PRESS RELEASE

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Arizona Department of Insurance Orders United Healthcare to Correct Violations and Pay Fines

Today, Insurance Director, Christina Urias, announced the results of market conduct examinations of United HealthCare of Arizona, Inc. and United HealthCare Insurance Company, ordering United HealthCare of Arizona to pay a civil penalty of $243,250 and United HealthCare Insurance Company to pay a civil penalty of $121,250, for violations of Arizona's insurance laws. The combined fine of $364,750 is the largest the Insurance Department has ever assessed for such unlawful practices and both companies have agreed to take corrective action to prevent future violations.

United HealthCare Insurance Company is the largest group healthcare insurer in Arizona's Preferred Provider Organization ("PPO") and indemnity insurance market. Within that market, the Company insures more small businesses (50 employees or less) than any other group health insurer. United HealthCare of Arizona, Inc. (United's Health Maintenance Organization, or "HMO") is currently the sixth largest HMO in Arizona. (Arizona law refers to an HMO as a Health Care Services Organization).

In particular, the Department found that both companies had violated state laws governing: (a) member appeals of denied services and claims; (b) timely payments to providers; (c) provider grievances; and, (d) record keeping and documentation requirements. In addition, the Department found that United's HMO practices also violated the Department's 2002 Consent Order in which United's HMO had agreed to correct appeals violations found in a prior examination *and* that United's HMO had knowingly repeated some of those same violations, despite the existing Consent Order. The Department also found that United's HMO managed health care plan was not "effective" in certain respects, as required by law, and that United's HMO had improperly denied physician claims for certain services the physicians provided to members in network hospitals.

"These are significant findings in areas that directly affect members and providers," said Director Urias. "I will continue to insist that insurers and HMOs follow the law when it comes to processing member appeals or provider claims and grievances and the Department will monitor these practices in the future."

The Department's authority to regulate the area of provider pay and grievances stems from legislation enacted in 2000 and amended in 2005. The Department's jurisdiction over HMO health plan management began only 6 years ago, in 2000, when the legislature transferred HMO plans and service delivery oversight from the Department of Health Services to the Department of Insurance.

Both United HealthCare companies have adopted corrective action programs to modify their operations in these troubled areas and the Department will monitor their progress closely. "I will not tolerate knowing violations of Consent Orders," Director Urias said. "Our scrutiny will continue as long as necessary after we conclude examinations in order to make sure insurers actually correct any violations we find."

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