

MARKET CONDUCT REPORT ON EXAMINATION

OF

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

AND

UNITEDHEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2013

DATE OF REPORT

OCTOBER 24, 2016

EXAMINER

FROILAN ESTEBAL

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

October 24, 2016

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31120 and 31121, both dated March 21, 2014, attached hereto, I have made an examination into the affairs of UnitedHealthcare Insurance Company of New York, a for-profit stock accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2013 and UnitedHealthcare of New York, Inc., a for-profit health maintenance organization (“HMO”) licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2013. The following report is respectfully submitted thereon.

The examination was conducted at the offices of UnitedHealthcare Insurance Company of New York and UnitedHealthcare of New York, Inc., located at 4 Research Drive, Shelton, Connecticut and 185 Asylum Street, Hartford, Connecticut.

Wherever the designation “UHIC NY” appears herein, without qualification, it should be understood to refer to UnitedHealthcare Insurance Company of New York.

Wherever the designations “UHC NY” or the “Plan” appear herein, without qualification, they should be understood to refer to UnitedHealthcare of New York, Inc.

Wherever the designations “United” or the “Companies” appear herein, without qualification, they should be understood to refer to both UnitedHealthcare Insurance Company of New York and UnitedHealthcare of New York, Inc., collectively.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to refer to the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

Market Conduct was last reviewed for the subject Companies as of December 31, 2003 and the reports were filed January 11, 2008. No reviews were conducted between that date and this current examination due to an arrangement made between the UnitedHealthcare Companies and the National Association of Insurance Commissioners (“NAIC”). As a result of the time elapsed, the specific recommendations from the prior examinations are not listed herein.

Financial condition examinations were conducted for the two Companies as of December 31, 2013 and filed March 5, 2015 and May 18, 2015, respectively. This market conduct examination covers the period from January 1, 2004 through December 31, 2013. Where deemed appropriate by the examiner, events subsequent to December 31, 2013 were also reviewed.

This report deals with the manner in which United conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE COMPANIES

UHIC NY is a domestic insurer licensed to write accident and health insurance, as defined in Paragraphs 3(i) and 3(ii) of Subsection (a) of Section 1113 of the New York Insurance Law. UHIC NY was originally incorporated on February 8, 1995, as The MetraHealth Insurance Company of New York and commenced business on December 28, 1995. The Company is a

wholly-owned subsidiary of UnitedHealthcare Insurance Co. (formerly known as The MetraHealth Insurance Company and Travelers Insurance Company of Illinois), a Connecticut stock corporation. The ultimate parent is UnitedHealth Group, Inc., a publicly held company trading on the New York Stock Exchange.

UHC NY is a for-profit HMO licensed pursuant to Article 44 of the New York Public Health Law. UHC NY was originally incorporated on July 10, 1986, as MetLife HealthCare Network of New York, Inc., an HMO licensed in the State of New York. The Plan was an indirect wholly-owned subsidiary of Metropolitan Life Insurance Company and commenced business on January 1, 1987. The Plan was granted a Certificate of Authority under the provisions of Article 44 of the New York Public Health Law, effective July 31, 1987, to operate as a for-profit independent practice association (“IPA”) model HMO. On January 2, 1997, the Plan changed its name to UnitedHealthcare of New York, Inc.

UHC NY is a direct wholly owned subsidiary of UnitedHealthcare, Inc., which is a wholly-owned subsidiary of UnitedHealth Group, Inc. (UHG), the ultimate Parent. UnitedHealthcare of New York, Inc. and UnitedHealthcare of Upstate New York, Inc. (formerly known as Travelers Health Network, Inc.) merged effective 12/31/02. The surviving entity (UHC NY) retained the name UnitedHealthcare of New York, Inc.

3. **AGENTS AND BROKERS**

Section 2112(d) of the New York Insurance Law states:

“Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent, or title insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause.”

The review of UHC NY’s terminated producer files revealed that in four out of the fifteen files randomly selected, the Plan did not file termination notices with the Department. Termination notices are to be filed within thirty days of the termination as required by Section 2112(d) of the New York Insurance Law.

The Department recommends that UHC NY comply with the provisions of Section 2112(d) of the New York Insurance Law by reporting the termination of agents to the Superintendent within the prescribed time frame.

4. PROVIDER NETWORK ADEQUACY

The following findings relate to laws that were enacted subsequent to the date of the examination.

Section 3217-a(a)(17) of the New York Insurance Law states in part:

“(a) Each insurer subject to this article shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below.

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. *The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation; ...*” (italics added)

A similar law may be found in Section 4408(1)(r) of the Public Health Law.

In order to comply with the various requirements listed above, the Companies’ maintain an on-line directory of participating providers. In order to test UHIC NY’s network for availability and participation, the examiner telephoned a randomly selected sample of thirty providers from the UnitedHealthcare Insurance Commercial Plan on-line directory.

During the calls for UHIC NY, it was revealed that twelve, or forty percent (40%) of the providers sampled were incorrectly listed. Three providers did not accept new patients, two provider’s telephone numbers were out of service or incorrect, six providers were no longer at the address in the directory, and one did not reply to a recorded message.

During the calls for UHC NY, it was revealed that nine, or thirty percent (30%) of the providers were incorrectly listed. One provider did not accept the UHC community plan, four

telephone numbers were out of service or incorrect, and four providers were no longer at the address noted within the directory.

Although these exceptions are not violations of law and the Department understands that the Companies need to rely on providers to update their information, the directories contain vital information for members and so the Companies should strive for accuracy. As such, the Department recommends that the Companies implement additional quality control measures to reduce the number of exceptions between annual updates.

5. EXHIBIT OF GRIEVANCES AND UTILIZATION REVIEW APPEALS

The instructions in the Annual Statement Supplement regarding the recording of utilization review cases within the statement, read as follows:

“Article 49 of the Insurance Law provides for expedited and non-expedited utilization review appeals. A non-expedited utilization review appeal should be considered closed when the utilization review agent notifies a subscriber of the appeal determination. An expedited utilization review appeal should be considered closed, for purposes of Part Two, when the utilization review agent notifies the subscriber of the expedited appeal determination and the subscriber does not further appeal the determination within the calendar year in which the expedited appeal determination was rendered. If the subscriber appealed the expedited appeal in the subsequent calendar year, in a timely manner, the disposition of the appeal should be reported in Part Three.”

UHIC NY reported an incorrect number of utilization review cases in its 2013 New York Annual Statement Supplement, Exhibit of Grievances and Utilization Review Appeals-Part Two. UHIC NY provided the examiner with a listing of 183 utilization review appeal cases for 2013. However, the Company incorrectly reported a total of 54,712 cases in its 2013 New York Annual

Statement Supplement, Exhibit of Grievances and Utilization Review Appeals-Part Two, which differs greatly from the list provided.

The Department recommends that UHIC NY complete the Annual Statement Supplement Exhibit of Grievances and Utilization Review Appeals in accordance with the instructions and re-file the corrected exhibit with the Department.

Further, instructions for the New York Supplement to the Annual Statement read as follows:

“Insurers offering a contract that meets the definition of a managed care health insurance contract in Section 4801(c) of the New York Insurance Law Or that offers a non-managed care contract that provides comprehensive coverage through a provider network as described in Section 3217-d should report in Part Two, line 2, the number of initial grievance filed in the current reporting year....”

In addition, Section 3217-d (a) of the New York Insurance Law states:

“An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter.”

UHIC NY reported an incorrect number of grievances in its 2013 Annual Statement Supplement, Exhibit of Grievances and Utilization Review Appeals, Part Two. Exhibits of Grievances Part Two and Part Three show zero cases. However, the grievance log provided by the Company indicated there were 319 cases. These cases should be reflected accurately in the Annual Statement Supplement.

The Department recommends that UHIC NY accurately report the number of member grievances in the New York Annual Statement Supplement, Exhibit of Grievances.

6. CLAIMS DATA AND RECONCILIATION

As part of the review of claims processing, a request for the detail on all claims paid between January 1, 2013 and December 31, 2013 was forwarded to UHIC NY and UHC NY on July 9, 2014. Responses to the requests were not received until March 3, 2015 and March 12, 2015 from the two Companies, respectively. When asked for the cause of the delays, the examiners were advised that difficulties were encountered in reconciling the data with the filed Annual Statements. The two Companies also attributed delays to the large amount of data and the numerous claim systems and platforms that are maintained by the Companies. While the examiner acknowledges the challenges that can be encountered in accumulating claims data, such requests are a routine part of any Market Conduct examination and the Companies should have a procedure in place to expedite the process.

The Department recommends that the Companies establish procedures to expedite the provision of claims data, in order to facilitate the examination process.

7. PATIENT PROTECTION AND AFFORDABLE CARE ACT

Section 3221(l)(8)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the individual or group market to provide certain benefits but to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Similar references are included within New York Insurance Law Sections 3216(i)(17)(E) and 4303(j)(3) as well as Section 2713 of the Public Health Service Act.

During the review of preventive care services, it was noted that UHC NY erroneously deducted multiple copays on certain claims that included charges for an office visit and a preventive care service. After disclosing the error to the Plan, the Plan acknowledged a systemic error was occurring based on an improper system configuration. Upon conducting research on the issue, the Company found there were 3,979 claims on a new claim adjudication system that improperly charged dual copays during the Third Quarter of 2013. An additional 2,257 claims that also improperly charged dual copays were found on a separate claim processing system.

As a result, the Company was in violation of New York Insurance Law Section 3221(l)(8)(E) and the US Department of Labor Regulation 45 C.F.R. 147.130(a)(2) for assessing dual copayments, when claims were submitted with codes defined as preventive care by the USPSTF.

The Department recommends that the Plan comply with New York Insurance Law Section 3221(l)(8)(E) and US Department of Labor Regulation 45 C.F.R. 147.130(a)(2) and not charge dual co-payments when claims are submitted with codes defined as preventive care by the USPSTF.

8. UTILIZATION REVIEW

A. Initial Adverse determinations

Section 4903(b) of the New York Insurance Law states in part:

“A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured’s designee and the insured’s health care provider by telephone and in writing within three business days of receipt of the necessary information.”

The examiner reviewed eighteen utilization review files for UHIC NY to ensure authorization decisions were being made timely, in accordance with the cited Law. Of the eighteen files reviewed, there were two cases where UHIC NY failed to make determinations for services requiring pre-authorization within three business days, as required by Section 4903(b) of the New York Insurance Law.

The Department recommends that UHIC NY comply with the provisions of 4903(b) of the New York Insurance Law, by making adverse determinations for services requiring pre-authorization within three business days of receipt of the necessary information.

Section 4903(e) of the New York Insurance Law states in part:

“Notice of an adverse determination made by a Utilization Review agent shall be in writing ...”

During the examiner’s review of the eighteen cases, there was one instance where the Utilization Review agent rendered an adverse determination and the notice of Adverse Determination was not sent, in violation of Section 4903(e) of New York Insurance Law.

The Department recommends that UHC NY comply with Section 4903(e) of the New York Insurance Law and send timely adverse determination notices when such are required.

Section 4903(2) of the New York State Public Health Law states:

“A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee’s designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information.”

In addition, Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243) states:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain:
(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.”

The examiner reviewed twenty-five utilization review files for UHC NY to ensure authorization decisions were being made timely, in accordance with the cited Law. Of the twenty-five files reviewed, there was one case where UHC NY failed to make adverse determinations for services requiring pre-authorization within three business days.

In addition, in two of the twenty-five files reviewed, UHC NY failed to maintain documentation that had it notified the insured or insured's designee and the insured's health care provider in writing of the results of the utilization review.

The Department recommends that UHC NY comply with the requirements of Sections 4903(b) of the New York Insurance Law and 4903(2) of the New York Public Health Law and make timely adverse determinations.

The Department further recommends that UHC NY comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 and maintain documentation of all required utilization review notices.

B. Appeals

Section 4904(c) of New York Insurance Law states in part:

“...The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.”

The examiner selected a sample of appeals obtained from UHIC NY's listing of medical and behavioral health utilization review appeals to determine whether UHIC NY sent appeal determination letters to notify the insured/insured's designee of the Company's decisions within two business days of making such determination, as required by Section 4904(c) of the New York Insurance Law. The review reveals that in nine instances of the thirty six cases reviewed, UHIC NY did not send the required letters timely, in violation of the cited statute.

The Department recommends that UHC NY comply with Section 4904(c) of the New York Insurance Law and send appeal determination letters to notify the insured/insured's designee of the Company's decisions within 2 business days of making such determination.

Section 4904(2) (b) of the New York Public Health Law states in part:

“A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section four thousand nine hundred three of this article or (b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination... Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal...”

In five of the thirty-seven cases reviewed, UHC NY failed to notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the expedited appeal determination within two business days of the rendering of such determination.

The Department recommends that UHC NY comply with the requirements of Section 4904 (2)(b) of the New York Public Health Law and provide notification to the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the expedited appeal determination within two business days of the rendering of such determination.

It is noted that once the delay was identified by UHC NY, the Company overturned the denial, as required by New York Insurance Law Section 4904 (e), which states:

“Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.”

Section 4904(c) of New York Insurance Law states in part:

“ ... The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing...”

During the review of Utilization Review appeals, the examiner noted two instances of the thirty-six cases reviewed where UHIC NY failed to provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing. This is in violation of Section 4904(c) of New York Insurance Law.

The Department recommends that UHIC NY comply with the provisions of Section 4904(c) of the New York Insurance Law by providing written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing.

The number and variety of statutory violations noted during the examination of Utilization Review cases is indicative of a need to strengthen over the process. As a result, the Department recommends that the Companies strengthen quality control measures to reduce the number of exceptions within its work.

9. **SUMMARY OF COMMENTS AND RECOMMENDATIONS**

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The Department recommends that UHC NY comply with the provisions of Section 2112(d) of the New York Insurance Law by reporting the termination of agents to the Superintendent within the prescribed time frame.	5
B. <u>Provider Network Adequacy</u>	
The Department recommends that the Companies implement additional quality control measures to reduce the number of exceptions between annual updates.	7
C. <u>Exhibit of Grievances and Utilization Review Appeals</u>	
i. The Department recommends that UHIC NY complete the Annual Statement Supplement Exhibit of Grievances and Utilization Review Appeals in accordance with the instructions and re-file the corrected exhibit with the Department.	8
ii. The Department recommends that UHIC NY accurately report the number of member grievances in the New York Annual Statement Supplement Exhibit of Grievances.	8
D. <u>Claims Data and Reconciliation</u>	
The Department recommends that the Companies establish procedures to expedite the provision of claims data, in order to facilitate the examination process.	9

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E. <u>Patient Protection and Affordable Care Act</u>	
The Department recommends that the Plan comply with New York Insurance Law Section 3221(1)(8)(E) and US Department of Labor Regulation 45 C.F.R. 147.130(a)(2) and not charge dual co-payments when claims are submitted with codes defined as preventive care by the USPSTF.	11
F. <u>Utilization Review</u>	
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ii. The Department recommends that UHIC NY comply with Section 4903(e) of the New York Insurance Law and send timely adverse determination notices when such are required.	12
iii. The Department recommends that UHC NY comply with the requirements of Sections 4903(b) of the New York Insurance Law and 4903(2) of the New York Public Health Law and make timely adverse determinations.	13
iv. The Department further recommends that UHC NY comply with the requirements of Part 243.2(b)(8) of Department Regulation No. 152 and maintain documentation of all required utilization review notices.	13
v. The Department recommends that UHIC NY comply with Section 4904(c) of the New York Insurance Law and send appeal determination letters to notify the insured/insured's designee of the Company's decisions within 2 business days of making such determination.	14

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vi. The Department recommends that UHC NY comply with the requirements of Section 4904 (2)(b) of the New York Public Health Law and provide notification to the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the expedited appeal determination within two business days of the rendering of such determination.	14
vii. The Department recommends that UHIC NY comply with the provisions of Section 4904(c) of the New York Insurance Law by providing written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing	15
viii. The Department recommends that the Companies strengthen quality control measures to reduce the number of exceptions within its work.	15

Respectfully submitted,

Froilan Estebal
Senior Insurance Examiner

STATE OF NEW YORK)
) SS
)
COUNTY OF NEW YORK)

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

Froilan Estebal

Subscribed and sworn to before me
this _____ day of _____

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, **BENJAMIN M. LAWSKY**, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Froilan Estebal

as a proper person to examine the affairs of

UnitedHealthcare Insurance Company of New York

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

Company

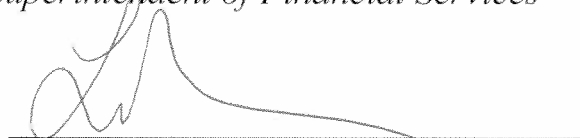
with such other information as he shall deem requisite.

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

this 21st day of March, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau



NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Froilan Estebal

as a proper person to examine the affairs of

UnitedHealthcare of New York, Inc.

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

HMO

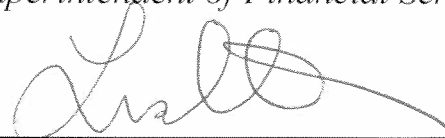
with such other information as he shall deem requisite.

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

this 21st day of March, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



Lisette Johnson
Bureau Chief
Health Bureau

