been rectified.

33. Establish and maintain procedures to ensure that complaint and appeal response letters provide complete, clear, and accurate information as required by subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in UHIC's Corrective Action Plan of September 14, 2015.

34. Establish and maintain procedures to ensure that forms are included with the notice of the right to external review in applicable final adverse determination letters, as required by § 38.2-3559 D of the Code.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in UHIC's Corrective Action Plan of September 14, 2015.

35. Establish and maintain procedures to ensure that contact information for the Bureau of Insurance and the Office of the Managed Care Ombudsman is included in all adverse determination letters, as required by 14 VAC 5-216-30 B.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in UHIC's Corrective Action Plan of September 14, 2015.

36. Establish and maintain procedures to ensure that appeal and complaint response correspondence includes correct information regarding consumer assistance and external review based upon the funding and situs of the policy, as required by § 38.2-5804 A 2 and Administrative Letter 2011-05.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in UHIC's Corrective Action Plan of September 14, 2015.

37. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

Company Response: UHIC will provide the documentation requested.

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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January 3, 2017

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RETURN RECEIPT REQUESTED

Joseph Stangl
Director, Regulatory Affairs-Market Conduct
UnitedHealthcare Insurance Company, Inc.
4 Research Drive
5th Floor
Shelton, Connecticut 06484

RE: UnitedHealthcare Insurance Company, Inc.'s (UHIC) Response to the Draft Examination Report

Dear Mr. Stangl:

The examiners have received and reviewed UHIC's response to the Draft Report dated April 8, 2016. This letter will primarily address those areas of the response where UHIC disagreed with the findings and corrective actions of the Report or where upon further review, the examiners determined that modifications to the findings were necessary.

Corrective Action #1

Based on the additional information provided, this Corrective Action has been removed. Please note that any material transaction described in Administrative Letter 1998-11 is required to be provided in writing to the Company Licensing and Regulatory Compliance Section of the Financial Regulation Section of the Bureau of Insurance, not the Forms Section of the Life and Health Market Regulation Division.

Corrective Action #2

Based on the additional information provided, this Corrective Action has been removed. However, as a practical matter, a covered person who receives a description of the Shared Savings Program (SSP) in his or her Certificate of Coverage would have access to a list of the providers that participate in this program. Additionally, when the description of the SSP is included in the Certificate of Coverage, UHIC cannot elect whether or not to pay the provider at the contracted rate. To do so, would create the

potential for possible violations of the Unfair Claim Settlement Practices Act and issues with unfair discrimination.

Corrective Action #4

In regards to § 38.2-3407.15 B 8 of the Code, updating the Regulatory Appendix to remove "provider acknowledges" would not necessarily bring UHIC's provider contracts into compliance with this section. Section 38.2-3407.15 B of the Code requires that every provider contract entered into by a carrier contain specific provisions and § 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution the fee schedule or reimbursement methodology. There is no requirement in the statute for the provider to acknowledge that the fee schedule was in fact attached at the time of execution.

The violations of §§ 38.2-3407.15 B 4 a (i) and 38.2-3407.15 B 9 have been removed for the providers that received the updated Virginia Regulatory Requirements Appendix, *UHCREGAPX.1110.VA,* in November of 2010.

UHIC's response failed to address the deficiencies in the Virginia Regulatory Requirements Addendum, 2011DBPRegAttachmentVA, sent to dental providers in 2011.

UHIC's response failed to address the deficiencies in the Virginia Regulatory Requirements Attachment sent to vision providers in 2011.

The requirements of § 38.2 3407.15 B 10 of the Code specifically refer to a carrier's provision of a policy required to be provided under subsections 8 or 9 of this section. Section 4.(g) of the Virginia Regulatory Requirements Appendix, UHCREGAPX.1110.VA, only refers to the provision of policies discussed in subsection 4.(f) of the Appendix. No changes to the Report are necessary.

The number of violations of § 38.2-3407.15 B 7 of the Code will be reduced from 10 to 6.

Corrective Action #5

In regards to EF05A, UHIC informed the examiners in writing in an April 17, 2014, email that for its Student Health Line-of-Business "The average number of days for check/EOB generation and mailing is 4 business days. This is the same for paper and electronic." Therefore, it took greater than 15 working days to pay this claim and statutory interest in the amount of $0.09 was due. The Report appears correct as written.

Corrective Action #18

In regards to the Student Resources EOB, UHIC has made substantive revisions to this Explanation of Benefits form EOB (8/05) since it was initially approved on December 19, 2005, by the Bureau of Insurance. The original filing did not indicate any variability in the names of the columns or permit additional columns to be added. The Report has been changed to reference the forms EOB (9/12) and EOB (8/05). The reference to form STD-EOB has been removed.

Corrective Action #22

The examiners are not questioning UHIC's assertions concerning the legitimacy of these charges. However, the exception allowed for this covered person was not allowed for other covered persons in similar situations and notes in the claim file indicate no action was taken by UHIC to address the issue on behalf of the covered person until a broker intervened. The examiners acknowledge that that the revised EOB language would appear to appropriately address the issue and prevent possible instances of unfair discrimination from occurring in the future. However, UHIC must implement procedures and train staff to consistently handle situations where out-of-network providers continually balance bill covered persons for these services. . The Report appears correct as written and no changes are necessary.

Corrective Actions #23 and #24 (Violations of § 38.2-3407.1 B Associated with Visions Claims)

In regards to Review Sheets CL46 and CL55, § 38.2-3407.1 B of the Code sets forth the requirements for the payment of interest on accident and sickness claim proceeds for policies issued in Virginia and is not a "prompt pay" statute. The Virginia requirements would apply absent documentation of a provision in a non-Virginia provider contract indicating that another jurisdiction's *statutory interest* requirement was controlling.

The additional documentation provided has been reviewed and the violations of § 38.2-3407.1 B of the Code associated with Review Sheets CL47, CL48, CL49, CL51, CL52, CL53, CL57 and CL60 have been removed.. The statements in the Excel spreadsheet (Exhibit #5) stating that "VA applies only for Providers" is incorrect and would indicate an error in UHIC's established procedures for the processing of vision claims under policies issued in Virginia. Section 38.2-3407.1 B of the Code is applicable to claim proceeds paid to a policyholder, insured, claimant, or assignee.

The violation of § 38.2-3407.1 B of the Code associated with Review Sheet CL50 was removed by the examiners on January 22, 2015.

In regards to Review Sheet CL54, UHIC underpaid the amount of interest due by $0.03 and the violation will remain in the Report.

In regards to CL56, UHIC underpaid the amount of interest due by $0.01 and the violation will remain in the Report.

In regards to CL58, UHIC underpaid the amount of interest due by $0.02 and the violation will remain in the Report.

The violation of § 38.2-3407.1 B of the Code associated with Review Sheet CL59 was removed by the examiners on January 22, 2015.

Corrective Action #24

Medical – In regards to Review Sheets CL16 and CL31, On April 17, 2014, the examiners sent an email to UHIC requesting:

> ...the average number of days it takes to place a check...in the mail once a claim is finalized on your claims processing systems. If claim payments are sent electronically, the examiners will need the average number of days it takes for the electronic transaction to occur. Please indicate if the average number of days varies by claim type or system platform.

UHIC responded by email on April 30, 2014, and stated that "For electronic payments the average is 2-3 business days and for paper check payments...it is 3-5 business days, once a claim is finalized and released from the payment consolidation system based on the provider payment release schedule."

The interest calculations described in Exhibit #4 relating to the claims associated with Review Sheets CL16 and CL31 fail to take into account the additional days to place a check in the mail or initiate an electronic transfer. The date a check is placed in the mail or the date an electronic transfer of funds is initiated is considered to be the date of claim payment.

In regards to Review Sheet CL32, the fact that UHIC made a business decision to allow an exception and pay the claim would not exempt it from the statutory interest requirements of § 38.2-3407.1 B of the Code.

The review of claims indicated that UHIC's claim processing practices in certain instances, fail to account for the actual date of claim payment and specifically stated interest is not due "...when paying member." Therefore, "...management coaching to the individuals responsible for the errors" while advisable, would not adequately address all of the procedural and systemic errors that occurred. The examiners have revised the Report to limit the review to 2013, 2014, 2015 and the current year.

Student Health – As stated in the Report, in all 3 instances, statutory interest was due and UHIC failed to pay any interest on these claims. Management coaching to the individuals responsible for the errors, while advisable, is not an acceptable corrective

action measure. The examiners have revised the Report to limit the review to 2013, 2014, 2015 and the current year.

Dental - The review of dental claims indicated that UHIC's procedures fail to account for the actual date of claim payment. Therefore, coaching to the individuals responsible for the errors, while advisable, is not an acceptable corrective action measure. The examiners have revised the Report to limit the review to 2013, 2014, 2015 and the current year.

Vision – Please see the examiners' prior comments concerning the vision claims. The examiners have revised the Report to limit the review to 2013, 2014, 2015 and the current year.

Corrective Action #25

The Corrective Action will remain in the Report. The review revealed 53 instances where claims were paid at the out-of-network level of benefits under the Shared Savings Program (SSP) when the claims should have been paid in-network under direct UHIC provider contracts accepting reimbursement for UHIC's Choice Plus, Options and Non-Differential products. The reference to §§ 38.2-510 A 1 and 38.2-510 A 6 of the Code will be removed.

Corrective Action #26

The Corrective Action has been revised.

Review Sheet CL101

The provider contract documentation provided does not confirm an effective date of November 7, 2012, for Provider A. The instances of non-compliance will remain in the Report.

The examiners' findings associated with Provider B were not included in the draft Report.

Provider E was listed as a participating behavioral health provider on UHIC's website on January 15, 2015. UHIC has not provided the examiners with a copy of the executed provider contract. The instances of non-compliance will remain in the Report.

Provider D is an Oral and Maxillofacial Surgeon who was listed as participating on UHIC's website on January 15, 2015. UHIC has not provided the examiners with a copy of the executed provider contract. The instances of non-compliance will remain in the Report.

Upon review of the additional documentation provided, the instances of non-compliance associated with Review Sheet CL101 has been reduced from 19 to 5.

Review Sheet CL102

The examiners' prior findings associated with Provider O, Provider H, Provider J and Provider K were not included in the draft Report.

Provider L was listed as a participating provider on UHIC's website on January 28, 2015. UHIC has not provided the examiners with a copy of the executed provider contract. The instances of non-compliance will remain in the Report.

Upon review of the additional documentation provided, the instances of non-compliance associated with Review Sheet CL102 has been reduced from 84 to 40.

The examiners maintain that the number of claims of concern in regards to the SSP was 111 and that our population numbers are correct.

Corrective Action #27

This corrective action does not involve the Shared Savings Program and will remain in the Report. Since Exhibit #7 documents that UHIC sent a refund to the insured as requested, the last sentence of this corrective action item has been removed.

Corrective Action #29

UHIC needs to confirm that procedures are in affect to advise a claimant of acceptance of a claim within 15 working days of receipt of proof of loss.

Corrective Action #33, 34, 35, 36

The Bureau continues to communicate with UHIC regarding the corrective action measures that UHIC has taken to date to ensure that all concerns have been adequately addressed.

Additional Report Revisions

Upon further review and receipt of recent legal guidance, references to violations of §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 have been removed from the Unfair Claim Settlement Practices Review section of the Report, as well as the corresponding Corrective Action Items and Area Violations Summary by Review Sheet.

A copy of the entire Report with the revised pages noted is attached and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that UHIC violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 of the Code,

§ 38.2-503 of the Code, subsection 2 (ii) of § 38.2-508 of the Code and § 38.2-510 A 15 of the Code, in addition to 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-60 B 6, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-100 A and 14 VAC 5-90-170 A of Rules Governing the Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 4 VAC 5-400-70 A and 14 VAC 5-400-70 B of Rules Governing Unfair Claim Settlement Practices.

It also appears that UHIC violated §§ 38.2-316 B, 38.2-316 C 1, 38.2-1715 B, 38.2-1812 A, 38.2-1822 A, 38.2-1833. A 1, 38.2-1834 D, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3559 D, 38.2-5804 A, 38.2-5804 A 2 of the Code, in addition to 14 VAC 5-216-30 B of Rules Governing Internal Appeal and External Review.

Violations of the above sections of the Code can subject UHIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Jeffrey D Alter
CEO
UnitedHealthcare Insurance Company, Inc.
One Penn Plaza
New York, New York 10119

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

RE: Alleged violations of Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 of the Code, § 38.2-503 of the Code, subsection 2 (ii) of § 38.2-508 of the Code and § 38.2-510 A 15 of the Code, in addition to 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-60 B 6, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-100 A and 14 VAC 5-90-170 A of Rules Governing the Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 4 VAC 5-400-70 A and 14 VAC 5-400-70 B of Rules Governing Unfair Claim Settlement Practices, as well as §§ 38.2-316 B, 38.2-316 C 1, 38.2-1715 8, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3559 D, 38.2-5804 A, 38.2-5804 A 2 of the Code, in addition to 14 VAC 5-216-30 B of Rules Governing Internal Appeal and External Review.

Dear Ms. Battle:

This will acknowledge receipt of your letter dated January 5, 2017, concerning the above-captioned matter.

UHIC wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $79,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing; and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

CEO

1/31/17
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA 170310044

STATE CORPORATION COMMISSION

AT RICHMOND, MARCH 1, 2017

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2017-00002

UNITEDHEALTHCARE INSURANCE COMPANY, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that UnitedHealthcare Insurance Company, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), violated: §§ 38.2-316 B and 38.2-316 C (1) of the Code of Virginia ("Code") by failing to comply with policy and form filing requirements; § 38.2-502 (1) of the Code by misrepresenting the terms of the policy; §§ 38.2-503 of the Code, as well as 14 VAC 5-90-55 A, 14 VAC 5-90-60 A (1), 14 VAC 5-90-60 A (2), 14 VAC 5-90-60 B (3), 14 VAC 5-90-60 B (4), 14 VAC 5-90-60 B (6), 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-100 A, and 14 VAC 5-90-170 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; § 38.2-508 (2) of the Code by unfairly discriminating or permitting any unfair discrimination between individuals of the same class; § 38.2-510 A (15) of the Code, as well as 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-70 A, and 14 VAC 5-400-70 B of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to properly handle claims with such frequency as to indicate a general business practice; § 38.2-1715 B of the Code by failing to

properly notify policy owners; § 38.2-1812 A of the Code by paying commissions for services as an agent to persons who were not properly licensed and appointed; § 38.2-1822 A of the Code by permitting a person to act as an agent without first obtaining a license in a manner and form prescribed by the Commission; §§ 38.2-1833 A (1) and 38.2-1834 D of the Code by failing to comply with agent appointment requirements; § 38.2-3407.1 B of the Code by failing to pay interest at the legal rate of interest from the date of 15 working days from the Defendant's receipt of proof of loss to the date that the claim was paid; § 38.2-3407.4 A of the Code by failing to comply with explanation of benefits requirements; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (5), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (8), 38.2-3407.15 B (9), 38.2-3407.15 B (10), and 38.2-3407.15 B (11) of the Code by failing to comply with ethics and fairness requirements for business practices; § 38.2-3559 D of the Code by failing to comply with notice requirements for external review; §§ 38.2-5804 A and 38.2-5804 A (2) of the Code by failing to comply with procedures to establish and maintain an approved complaint system for each of its Managed Care Health Insurance Plans; and 14 VAC 5-216-30 B of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to comply with internal appeal and external review procedures.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to

the Commission wherein the Defendant has tendered to Virginia the sum of Seventy-nine Thousand Dollars ($79,000), waived its right to a hearing, and agreed to comply with the corrective action plan contained in the target market conduct examination report as of June 30, 2013.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Jeffrey D. Alter, CEO, UnitedHealthcare Insurance Company, Inc., One Penn Plaza, New York, New York 10119; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission