STATE OF ARIZONA
FILED
MAR 10 2006
DEPT OF INSURANCE
BY Kath

1 STATE OF ARIZONA

2 DEPARTMENT OF INSURANCE

3

4 In the Matter of:) Docket No. 06A-034-INS
)
5 **UNITED HEALTHCARE INSURANCE COMPANY**)
NAIC #79413) **CONSENT ORDER**
6)
7 Respondent.)

8 On September 11, 2003 the Arizona Department of Insurance ("Department") called a
9 healthcare insurance compliance examination ("Examination") of United HealthCare
10 Insurance Company ("UHIC") covering the time period from July 1, 2001 through June
11 30, 2003 ("Examination Period"). The Examination Period was divided into four six-
12 month periods ("Partial Examination Periods" or "PEPs") as follows:

13 PEP 1: July 1, 2001 – December 31, 2001

14 PEP 2: January 1, 2002 – June 30, 2002

15 PEP 3: July 1, 2002 – December 31, 2002

16 PEP 4: January 1, 2003 – June 30, 2003

17 The Report of the Compliance Examination of United HealthCare Insurance Company,
18 dated October 3, 2004 ("Report"), which is included herein by reference, alleges that
19 UHIC violated A.R.S. § 20-157, A.R.S. §§ 20-2533 through 20-2537, and A.R.S. § 20-
20 3102. UHIC wishes to resolve this matter without formal proceedings. UHIC admits the
21 following Findings of Fact are true and consents to the entry of the following
22 Conclusions of Law solely for the purposes of resolving the allegations contained in the
23 Report and consents to the entry of the following Order.

24

25

FINDINGS OF FACT

I. Jurisdiction.

UHIC is, and throughout the Examination Period was, authorized to operate as a disability insurer pursuant to a Certificate of Authority issued by the Arizona Insurance Director ("Director").

II. Utilization Review and Health Care Appeals.

A. During PEPs 3 and 4, UHIC failed in certain files the Department reviewed to provide a health care appeals information packet to members within five business days of the members initiating an appeal.

B. During PEP 4, in certain files that the Department reviewed, UHIC failed to inform the member and the member's treating provider of the expedited decision within one business day.

C. During PEPs 3 and 4, in certain files that the Department reviewed, UHIC failed to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

D. During PEP 4, in certain files that the Department reviewed, UHIC failed to mail notice of its decision to the member within thirty business days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty business days after receiving a request for informal reconsideration or to include the criteria used and the clinical reasons for the decision.

E. During PEPs 3 and 4, in certain files that the Department reviewed that resulted in a denial of informal reconsideration, UHIC failed to provide the

1 member and the treating provider with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation and a notice of the option to proceed after the formal appeal process to an external independent review.

F. During PEP 4, when handling formal appeals, UHIC failed in certain files that the Department reviewed to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal.

G. During PEP 4, in certain files that the Department reviewed for adverse decisions in formal appeals relating to services not yet provided, UHIC failed to provide written notice of its adverse decision to the member within thirty business days after receiving the written appeal or failed to include the criteria used and the clinical reasons for the decision with the notice.

H. During PEP 4, in certain files that the Department reviewed for adverse decisions in formal appeals relating to claims for services that already had been provided, UHIC failed to provide written notice of its adverse decision to the member within sixty business days after receiving the written appeal, or to include the criteria used and the clinical reasons for the decision.

I. During PEP 4, in formal appeals that UHIC denied, it failed in certain files that the Department reviewed to provide the member with notice of the option to proceed to an external independent review.

J. During PEP 4, in requests for external independent review or expedited external independent review, UHIC failed in certain files that the

Department reviewed to forward the request to the director within five days, or failed to submit the required information to the director.

III. Provider Timely Pay and Provider Grievances.

A. During the Examination Period, in certain files that the Department reviewed UHIC paid no interest or paid too little interest on clean claims it paid late.

B. During the Examination Period, in certain files that the Department reviewed UHIC denied unclean claims before requesting additional information from the provider.

C. During the Examination Period, UHIC's grievance system failed in certain files that the Department reviewed to:

1. Timely resolve provider payment disputes and other grievances.
2. Maintain records.
3. Include all the information required by law in the records it did maintain.
4. Generate semi-annual statutory reports that accurately summarized all records of grievances during the prior six months.

IV. Access to Insurer Records; Insurer Record-Keeping.

A. During the course of the Examination, UHIC failed to produce or maintain and make freely accessible certain claims data, its "data dictionary", certain pharmacy benefit records and utilization review denials relating to the Examination.

B. During PEP 4, in certain files the Department reviewed, UHIC failed to maintain original data for electronic grievance files and records for the Examination Period easily accessible to the Department in readable form and obtainable as readable reproduced copies.

CONCLUSIONS OF LAW

I. Jurisdiction.

The Director has the authority to enter and enforce this Order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals.

A. During PEPs 3 and 4, UHIC violated A.R.S. § 20-2533(C) by failing in certain files that the Department reviewed to provide a health care appeals information packet to members within five business days of the members initiating an appeal.

B. During PEP 4, UHIC violated A.R.S. § 20-2534(B) by failing in certain files that the Department reviewed to inform the member and the member's treating provider of the expedited healthcare appeal decision within one business day.

C. During PEPs 3 and 4, UHIC violated A.R.S. § 20-2535(B) by failing in certain files that the Department reviewed to mail a written acknowledgment to the member within five business days after receiving a request for an informal reconsideration, or failing to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failing to do either.

D. During PEP 4, UHIC violated A.R.S. § 20-2535(D) by failing in certain files that the Department reviewed to mail notice of its informal reconsideration decision to the member within thirty business days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty business days after receiving a request for informal reconsideration or to include the criteria used and the clinical reasons for the decision.

E. During PEPs 3 and 4, UHIC violated A.R.S. § 20-2535(F) by failing in certain files that the Department reviewed to provide the member and the treating provider, when an informal reconsideration resulted in a denial, with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation and a notice of the option to proceed after the formal appeal process to an external independent review.

F. During PEP 4, UHIC violated A.R.S. § 20-2536(B) by failing in certain files that the Department reviewed to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal.

G. During PEP 4, UHIC violated A.R.S. § 20-2536(E)(1) by failing in certain files that the Department reviewed to provide written notice of its adverse decision of formal appeals relating to services not yet provided to the member within thirty business days after receiving the written appeal or failing to include the criteria used and the clinical reasons for the decision with the notice.

H. During PEP 4, UHIC violated A.R.S. § 20-2536(E)(2) by failing in certain files that the Department reviewed to provide written notice of its adverse decision, in formal appeals relating to claims for services that already had been provided to the member, within sixty business days after receiving the written appeal, or to include the criteria used and the clinical reasons for the decision.

I. During PEP 4, UHIC violated A.R.S. § 20-2536(G) by failing in certain files that the Department reviewed to provide the member whose formal appeal

1 was denied, with notice of the option to proceed to an external independent
2 review.
3 J. During PEP 4, UHIC violated A.R.S. § 20-2537(C)(2) by failing in certain
4 files that the Department reviewed to forward requests for external
5 independent review or expedited external independent review to the director
6 within five business days, or by not submitting the required information to
7 the director.
8 III. Provider Timely Pay and Grievances.
9 A. During the Examination Period, UHIC violated A.R.S. § 20-3102(A) in
10 certain files that the Department reviewed by paying no interest or too little
11 interest on clean claims it paid late.
12 B. During the Examination Period, UHIC violated A.R.S. § 20-3102(B) in
13 certain files that the Department reviewed by denying unclean claims before
14 requesting additional information from the provider.
15 C. During the Examination Period, UHIC violated A.R.S. § 20-3102(F) in
16 certain files that the Department reviewed by having a grievance system
17 that failed to:
18 1. Timely resolve provider payment disputes and other grievances.
19 2. Maintain records.
20 3. Include all the information required by law in the records it did
21 maintain.
22 4. Generate semi-annual statutory reports that accurately
23 summarized all records of grievances during the prior six months.
24 IV. Access to Insurers' Records; Insurer Record-Keeping.
25 A. During the course of the Examination , UHIC violated A.R.S. § 20-157(A) by

failing to produce or maintain and make freely accessible certain claims data, its "data dictionary", certain pharmacy benefit records and utilization review denials relating to the Examination.

B. During PEP 4, UHIC violated A.R.S. § 20-157(D) by failing in certain files the Department reviewed to maintain original data for electronic files and records easily accessible to the Department in readable form and obtainable as readable reproduced copies.

ORDER

IT IS HEREBY ORDERED THAT:

1. Health Care Appeals Practices. Within 120 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 1) that provides specific steps UHIC will take by certain dates to assure that by a specified implementation date, UHIC is:

   a. Providing a health care appeals information packet to members within five business days of the members initiating an appeal.

   b. Informing members and the members' treating provider of the expedited healthcare appeal decision within one business day.

   c. Mailing a written acknowledgment to the member and the member's treating provider within five business days after receiving a request for an informal reconsideration.

   d. Mailing notice of its informal reconsideration decision to the member and the member's treating provider within thirty business days after receiving a request for informal reconsideration. The notice is to include the criteria used and the clinical reasons for the decision.

   e. When an informal reconsideration results in a denial, providing the member

1 and the treating provider, with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation and a notice of the option to proceed after the formal appeal process to an external independent review.

f. Mailing a written acknowledgment letter to the member and the member's treating provider within five business days after receiving a formal appeal.

g. In formal appeals relating to services not yet provided, providing written notice of the decision, including the criteria used and the clinical reasons for the decision, to the member within thirty business days after receiving the written appeal.

h. In formal appeals relating to claims for services that already had been provided to the member, providing written notice of the adverse decision, including the criteria used and the clinical reasons for the decision within sixty business days after receiving the written appeal.

i. Providing a member whose formal appeal is denied with notice of the option to proceed to an external independent review.

j. Forwarding requests for external independent review or expedited external independent review, to the director within five business days, with the required information.

2. Provider Timely Pay. Within 120 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 2) that provides specific steps UHIC will take by certain dates to assure that by a specified implementation date, UHIC is:

a. Paying the correct amount of interest on clean claims paid late, including clean claims paid late after receiving additional information.

b. Not denying unclean claims before requesting additional information from the provider.

c. Accurately identifying and handling clean claims it is not obligated to pay (which is independent of the Findings of Fact and Conclusions of law set forth above).

3. Provider Grievances. Within 90 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 3) that provides specific steps UHIC will take by certain dates to assure that by a specified implementation date, UHIC shall establish and maintain a grievance resolution system that without limitation:

a. Timely resolves provider payment disputes and other grievances.

b. Maintains records and includes in the records all the information required by law.

c. Generates semi-annual statutory reports that accurately summarize all records of grievances it received in the six-month period covered by the report.

4. Insurer Record-Keeping (Utilization Review Denials). Within 90 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 4) that provides specific steps UHIC will take by certain dates to assure that by a specified implementation date, UHIC shall maintain copies of its utilization review denials and be able to make copies available to the Department during regular business hours.

5. Insurer Record-Keeping (Original Data). Within 90 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 5) that provides specific steps UHIC will

take by certain dates to assure that by a specified implementation date, UHIC shall keep original data for electronic files or records, including provider grievance files or records, easily accessible to the Department in readable form and obtainable as readable reproduced copies.

6. Insurer Record-Keeping (Company Data). Within 90 days of the filed date of this Order, UHIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 6) that provides specific steps UHIC will take by certain dates to assure that by a specified implementation date, UHIC shall:
   a. Separate records of self-insured or other enrollees whose coverage is not subject to the Department's jurisdiction from the records of insured enrollees whose coverage is subject to the Department's jurisdiction, and
   b. Separate the records of UHIC enrollees from the records of affiliated companies, including without limitation United HealthCare of Arizona, Inc.
7. Progress in Development of CAPs. Until the Director approves each CAP, UHIC shall report to the Director each month on its progress in developing that CAP. Each such monthly report shall include a current draft of that CAP.
8. Corrective Action Plan Requirements. Each CAP described above shall:
   a. Contain enough detail to allow the Director to determine whether the CAP will accomplish its purpose.
   b. Include testing before final implementation of the CAP.
   c. Include Quality Improvement review and follow-up.
   d. Identify one individual responsible and accountable for implementation of the CAP.

e. Provide for UHIC to report to the Director each month regarding implementation of the CAP, in a form that includes documentation and is approved by the Director.

f. Provide that within 10 business days of receiving notice that the Director has approved the CAP, UHIC shall submit to the Director evidence that UHIC has communicated the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memos, bulletins, e-mails, correspondence, procedure manuals, print screens and training materials.

9. UHIC shall pay a civil penalty of $121,250 to the Director for deposit in the State General Fund for violations cited above as Conclusions of Law. UHIC shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report of the Compliance Examination of United HealthCare Insurance Company upon the filing of this order.

DATED at Phoenix, Arizona this 10th day of March 2006.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. UHIC has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. UHIC believes that it is able and prepared to comply fully with the Order, notwithstanding any of its other business and regulatory requirements.
2. UHIC admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact and consents to the entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.
3. UHIC is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. United HealthCare Insurance Company irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.
4. UHIC states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.
5. UHIC acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.

6. Allen J. Sorbo, who holds the office of President and CEO of United HealthCare Insurance Company is authorized to enter into this Order for UHIC and on its behalf.

UNITED HEALTHCARE INSURANCE COMPANY

2/23/06
Date

By
Allen J. Sorbo, President and CEO
United HealthCare Insurance Company

Delet

COPY of the foregoing mailed/delivered
this 10th day of March, 2006 to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Paul J. Hogan
Market Oversight Division Chief
~~Deloris E. Williamson~~ Dean Ehler
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
Alan Griffieth
Chief Financial Examiner
Alexandra Shafer
Assistant Director
Life and Health Division
Terry L. Cooper
Fraud Unit Chief

ARIZONA DEPARTMENT OF INSURANCE
2910 North 44th Street, Suite 210
Phoenix, AZ 85018

United HealthCare Insurance Company
Allen J. Sorbo, President and CEO
3141 North Third Avenue
Phoenix, Arizona 85013

Charles R. Cohen, Esq.
Ridenour, Hienton, Kelhoffer, Lewis & Garth
201 North Central Avenue, Suite 3300
Phoenix, Arizona 85004-1053

Kathy Linder