Report on

Market Conduct Examination

of

UnitedHealthcare Insurance Company of the River Valley

Moline, Illinois

by Representatives of the

North Carolina Department of Insurance

as of

April 25, 2016

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Raleigh, North Carolina
April 25, 2016

Honorable Wayne Goodwin
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Department of Insurance
State of North Carolina
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Raleigh, North Carolina 27603

Honorable Anne Melissa Dowling
Acting Director
Illinois Department of Insurance
320 W. Washington Street, 4th Floor
Springfield, Illinois 62767

Honorable Commissioner and Director:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of

UnitedHealthcare Insurance Company of the River Valley
(NAIC #12231)
NAIC Exam Tracking System Exam Number: NC-NC299-2
Moline, Illinois

hereinafter generally referred to as the Company, at the Company's office located at 1300 River Drive Suite 200, Moline, Illinois and at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Department conducted a target examination of the Company. This examination commenced on February 8, 2016, and covered the period of January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through April 4, 2016. This action was taken due to analysis of the market conduct annual filing submission. 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 (NAIC). The scope of this examination was not comprehensive, but included a limited review of the Company's practices and procedures in utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring. The findings and conclusions contained within the report are based solely 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 timeliness of utilization review, member appeal and grievance acknowledgement and determination letters. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals and grievances. Sample sizes were generated using Audit Command Language (ACL) software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

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

Utilization Management – Failure to provide timely determinations for utilization review requests; failure to provide compliant written acknowledgement and decision notification letters to covered persons for utilization reviews, member appeals, and expedited

appeals; failure to provide timely acknowledgement letters to covered persons for member appeals, and failure to provide timely decision letters for expedited appeals.

Policyholder Grievances – Failure to provide timely written acknowledgement and decision letters to covered persons; failure to provide compliant written acknowledgement and decision letters to covered persons; and failure to re-adjudicate claims which remained denied in error based on an upheld grievance decision (claims were identified as a result of the Department's review of grievance files).

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 Web site www.ncdoi.com by clicking "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

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

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Utilization Management Program. This Program is integrated with other operational areas of the Company in adherence to the provisions of NCGS 58-50-61.

Policies and Procedures

The Company's Utilization Management policies and procedures were examined to determine compliance with appropriate North Carolina statutes. No adverse trends or unfair trade practices were revealed during this review.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning. Written noncertifications are communicated to members as required by the provisions of NCGS 58-50-61.

The Company received a total of 1,347 prospective utilization review requests during the examination period. One hundred thirty one utilization review files were examined to assess the Company's compliance with the provisions of NCGS 58-50-61, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 as follows:

- Two files contained a noncompliant adverse determination letter which contained an incorrect address and telephone number for the 'Health Insurance Smart NC' program.
- The review was not completed and communicated to the provider and member within three business days within one file.

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his/her appeal if a delay in the rendering of health care would be detrimental to his/her health.

Appeal Records Review

The Company received a total of fifteen first-level member appeals during the examination period. The total population of fifteen appeal files was reviewed to assess the

Company's compliance with the provisions of NCGS 58-50-61 and NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(k) as follows:

- Fifteen files contained a non-complaint acknowledgement letter to the insured, as the letters did not specify the name and contact information of the Company coordinator assigned to the appeal.
- Two files contained an acknowledgement letter which was not sent to the insured within three business days.

The average service time to process a member appeal was 14 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	3	20.0
8 - 14	8	53.3
15 - 21	3	20.0
22 - 30	1	6.7
Total	**15**	**100.0**

Expedited Appeal Records Review

The total population of 20 expedited member appeal files received by the Company during the examination period was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(l) as follows:

- Eight files contained a non-compliant decision letter to the insured, as the letter did not contain the correct address or telephone number for the 'Health Insurance Smart NC' program.
- One file contained a decision letter to the insured which was not sent within four business days after receiving the expedited appeal request.

POLICYHOLDER GRIEVANCES

The total population of 61 member grievance files received by the Company during the examination period was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62 as follows:

- Within 58 files, the acknowledgement letter did not specify the name and contact information of the Company coordinator assigned the grievance.
- Nineteen files contained a written adverse decision letter which contained an incorrect phone number for the 'Health Insurance Smart NC' program.
- Within one file, an acknowledgement letter was not sent to the insured.
- A written decision was not completed and sent to the insured within 30 days for one file.
- Four grievance files which resulted in an upheld decision involved claim denials for out-of-network ancillary charges related to in-network services. Upon further review of these files, it was determined that the claims were denied due to analyst error. The Company was instructed to overturn the upheld grievance decision for these four files and reprocess each associated claim, as well as inform the member. The payments for these claims totaled $1,808.51 (including interest as applicable).

The average service time to process a member grievance was eight calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	30	49.2
8 - 14	27	44.3
15 - 21	2	3.3
22 - 30	1	1.6
31 - 60	1	1.6
Total	**61**	**100.0**

PROVIDER NETWORK AVAILABILITY AND ACCESSIBILITY

The Company's policies and standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards were reviewed to ascertain compliance with the provisions of 11 NCAC 20.0301(3) and 20.0302(3).

The Company's goal is for performance results not to exceed five percent below the standard. The Company's performance results were within these parameters during the examination period. These standards and results are specific to North Carolina membership, and are displayed in the following chart:

2014 Market Description	Routine Care Appointments	Urgent Care Appointments	Specialty Care Appointments	After Hours Care Appointments
UHIC of the River Valley Standard (%)	87.11 within 14 days	92.21 within same day	87.93 as soon as needed	70.53 within 24 hrs/ 7 days wk
UHIC of the River Valley Performance (%)	83.29	90.16	87.01	78.78

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must complete and implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to: compliance with statutory requirements regarding member utilization review, appeal and grievance written notification decisions and acknowledgement letters (including timeliness and content of notifications); and meeting established provider accessibility standards for the average or expected waiting time for routine, urgent, and specialist appointments.

CONCLUSION

A target examination has been conducted on the market conduct affairs of UnitedHealthcare Insurance Company of the River Valley for the period January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through April 4, 2016.

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 utilization

reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring.

In addition to the undersigned, Marion A. Flemmings, HIA, HIPAAP, HCSA, MCM, North Carolina Market Conduct Senior Examiner, participated in this examination.

Respectfully submitted,

Scott D. Grindstaff

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

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.

Tracy M. Biehn

Tracy M. Biehn, MBA, MCM, LPCS
Deputy Commissioner
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