THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGET MARKET CONDUCT
FINAL EXAMINATION REPORT

OF

UNITEDHEALTHCARE INSURANCE COMPANY
NAIC COMPANY CODE: 79413

UNITEDHEALTHCARE OF FLORIDA, INC.
NAIC COMPANY CODE: 95264

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.
NAIC COMPANY CODE: 95123

ISSUED ON
OCTOBER 30, 2019

NAIC GROUP CODE: 707

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EXECUTIVE SUMMARY

This was a targeted market conduct examination of UnitedHealthcare Insurance Company, UnitedHealthcare of Florida, Inc., and Neighborhood Health Partnership, Inc. that are all within the same holding company group. The focus of this examination was to determine the circumstances surrounding the payment of claims from a medical laboratory provider and whether the procedures followed in handling payments, appeals, and other processes were in compliance with Florida law. The examiners reviewed company operations and management, complaint handling, utilization review, grievances, appeals, and claims related to this provider from January 1, 2015 to June 30, 2018. The Company was found to have failed to report possible or suspected fraud and has subsequently contracted with the entity as an "in-network' provider. In addition, the grievance procedures of the two HMOs are not in compliance with Florida Statutes.

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of UnitedHealthcare Insurance Company (UHIC), UnitedHealthcare of Florida, Inc. (UHCFL), and Neighborhood Health Partnership, Inc. (NHP) (collectively, "the Company") pursuant to Section 624.3161, Florida Statutes. The examination was performed by INS Regulatory Insurance Services, Inc. (InsRis). The scope period of this examination was January 1, 2015 to June 30, 2018. The examination began September 5, 2018 and ended June 10, 2019. The on-site examination took place November 7-9, 2018 and November 29-30, 2018 with off-site analysis continuing through June 10, 2019.

The focus of this examination was to determine the circumstances surrounding the payment of claims from a medical laboratory provider during the examination period and whether the procedures followed in handling payments, appeals, and other processes for those claims were in compliance with Florida law. The examination included the following reviews:

Company Operations and Management Review - Policies and procedures were reviewed relating to audits, anti-fraud efforts, Company history, proper reporting to the Office, and other compliance and governance matters relating to Sections 624.318, 626.875, 626.989, 626.9891, 627.062(3)(a), and 628.281(2), Florida Statutes and Rules 69D-2.003, 69O-153.001 through 69O-153.004, and 69O-191.074, Florida Administrative Code.

Claims - Policies, procedures, and files of the Company were requested for review relating to Sections 626.9541, 627.6131, 627.64194, 641.3154, 641.3155, and 641.3903, Florida Statutes. The Company also provided a list of related paid claims, denied claims, claims closed without payment and partially paid claims. The Company identified a universe of claims by claim line. The examiners combined the claims into unique claim numbers of 3,030 paid claims, 5,900 denied claims, 4,286 partially paid claims and 547 closed claims. A prorated random sample of 109 claim files were reviewed for compliance with Florida Statutes.

Complaint Handling, Utilization Review, Grievances and Appeals - Policies, procedures, recurring reports, and files of the Company were requested for review relating to Sections 624.307, 626.9541, 627.6131, 627.4234, 627.6406, 627.6141, 627.64171, 641.3155, 641.47, 641.51 and 641.511, Florida Statutes and Rules 69O-142.002 and 69O-191.078, Florida Administrative Code.

Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners. All unacceptable or non-compliant practices may not have been discovered or noted in this examination report. Failure to identify unacceptable or non-compliant business practices does not constitute acceptance of such practices. When applicable, corrective actions should be taken in all companies.

COMPANY OPERATIONS

UnitedHealthcare Insurance Company (UHIC), UnitedHealthcare of Florida, Inc. (UHCFL), and Neighborhood Health Partnership, Inc. (NHP) are part of an insurance holding company group ultimately controlled by UHIC Holdings, Inc. UHIC is a foreign life and health insurer authorized to conduct business in the State of Florida on October 1, 1973. UHCFL is a domestic health maintenance organization authorized to conduct business in the State of Florida on March 6, 1973. NHP is a domestic health maintenance organization authorized to conduct business in the State of Florida on November 9, 2000. The examination involved commercial health coverage. The coverages provided in the State of Florida are as follows:

- UHIC – Commercial, Medicare, Medicaid, and Vision/Dental
- UHCFL – Commercial, Medicare, and Medicaid
- NHP, Inc. – Commercial

Total accident and health premiums written in Florida are as follows:

UHIC

Year	Total Written Premiums in Florida (Per Schedule T of Annual Statement)
2018	6,564,655,287
2017	6,023,492,876
2016	5,759,832,634
2015	5,327,209,563

UHCFL

Year	Total Written Premiums in Florida (Per Schedule T of Annual Statement)
2018	650,775,316
2017	594,645,042
2016	1,058,894,133
2015	1,071,496,168

NHP

Year	Total Written Premiums in Florida (Per Schedule T of Annual Statement)
2018	708,765,415
2017	626,797,043
2016	578,723,990
2015	528,412,163

REVIEW OF COMPANY OPERATIONS AND MANAGEMENT

The Company was requested to provide documents related to audits, the anti-fraud unit, operations and management, data reporting, compliance and governance, and previous market conduct reports.

FAILURE TO REPORT POSSIBLE OR SUSPECTED FRAUD

Pursuant to Sections 626.989(6) and 626.9891(2)(a)(1), Florida Statutes, and Rule 69D-2.003(2)(a), Florida Administrative Code, each licensed entity shall report possible or suspected insurance fraud to the Division of Investigative and Forensic Services. Section 626.989(6), Florida Statutes, states in pertinent part, that *"…any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed shall send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require."* Section 626.9891(2)(a)(1), Florida Statutes, further requires that every insurer admitted to conduct business in Florida "*Establish and maintain a designated anti-fraud unit or division within the company to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds…".*

With regard to the aforementioned provider, an investigation was conducted by The Payment Integrity Unit (PIU) of Optum, a related company within the UnitedHealthcare umbrella. A part of this unit's responsibility is data analytics to detect fraud, waste or abuse. The PIU found sufficient evidence to refer the case to its Special Investigations Unit (SIU) in December of 2015. The Company, however, failed to report the matter to the Division of Insurance Fraud.[1]

The Director of the Company's Special Investigations Unit provided an onsite interview and a written summary indicating that an investigation was initiated in December 2015 and actively continued into the Fall of 2017 with the file currently remaining open. In addition to reiterating similar findings as reported by the Payment Integrity Unit, the SIU conducted other investigative activity such as onsite visits and member interviews. UHC reports that numerous requests were made for medical records from the provider so that the SIU could review the claims of 30 members. These records were not received, and the Company made the decision to stop paying claims. The Company has failed to make the required report to the Division of Investigative and Forensic Services even though there is ample proof of possible or suspected fraud to the point that the Company even stopped paying claims for over a year.

The Company and the provider came to an agreement on May 18, 2017 that the provider would revise many of its billing practices and the Company would resume paying claims. The parties

[1] Prior to July 2016, the Department of Financial Services, Division of Investigative and Forensic Services was known as the Department of Financial Services, Division of Insurance Fraud.

signed an agreement placing the provider in-network. The parties then worked toward a settlement agreement that included a compliance agreement, scheduled to be effective for four years. The SIU file presently remains open. According to the onsite interview of the Director of the Company's SIU and, contrary to Florida law, the Company procedure requires an investigation to be closed prior to reporting possible or suspected fraud.

RECOMMENDATION: The Office recommends that the company report to the Division of Investigative and Forensic Services all instances of possible or suspected fraud not previously reported on all cases which are currently active and/or open from January 1, 2019, forward. The Office further recommends that the Company review its existing procedures and implement necessary changes to ensure the prompt reporting of actual, possible, or suspected fraud.

REVIEW OF GRIEVANCES

The Company was requested to provide a list of all grievance files and the policies and procedures for handling grievances. The Company reported no grievance files related to this provider, within the scope of this exam.

NON-COMPLIANT GRIEVANCE TIMELINE

A review of company grievance procedures revealed that although the company may be in compliance with the minimum claims procedures of the regulations of The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R., Section 2560.503-1, its policies and procedures do not comply with Section 641.511(1), Florida Statutes, or Rule 69O-191.078(10), Florida Administrative Code. Section 641.511(1), Florida Statutes, states in pertinent part, that *"…Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance..."* and Rule 69O-191.078(10), Florida Administrative Code, states *"The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance".* While HMOs within the Company are using approved forms, each HMO limits subscribers to 180 days in which to file a grievance.

RECOMMENDATION: The Office recommends that the company identify all policy types and forms in need of revision. The Office also recommends that the Company review its existing procedures and implement all necessary changes, including providing notifications, to ensure compliance with Section 641.511, Florida Statutes, and Rule 69O-191.078(10), Florida Administrative Code. The Office further recommends that the Company submit the aforementioned forms, in need of revision, for approval by the Office, in a timely manner when due in 2020.

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.