Report on

Market Conduct Examination

of

UnitedHealthcare of North Carolina, Inc.
Greensboro, North Carolina

and

UnitedHealthcare Insurance Company
Hartford, Connecticut

by Representatives of the

North Carolina Department of Insurance

as of

January 24, 2025

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Raleigh, North Carolina
January 24, 2025

Honorable Mike Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
3200 Beechleaf Court
Raleigh, North Carolina 27604

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Commissioner of Insurance
Connecticut Insurance Department
153 Market Street, 7th Floor
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Honorable Commissioners:

In accordance with the provisions of North Carolina General Statutes §§ 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of the following entities:

UnitedHealthcare of North Carolina, Inc. (NAIC #95103)
Greensboro, North Carolina
UnitedHealthcare Insurance Company (NAIC #79413)
Hartford, Connecticut
NAIC Exam Tracking System Exam Number: NC-NC094-27

(hereinafter generally referred to as "the Companies")

The examination was conducted at the North Carolina Department of Insurance (Department) office located at 325 N. Salisbury Street, Raleigh, North Carolina and 3200 Beechleaf Court. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

This examination commenced on June 15, 2020, and covered the period of January 1, 2019, through May 31, 2020, with analyses of certain operations of the Companies being conducted through December 31, 2021. This action was taken based on a significant increase in consumer complaints submitted to the Department's Consumer Services Division (CSD). All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners. The scope of this examination was not comprehensive and consisted of an examination of the Companies' practices and procedures in member grievances, as well as an examination of claims processing, targeted to anesthesia services and emergency room services submitted by non-contracted (out-of-network) providers and facilities. The observations, findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 0% percent tolerance level for member grievances. A tolerance level of 7% was applied for claims processing. When errors are detected in a sample, but the error rate is below the applicable threshold for citing a violation, the Department issues a reminder to the company. Sample files were randomly selected using Audit Command Language software.

EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with company procedures and practices in the following areas:

Member Grievances

- Failure (based on grievance decision outcomes) to overturn/reprocess claims for out-of-network anesthesia services provided at in-network facilities and for non-contracted emergency room services to hold the member harmless.
- Failure to provide both timely and compliant written acknowledgement and decision letters to the member or provider submitting the grievance.
- Failure to notify the member of the second-level grievance review panel meeting at least 15 days prior to the scheduled meeting date.
- Failure to convene/hold a second-level grievance review panel meeting.
- Failure to adhere to provisions of North Carolina's "prompt pay" law.

Claims Processing

- Misstating pertinent facts or insurance policy provisions relating to coverages at issue.
- Failure to process claims for out-of-network anesthesia and laboratory services provided at in-network facilities to not penalize and hold the member harmless for excess cost when in-network providers were not reasonably available to meet health needs of the members without unreasonable delay for services rendered at in-network facilities.
- Imposing cost sharing for out-of-network emergency services that differed from the cost sharing for in-network emergency services, resulting in actual or potential balance-billing liability for the member.
- Failure to pay applicable interest on late claim payments.
- Failure to issue certificate of coverage documents to members which reflect compliant application of benefits for emergency health care services.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance website: www.ncdoi.gov.

This examination identified violations which may extend to other jurisdictions. The Companies are directed to take immediate corrective action to demonstrate their ability and intention to conduct business in North Carolina according to its insurance laws and regulations.

All violations may not have been discovered or noted in this report. Failure to identify violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

INTERROGATORY RESPONSE AND TARGET EXAM ACTION

The Department's Market Regulation Division (MRD) was alerted by CSD of a sustained trend in complaints received from the Companies' members and their providers. A review of these complaints by CSD showed members were being subjected to cost sharing in excess of applicable deductible, copayment and coinsurance liabilities for certain services and balance billing from providers. These medically necessary services were mainly provided by out-of-network anesthesiology providers, laboratory providers and emergency room departments. The anesthesia and laboratory services were performed in conjunction with procedures and services provided at in-network facilities where a member received services from an out-of-network provider. The Companies' failure to have in-network anesthesiology and laboratory providers available at in-network facilities should not affect the member's benefit levels or cost-sharing responsibilities for covered services.

Establishing and monitoring provider availability and accessibility, or network adequacy, standards is required by 11 NCAC 20.0301 through 11 NCAC 20.0304. In situations where an in-network provider is not available, such as when there is no in-network anesthesiologist at an in-network facility, N.C.G.S. § 58-3-200(d) states, "[n]o insurer shall penalize an insured or subject an insured to the out-of-network benefit levels . . . unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay."

Similar protections apply in situations where an insured receives emergency services from an out-of-network provider because either a prudent layperson acting reasonably would have believed that a delay would have worsened the emergency, or the choice of a provider was beyond the control of the covered person. In those situations, N.C.G.S. § 58-3-190 prohibits insurers from imposing cost sharing for emergency services that differs from the cost sharing that would have been imposed if the provider had been in-network.

MRD issued a brief "Interrogatory" document to the Companies at the start of this target examination requesting responses and documentation showing how the Companies handle services provided outside their networks when contracted providers are not able to meet members' health needs consistent with N.C.G.S. §§ 58-3-200(d) and 58-3-190. After requesting an initial extension, the Companies took 45 days to submit their response.

The Companies' responses included a "*Weekly Network Adequacy Report*" from May 2020 that tracked 32 provider specialty types by North Carolina county and reported a percentage of members with access to the specialty type. Anesthesiology was not one of the provider specialty types tracked by this report. One specialty type tracked by the report, "Lab Services," was identified as "not meeting access" in 37 of 100 North Carolina counties. The report showed percentages of members with access to Lab Services ranging from 40% to 85% within these 37 counties. The variation detail given for these network inadequacies is "System Limitations."

The Companies submitted standard operating procedures ("SOP" or "Procedures") addressing claims subject to N.C.G.S. §§ 58-3-200(d) and 58-3-190. The Procedures involve paying the out-of-network provider the "allowed amount" established by the Companies and applying the member's in-network benefit level (i.e., copay, deductible, coinsurance) based on that allowed amount. Additionally, Explanations of Benefits (EOB) for these claims are supposed to include a narrative advising the member that, should an out-of-network provider seek additional reimbursement for the difference between the billed amount and the allowed amount (via balance billing), the member should contact the Company for assistance.

For fully-insured plan members in North Carolina, pricing for out-of-network services from non-contracted providers was established via the Companies' Extended Non-Network Reimbursement Program (ENRP). These rates were derived from CMS-approved rates based on publicly available industry data relative to the appropriate geographic region and were not contracted rates. If for some reason there was no CMS rate, the program would utilize a default

rate established by Data iSight, a proprietary pricing methodology utilized by MultiPlan, a contracted vendor.

If the member notified the Companies that he or she had received a balance bill from the non-contracted provider, the Companies would attempt to negotiate a reasonable rate with the non-contracted provider and ensure that the member ultimately was held harmless. The Companies' Procedures upon receiving this type of dispute from a provider or a balance-billing complaint/grievance from a member reflect that the case would go into a customer portal requesting negotiation. MultiPlan would attempt a reimbursement negotiation with the provider. The SOP continues by stating that if the provider ultimately attempts to balance bill the member, UnitedHealthcare *"takes a series of escalating legal actions to protect and remove the member from the middle."*

Upon review of the Companies' grievance and claim files submitted within the scope of this target examination, the Department has determined that the Companies failed in a substantial number of applicable cases to follow their Procedures. The following sections of this Report will demonstrate the outcomes and violations found in the files reviewed.

MEMBER GRIEVANCES

The Companies received a combined total of 1,978 member grievance review requests during the examination period. A random sample of 100 grievance files was produced from this total population. The sample represented a relatively even combination of files from both Companies. The files were reviewed to assess the Companies' compliance with statutes, including N.C.G.S. §§ 58-50-62, 58-3-200(d), and 58-3-190, administrative rules, as well as the Companies' internal policies and procedures.

First-level Grievance Files

General Observations

The review of the 100 first-level grievance files revealed the following general observations relevant to the scope of this target exam:

- The Companies issued a legitimate adverse (upheld) decision to the member in 31 grievance files. The documentation within these files adequately supported these decisions. The grievance issues reflected in these files did not involve balance billing. These grievances involved issues such as excluded benefits and certain service visit limits (i.e., physical therapy), among other topics.
- The Companies issued a favorable (overturned) decision to the member in 17 grievance files.
- Out of the 17 grievance files for which an overturned decision was issued, 13 files were grievances from members who had received a balance bill for out-of-network anesthesia services provided in an in-network facility. The Companies' resolution for these grievances resulted in reprocessing the applicable claim, with the member being held harmless from balance billing from the out-of-network provider.
- Forty-one of the grievance files within the sample contained some indication, through an actual balance bill or other communication, that the member could have been subjected to the difference between the amount billed and the Companies' allowed amount. However, the claims processed for these services accurately reflected application of the member's in-network benefits (i.e., copays, deductible, and coinsurance), which was consistent with the Companies' SOP.

Violations of Statutes and Policies

Review of the 100 first-level grievance files revealed that in 41 files, the Companies issued an adverse (upheld) decision without any indication that efforts were made to intervene on behalf of the member to prevent them from being subjected to the difference between the amount billed and the Companies' allowed amount. These grievances involved services from out-of-network anesthesiology or emergency room providers, received at in-network facilities. The adverse decision letter to the grieving members stated: *"You are responsible for all costs related to this* service(s)." In addition, a common narrative on the related claim's EOB within these files stated: *"You may be responsible for paying the difference between what the facility or provider billed and what was paid."* These 41 grievance outcomes show the Companies' failure to follow their

Policies and statutory requirements. The following violations were revealed within these 41 files based on review of the documentation, supporting facts, and lack of Company action:

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-200(d) within 30 grievance files, as those files contained some indication, through a balance bill or other communication, that the member could have been subjected to the difference between the amount billed and the Companies' allowed amount for medically necessary anesthesia or laboratory services from an out-of-network provider received at an in-network facility. The grievance determination letters in these 30 files referenced the balance billing amount as the member's responsibility. The Department determined that 4 members were penalized with additional cost sharing although contracted anesthesiology/laboratory providers were not reasonably available to meet health needs of the insured without unreasonable delay.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-190(d) within 11 grievance files, as those files contained some indication, through an actual balance bill or other communication, that the member could have been subjected to the difference between the amount billed and the Companies' allowed amount for emergency room services received from a non-contracted ER provider or facility. The Department determined that 6 members were penalized with actual additional cost sharing for emergency services that differ from the cost sharing that would have been imposed if the provider was under contract with the insurer.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-50-62(e) within 14 grievance files, as the acknowledgement letter within four files was not sent to the member within three business days after receiving the grievance; the acknowledgment letter within eight files did not specify the name and phone number of the grievance coordinator assigned to the review; the review within one file was not completed within 30 days of receipt of the grievance; and within one file a copy of the decision letter was not sent to the provider who submitted the grievance based on written consent of the member to do so on their behalf.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-225 (Prompt Pay Law) within 3 grievance files. One file's claim required interest which was not paid; one file's claim had an incorrect copayment applied; and one file's claim was improperly denied for coverage of a vaccine which is not specified on the list of exclusions within the member's schedule of benefits.

The amount of unresolved exposure to the difference between the amount billed and the Companies' allowed amount for members identified within the 10 grievance files noted above (the members who were penalized with additional cost sharing) totals $26,543.47. The amount of potential unresolved exposure to the difference between the amount billed and the Companies'

allowed amount for the remaining 31 members totals $85,279.28.[1] The average service time to process a member first-level grievance was 15 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	24	24.0
8 - 14	26	26.0
15 - 21	33	33.0
22 - 30	16	16.0
31 - 60	0	0.0
Over 60	1	1.0
Total	**100**	**100.0**

Second-level Grievance Files

General Observations

Members submitted a second-level grievance request in nine out of the 100 grievance files reviewed. Review of these nine files revealed that the Companies issued a favorable (overturned) decision in only two of these files. The remaining seven second-level grievance files involved claims that referenced the potential balance-billing amount as the member's responsibility. The Company issued an adverse (upheld) decision without any indication that efforts were made to intervene on behalf of the member to hold them harmless from actual or potential exposure to the difference between the amount billed and the Companies' allowed amount.

Violations of Statute and Policies

The following violations were revealed within these seven second-level grievance files based on review of the documentation, supporting facts, and lack of Company action:

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-200(d) within six files, as the member was subjected to the difference between the amount billed and

[1] North Carolina law does not require UHC to automatically pay the billed amount. During the exam time period, UHC's policy was to initially pay at the allowed amount set forth in its certificate of coverage and, if the non-contracted provider did not accept this payment as payment in full, attempt to negotiate a mutually-acceptable rate with the non-contracted provider.

the Companies' allowed amount for medically necessary anesthesia or laboratory services from an out-of-network provider, received at an in-network facility.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-190(d) within one file, as the member was subjected to the difference between the amount billed and the Companies' allowed amount for emergency room services received from a non-contracted provider. The Companies' actions imposed cost sharing to the member for emergency services that differ from the cost sharing that would have been imposed if the provider was under contract with the insurer.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-50-62(f)(1) within one file, as the acknowledgement letter did not specify the name and phone number of the grievance coordinator assigned to the review.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-50-62(g)(2) within four files, as the member was not notified in writing of the second-level grievance review panel meeting at least 15 days prior to the meeting date.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-50-62(f)(2) within two files, as the required second-level review panel meeting was not held, despite an adverse (upheld) decision being issued for the second-level grievance. These cases related to unresolved balance-billing issues for the member.

The average service time to process a member second-level grievance was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
8 - 14	1	11.1
15 - 21	1	11.1
22 - 30	7	77.8
Total	**9**	**100.0**

CLAIMS PROCESSING

Following review of the Companies' member grievance file sample, the Companies' claims administration practices were reviewed. An examination was conducted of paid claim files targeted to out-of-network anesthesiology and emergency room service claims, in order to more broadly assess the Companies' lack of adherence to their SOP found in the review of grievance files.

The Companies processed a total of 12,581 paid claim lines during the examination period specific to out-of-network anesthesiology services received at in-network facilities and non-contracted emergency room services received at both in-network and out-of-network facilities.

Random samples of 50 anesthesiology claims and 50 emergency room claims were produced from this population of claim lines for a total of 100 claim files. These paid claim files were reviewed to assess the Company's compliance with statutes, including N.C.G.S. §§ 58-3-225, 58-3-190, and 58-3-200(d), administrative rules, as well as the Companies' internal policies and procedures.

General Observations

For the claim files reviewed, due to network adequacy issues beyond the member's control, medically necessary anesthesia services and emergency room services could not be obtained from a provider under contract with the Companies to meet health needs of the insured without unreasonable delay. Review of these claim files revealed cost sharing (balance billing) exposure to the member that would not have been imposed if the provider was under contract with the insurer.

Violations of Statutes and Policies

The following violations were found in the 100 paid claim files based on review of the documentation, supporting facts, and lack of Company action:

- The companies were deemed to be in violation of the provisions of N.C.G.S. §§ 58-3-200(d) and 58-3-190(d), as sixty claim files contained evidence of member EOBs and provider Remittance Advices (RAs) which directly identified the difference between the provider's charge and the allowed amount as member responsibility. The EOBs for these claims identified member balance-billing financial exposure as "Amount You Owe" on both the cover/summary page (emphasized with an oval circle) and within the line-item detail. The corresponding provider RAs within these files identify these same amounts as "Patient Responsibility" in the line-item detail column. In addition, several EOB and RA forms contain line item remark notes directed to these balance billing amounts, such as: "Patient Responsibility – Services not provided by network/primary care providers"; "This out-of-network service was paid based on Medicare allowed amounts used even if the patient doesn't have Medicare"; or '"You may be responsible for paying the difference between what the provider billed and what was paid." A separate EOB remark note indicates that the member may call customer care for a claim review if a balance bill is received. However, this remark note fails to inform the member that they are not responsible for the difference between the provider's charge and the allowed amount, as reflected in their Certificate of Coverage. In some claim files reviewed, the EOB narrative instructed the member to contact Data iSight themselves to request assistance with the provider balance-billing issue.

- Of these 60 files, nine claim files indicated either a grievance for balance billing was submitted by the member, or a claims reconsideration request was received from the provider. In each

file, the Companies did nothing to address the grievance or request, with the grievance adverse decision letter containing the following statement to the member: "You are responsible for all costs related to this service." Of these sixty claims files, eleven files included evidence that a balance bill was submitted to the Companies. Of those eleven claims files, ten were resolved through negotiation under the Companies' SOP, and one was not, although the Company attempted negotiation.

- The Companies were deemed to be in violation of the provisions of N.C.G.S. § 58-3-190(d) within six emergency room service claims files, as the member's applicable emergency room benefits were not applied, and the entire deductible amount was applied to the member's out-of-network benefit accumulators.

- The "Certificate of Coverage, Riders, Amendments, and Notices" document in each emergency room claim file reviewed contained the following language that conflicts with the provisions of N.C.G.S. § 58-3-190:

> *Allowed Amounts for Emergency Health Care Services provided by an out-of-network provider will be determined as described below under Allowed Amounts in this Schedule of Benefits.* ***As a result, you will be responsible for the difference between the amount billed by the out-of-network provider and the amount we determine to be the Allowed Amount for reimbursement.***

In summary, within the 100 paid claim files reviewed, the DOI identified several claims with unresolved member exposures amounting to the difference between the amount billed and the Companies' allowed amount. The unresolved member exposure identified in those claims totals $17,779.77. The amount of unresolved potential member exposure in the remaining claims totals $207,191.03.[2]

The average service time to process a claim was 21 calendar days. A chart of the service time follows:

2 North Carolina law does not require UHC to automatically pay the billed amount. During the exam time period, UHC's policy was to initially pay at the allowed amount set forth in its certificate of coverage and if the provider did not accept this payment as payment in full, attempt to negotiate a reasonable rate with the non-contracted provider.

Service Days	Number of Files	Percentage of Total
0 - 7	9	9.0
8 - 14	27	27.0
15 - 21	36	36.0
22 - 30	11	11.0
31 - 60	7	7.0
Over 60	10	10.0
Total	**100**	**100.0**

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Companies are directed to:

- Without speaking to legal rights and remedies the Companies may have against non-contracted providers who seek reimbursement for amounts not reasonable in relation to the services provided, hold members harmless and not subject them to the difference between the billed charge and the Companies' allowed amount when contracting providers are not available to meet their health needs without unreasonable delay, including for anesthesia and emergency services provided by out-of-network/non-contracted providers at in-network facilities and/or emergency settings, as required by statutes and the Companies' Policies.

- Issue compliant decision outcomes for member/provider grievances; issue compliant grievance written acknowledgement and decision letters which contain required content; issue timely written acknowledgment and decision letters for grievances; convene and adequately conduct second-level grievance review panel meetings; and pay applicable interest on late claim payments.

- Issue compliant certificate of coverage documents that comply with statutory requirements.

Upon acceptance of the Report, the Companies shall provide the Department with a statement of corrective action plan to address the violations identified during the examination. The Department will conduct a future investigation, if warranted, to determine if the Companies successfully implemented their statement of corrective action.

CONCLUSION

A target examination has been conducted on the market conduct affairs of UnitedHealthcare of North Carolina Inc, and UnitedHealthcare Insurance Company for the period January 1, 2019, through May 31, 2020, with analyses of certain operations of the Company being conducted through December 31, 2021.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of member grievances and claims processing.

Respectfully submitted,

Scott D. Grindstaff

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
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I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Teresa Knowles

Teresa Knowles, ACS
Deputy Commissioner - Market Regulation Division
State of North Carolina