THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

UnitedHealthcare of Florida, Inc.

AS OF

March 1, 2013

NAIC COMPANY CODE: 95264
NAIC GROUP CODE: 0707

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EXECUTIVE SUMMARY

A sample of 218 claims, and policies and procedures as they apply to the adjudication of out of network medical provider claims were reviewed. The examination was expanded and a sample of 216 claims as they apply to the adjudication of BayCare Health System claims was also reviewed. The following table represents general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
641.3154 (1)	The Company incorrectly assigned subscriber liability for payment of out of network provider fees (balance billing).	218	55
641.3156 (2)	The Company improperly denied out of network provider claims.	218	1
641.3155 (3)(b) & (4)(b)	The Company did not pay, deny, or contest out of network claims within the required timeframe.	218	5
641.3903(5)(c)	The Company did not properly investigate prior to denying BayCare Health System's claims.	216	5
641.3156 (2)	The Company improperly denied BayCare Health System's claims.	216	2

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of UnitedHealthcare of Florida, Inc. pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC**.** The scope period of this examination was January 1, 2011, through December 31, 2011. The onsite examination began November 19, 2012, and concluded March 1, 2013.

The purpose of the examination was to review the Company's policies and procedures as they apply to the adjudication of out of network medical provider claims and to determine compliance with Florida Statutes and the Florida Administrative Code.

The examination included reviewing:

- The Company's claims handling procedures to ensure adoption and implementation of standards for proper investigation and settlement of claims;

- The Company's internal policies and procedures to determine the methodology for payment of out of network claims;

- The Company's definition of "usual and customary" for out of network claims; and

- Samples of paid and denied out of network claims to determine timely acknowledgements, reasonable and proper investigation, resolution, timely payment and for consistency with internal policies and procedures and Florida Statutes.

Subsequent to the beginning of the onsite review of out of network medical provider claims the exam was expanded to include the review of claims for BayCare Health System and the Company's compliance with Florida Statutes and the Florida Administrative Code. The scope for the expanded examination was January 1, 2011, to October 1, 2012.

The expanded examination included reviewing:

- Samples of paid, denied, and pended claims to determine timely acknowledgements, reasonable and proper investigation, resolution, timely payment and review for consistency with internal policies and procedures and Florida Statutes.

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

UnitedHealthcare of Florida, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on March 6, 1973. The Company provides group health coverage in the State of Florida.

Total Direct Health Premiums Written in Florida was as follows:

Year	Total Written Premiums In Florida (Per Schedule T of Annual Statement)
2011	642,748,431

The Company's claims records are maintained at a variety of processing locations and are assigned for adjudication as follows:

- Small group commercial medical claims are assigned to the Greensboro, NC office; and

- The remaining commercial medical claims are assigned to offices located in: Greensboro, NC; Kingston, NY; Springfield, MO; and Oldsmar, FL.

OUT OF NETWORK CLAIMS HANDLING REVIEW

I. COMPANY POLICIES AND PROCEDURES

The Company uses "Eligible Expenses" as the benchmarking standard for determining Usual, Customary, and Reasonable (UCR). Eligible expenses are calculated based on available data resources of competitive fees in a geographic area. Eligible expenses are determined solely in accordance with the Company's reimbursement policy guidelines. Reimbursement policy guidelines are developed following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

1) The most recent edition of the Current Procedural Terminology (CPT) manual;

2) The Medicare rate; or

3) Other data that may be obtained from professionals, consultants, or publications and accepted by the Company.

A policyholder or plan may elect reimbursement based upon a percentage of Medicare rates or a database of competitive fees as determined by the plan's Certificate of Coverage. For facility claims, the Company also follows the language contained in the Certificate of Coverage and applies shared savings re-pricing or considers the billed amounts. Prescription drug pricing and product information is provided by Redbook, which is published by Truven Health Analytics.

II. CLAIMS REVIEW

The Company was requested to provide a list of all out of network claims paid or denied during the scope period. The Company identified a universe of 19,990 paid or denied out of network claims. A random sample of 109 paid out of networks claim files and a random sample of 109 denied out of network claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) In 55 instances, the Company incorrectly assigned subscriber liability for payment of out of network provider fees (balance billing), in violation of Section 641.3154 (1), Florida Statutes.

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure subscribers are not incorrectly assigned liability for payment of out of network provider fees.

1b.) COMPANY RESPONSE: The Company disagreed with this violation stating that, when it made an internal business decision to pay the technical component of pathologist claims, only the remark code included in the Explanation of Benefits (EOB) incorrectly indicated member financial responsibility. The Company has since corrected the remark code to reflect that members are not responsible for the difference between the amount charged and the amount allowed. The remark code also now indicates that Florida law prohibits providers from balance billing patients.

1c.) **SUBSEQUENT EVENT**: A subsequent review of the EOBs was conducted and it was determined that, in addition to the remark code, a dollar value is reflected in the Member Responsibility section. The Company confirmed it is unable to provide specific documentation to conclusively show that members were not balance billed by providers or that members did not pay the amounts identified in the Member Responsibility section of the EOBs. The Company did conduct an internal review within the Appeals and Grievances department and the results did not reveal any appeals from members related to the 55 instances identified in the violation. In addition, the Company did not identify any complaints received from the Division of Consumer Services of the Florida Department of Financial Services regarding balance billing for such pathology claims during the period of January 1, 2009, through December 31, 2011.

2) In one (1) instance, the Company improperly denied out of network provider claims, in violation of Section 641.3156 (2), Florida Statute.

2a.) CORRECTIVE ACTION: The Company should implement procedures to prevent improper claim denials and issue interest payments on overdue claims.

2b.) COMPANY RESPONSE: The Company agreed with this violation.

3) In five (5) instances, the Company did not pay, deny, or contest out of network claims within the required timeframe, in violation of Section 641.3155 (3)(b) and (4)(b), Florida Statutes.

3a.) CORRECTIVE ACTION: The Company should implement procedures to ensure out of network claims are paid, denied, or contested within the required timeframe and issue interest payments on overdue claims.

3b.) COMPANY RESPONSE: The Company agreed with this violation.

The following finding was also noted during the examination:

In October 2010, the Company made a business decision to implement an exception that allowed for the payment of the professional component of global laboratory services for Florida out of network pathologist claims when performed in a facility setting.

1) In 48 instances, the Company inappropriately denied out of network pathologist claims for the payment of the professional component of global laboratory services that were performed in a facility setting after October 2010.

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure the proper payment of claims after implementing business decisions that allow for additional payments to providers.

1b.) COMPANY RESPONSE: The Company disagreed with this finding stating that the process implemented by the Company is an exception to the Centers for Medicare and Medicaid Services' (CMS) guidelines and required manual reprocessing of the claims.

The Company's initial approach to identifying the claims did not capture all impacted provider claims; therefore some claims were omitted from the process. The approach to identifying the provider claims moved to reporting for accuracy and the finalized project was not implemented until June 2011.

III. BAYCARE HEALTH SYSTEM CLAIMS REVIEW

The Company was requested to provide a list of all BayCare Health System claims paid or denied during the scope period. The Company identified a universe of 19,178 paid or denied BayCare Health System claims. A random sample of 109 paid claim files and a random sample of 107 denied claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) **In five (5) instances, the Company did not properly investigate prior to denying BayCare Health System's claims, in violation of Section 641.3903(5)(c), Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure the proper investigation and payment of claims and issue interest payments on overdue claims.

1b.) COMPANY RESPONSE: The Company agreed with this violation.

2) **In two (2) instances, the Company improperly denied BayCare Health System's claims, in violation of Section 641.3156 (2), Florida Statutes**.

2a.) CORRECTIVE ACTION: The Company should implement procedures to prevent improper claim denials and issue interest payments on overdue claims.

2b.) COMPANY RESPONSE: The Company agreed with this violation.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.