STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

United HealthCare Insurance Company
450 Columbus Boulevard
Hartford, CT 06103

NAIC Number: 79413

December 20, 2010

EXAMINATION REPORT PREPARED BY INDEPENDENT CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE

Pursuant to Title 24-A M.R.S.A. § 221, I have caused a Targeted Market Conduct Examination to be conducted of United HealthCare Insurance Company. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

_____ 4/4/2011
Mila Kofman Date
Superintendent of Insurance
Maine Bureau of Insurance

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March 30, 2011

Mila Kofman
Superintendent of Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Superintendent Kofman:

Pursuant to Title 24-A M.R.S.A. § 221(5), a targeted Market Conduct examination (the Examination) of selected focus areas including behavioral health-related complaint handling, appeals, policyholder services, provider network, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

United HealthCare Insurance Company (the Company)

The Company's records were examined at United Behavioral Health (UBH), which is the Company's behavioral health vendor and a subsidiary of United HealthCare Insurance Company. Its offices are located in Philadelphia, Pennsylvania.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of the Examination of United HealthCare Insurance Company is, herewith, respectfully submitted.

_____
RSM McGladrey
Independent Market Conduct Examiner

SECTION I - EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) is conducting a targeted market conduct Examination of the United HealthCare Insurance Company (UHC or the Company) to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those benefits for physical illnesses for a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination includes but is not limited to the following:

1. Test the Company's processes to ensure that the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the insurer's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process, and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with Company representatives were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, workplan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the

Agreement to Purchase Services (the Agreement). Rider A also establishes the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those benefits for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used random samples where appropriate for the areas tested. Also, where applicable and consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted observations regarding the Company's claims handling practices, which are listed below in order of priority:

Finding #1

The Examiners identified five (5) of 130 denied and zero-paid claims which were not paid within 30 days of receipt, representing potential violations of Title 24-A Chapter 27 §2436(1) of the Maine Insurance Rule.

Finding # 2

The Examiners identified two (2) of 130 denied and zero-paid claims, representing failure to adjudicate the claims in accordance with the terms of the policy. Specifically, one claim was paid as authorized for out-of-network, when no authorization was included in the file. Another claim was paid with an incorrect benefit amount of 70%,

which was in conflict with the correct benefit amount of 50%. Finally, two claims were denied in violation of Title 24-A Chapter §2436 (1) as not having authorizations when upon review, it was determined the file contained an open authorization certification.

The details for each of the above referenced findings are discussed in Section V of this Report. Additionally, where applicable, the Examiners have included Additional Observations in each relevant area of the Examination.

SECTION II - SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of the Maine Insurance Rule, Title 24-A M.R.S.A §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act and Bureau of Insurance Rule Chapters 191 and 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

RSM McGladrey Inc. personnel participated in this Examination in their capacity as market conduct examiners. RSM McGladrey Inc. provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III - COMPANY PROFILE

United HealthCare Insurance Company was incorporated in 1972 and received its Certificate of Authority as a life and health insurer from the Connecticut Department of Insurance the same year. Throughout the years, the Company obtained licenses from other jurisdictions eventually becoming licensed in the District of Columbia and all states, except New York. United HealthCare Insurance Company is a subsidiary of Uniamerica, Inc., a subsidiary of United HealthCare Services, Inc., which is a subsidiary of UnitedHealth Group Incorporated (UHG), a publicly traded company.

On December 11, 2006, the Company purchased the Student Insurance Division (SID) from Mega Life and Health Insurance Company. The product provided single school year coverage to individual students at colleges and universities.

UHC is Maine's seventh largest domestic health benefits company serving approximately 2,252 enrollees, or 1% of the fully insured market, during the Period

based on statistics reported by the Bureau in its brochure titled, "*2008 Financial Results for Health Insurance Companies in Maine.*"

United Behavioral Health (UBH), a division of UHG, offers behavioral health benefit management services as well as employee assistance programs.

The UBH provider network includes psychiatrists, psychologists, social workers, psychiatric nurses and other mental health and employee assistance providers. The facility network includes hospital inpatient units, residential treatment centers, partial hospitalization programs and outpatient programs.

SECTION IV - EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed random samples, where applicable, to review and test specific attributes associated with policies that were marketed and sold to state of Maine residents. These populations included large group policies, small group policies with more than 20 covered employees and State of Maine employee plan and city and local governmental plans. Also, where applicable, the samples included groups with 20 or fewer employees for which the policyholders had elected mental health parity. Administrative services business, with the exception of the State of Maine employee plan, was excluded from the sample testing. The Company did not underwrite any individual policies in the state of Maine during the Period. The Examiner's sampling methodology was reviewed and pre approved by the Bureau. The Examiners' testing of each focus area was designed to evaluate whether mental health and substance abuse benefits are at least equal to those for physical illnesses for a person receiving medical treatment for any of the categories of mental illness as defined by Maine Insurance Rule, Title 24-A M.R.S.A §§2843 (5-C) and 4234-A (6) and (7).

The categories of mental illness were identified in the Bureau's Rider A as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM. The categories include the following:

1. Psychotic disorders, including schizophrenia;
2. Dissociative disorders;
3. Mood disorders;
4. Anxiety disorders;
5. Personality disorders;
6. Paraphilias;
7. Attention deficit and disruptive behavior disorders;
8. Pervasive developmental disorders;
9. Tic disorders,
10. Eating disorders, including bulimia and anorexia; and
11. Substance abuse-related disorders

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the Period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.
- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, pre-authorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- The population of denied and zero-paid claim lines, which had a primary, secondary or tertiary behavioral health diagnosis. Zero-paid claims are defined as those matters involving instances where the service is covered, however, co-insurance applies or the member's deductible has not yet been met and therefore no payment was due by the Company.
- The Company's claim manual.

In response to the Examiners requests, the Company provided a population of 345 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above and an additional population of 19 claim lines from the SID. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a random sample of 130 denied and zero-paid claims using a 95% confidence level, from the population of 345. All 19 claim lines from the SID were reviewed. The Examiners' methodology regarding the Company's claim adjudication practices included reviewing sampled claims as well as any prior or subsequent adjudication of the sample claim. The prior or subsequent claims may have included a payment or denial of the sampled claims. The claims were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. The Examiners also reviewed the member's insurance policy for each sampled claim to

determine if mental health coverages and limits were at least equal to the member's medical benefits.

The Examiners also conducted interviews with Company representatives and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of utilization reviews (UR) and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed as well as the disposition of the claim as a result of the UR.
- A listing of all behavioral health-related UR requests that were denied during the Period.
- A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

In response to the Examiners' data requests, the Company provided the requested documentation and a population of only one (1) UR performed. The Examiners reviewed the one (1) UR identified by the Company.

UHC's UR files were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed UHC's mental health UR processes in order to determine if they were equivalent to UHC's UR medical processes.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer. The results are summarized in Section V below.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.
- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider network specialists in the Company and their authorization levels for approving behavioral health-related services.

In response to the Examiners data requests, the Company provided the requested documentation and a population of 26 denied pre-authorization requests. The Examiners reviewed all 26 pre-authorization denials.

UHC's pre-authorization files were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed the UHC's mental health pre-authorization processes in order to determine if the processes were equivalent to UHC's pre-authorization medical processes.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The terms appeals and grievances are used interchangeably throughout this Report. The Examiners also requested the related policies and procedures the Company had in place for the Period. Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the State of Maine.
- A listing of training to educate the specialists on the Company's policies and procedures.
- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.

- The Company's definition of a complaint as applied to complaints relating to residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiners' data request, the Company provided the requested documentation and a listing of only one (1) complaint received during the Period. The Examiners reviewed the one complaint identified by the Company.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Company had no pharmacy complaints for the Period.

The results are summarized in Section V.

Appeals and Grievances

- Written policies and procedures for processing first and second level appeals and grievances for residents of the state of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.
- The Company's definition of appeals and grievances as applied to those received in connection with residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

In response to the Examiners' data requests, the Company provided the requested documentation and a listing of two (2) appeals (including administrative and clinical levels I and II). The Examiners reviewed both appeals.

The Examiners reviewed UHC's mental health appeal procedures and related notices to determine whether they comply with Maine's requirements and whether the Company's procedures and notices for behavioral health appeals are equivalent to medical appeals procedures and notices.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, complaints and appeals relating to claims or requests for authorizations for services denied for medical necessity were reviewed by an independent clinical peer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and state of Maine).
- Written policies and procedures provided to and used by the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges (the Charges).
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.
- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the state of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.
- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners reviewed a random sample of 43 from the 130 denied and zero-paid claim sample and compared the network status on the date of service to the Company listing of providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain UHC functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V - RESULTS OF THE EXAMINATION

The Examination identified nine (9) potential violations of Maine insurance laws involving two sections of the Maine Insurance Rule. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The Examiners tested a sample of 130 denied and zero-paid claims and a population of 19 SID claims. The SID claims were not included with the UHC claim population but rather were provided as a separate file. Consequently, given the limited number of SID claims, the Examiners elected to review these in addition to the sample of 130 denied and zero-paid claims. Testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing. Based on the review of the claim sample, the Examiners determined that during the Period, the Company did not impose any more restrictive filing requirements on providers who filed behavioral health related claims when compared to medical claim submissions.

Testing identified potential violations regarding two (2) Maine statutes. The Maine statutes and the exceptions noted are as follows:

1. Title 24-A Chapter 27 §2436(1) of the Maine Insurance Code, which reads in part:

   "A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof

of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue.

The Company failed to affirm or deny coverage within 30 calendar days in five (5) of the 130 denied and zero-paid claims or 3.8%. The errors are explained below:

There were no errors identified from the review of the SID population of 19 claims.

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A § 2436 (1)	The Company failed to affirm or deny coverage within 30 calendar days.	5	3.8%
TOTAL		**5**	**3.8%**

Note: The Examiners confirmed the Company did pay the appropriate interest on the claims in question.

2. Title 24-A Chapter 23 §2164-D(3) of the Maine Insurance Code, which reads in part:

3. Unfair practices. *Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:*

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; [1997, c . 634, Pt. A, §1 (NEW).]

Two (2) of the 130 denied and zero-paid claims, or 1.6%, involved a potential violation of Chapter 27 2436 (1) and two (2) claims were incorrectly processed in accordance with the terms of their policy. The Examiners' review revealed four (2) instances where the Company failed to process a claim correctly. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Policy Terms	A claim was not authorized by the Company for out-of-network services but was subsequently paid incorrectly as an authorized service. The claim was adjusted and reprocessed correctly on May 4, 2010.	1	.8%
Policy Terms	A claim was processed with an incorrect benefit amount of 70%. Per the contract, the correct benefit amount was 50%. As a result the Company made an overpayment of $29. The Company's procedures related to overpayments note in part that they will not pursue overpayments of amounts less than $40. Consequently, the $29. Overpayment was not pursued or recovered.	1	.8%
Title 24-A, §2436(1)	Two claims were incorrectly denied based on not having authorizations. However, it was determined that there were open authorizations certifications at the time the claim was processed. One claim was reprocessed on May 4, 2010 with a payment of $23.12 ($20.00 claim payment and $3.12 interest.) The other claim was reprocessed on May 4, 2010 and the allowable amount was applied to the in-network deductible.	2	1.6%
TOTAL		**4**	**3.2%**

Please note that there were no errors identified from the review of the SID population of 19 claims.

Utilization Review and Pre-Authorization

Utilization Review

The testing of the population of one UR claim that was denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing of UR requests. Based upon the results of the Examiners' testing of the sample UR population, it was determined that UHC's UR processes for managing mental health benefits were equivalent to the Company's UR processes for managing medical benefits. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that UR denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified one (1) UR file that was denied by the Company due to not meeting the medical necessity criteria as defined by the Company. Further, the claims were not overturned through the Company's appeal process. The complete files as provided by the Company were reviewed and referred for peer-to-peer review. No exceptions were noted.

Pre-Authorization

The testing of all 26 Pre-Authorization requests that were denied included assessing the Company's compliance with applicable Maine statutes in processing such requests, and testing the Company's policies and procedures. Based upon the results of the Examiners' testing of the sample pre-authorization population, it was determined that UHC's pre-authorization processes for managing mental health benefits were equivalent to the Company's pre-authorization processes for managing medical benefits. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified one (1) Pre-Authorization that was denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete file provided by the Company was reviewed and referred for peer-to-peer review. The Independent Peer Reviewer agreed with the Company's decision.

Complaints, Appeals and Grievance Handling

Complaints

The testing of one (1) complaint included assessing the Company's compliance with applicable Maine statutes and testing the Company's complaint handling procedures. No exceptions were noted.

Pharmacy Complaints

The Company did not have any pharmacy complaints.

Appeals

The testing of both appeals included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures. UHC's appeal process for mental health claim denials was determined to be equivalent to the UHC's appeal process for medical claim denial appeals. Based upon the results of the Examiner's review of the Company's processes no exceptions were noted.

Additional Observations

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified one (1) appeal that was upheld by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's further appeal rights. The complete file provided by the Company was reviewed and then referred for peer-to-peer review. The Independent Peer Reviewer agreed with the Company's decision.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine Statutes. The Company had separate policies, procedures and training on how to respond to behavioral health inquiries. No exceptions were noted.

Provider Network

The accuracy of a provider's network status on the date of service was tested through a review of 43 of the 130 denied and zero paid claim files. No exceptions were noted.

ADDENDUM - COMPANY'S RESPONSE

Addendum

United HealthCare

December 2, 2010

Via Email & U.S. Mail

Superintendent Mila Kofman
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 0433-0034

Re: United HealthCare Insurance Company - United Behavioral Health

Dear Superintendent Kofman:

This is in response to the draft Market Conduct Examination Report issued by RSM McGladrey, Inc. on behalf of the Bureau of Insurance concerning compliance with Maine's mental health parity law and related laws.

We appreciate the opportunity to review the Report and to recommend changes to it pursuant to 24-A M.R.S.A. § 226. RSM McGladrey identified (2) findings. United HealthCare Insurance Company recommends the following changes as described below.

Finding # 1

The Examiners identified five (5) of 130 denied and zero-paid claims which was not paid within 30 days of receipt, representing a potential violation of Title 24-A Chapter 27 §2436(1) of the Maine Insurance Rule.

Finding # 1: Recommended Change

United HealthCare Insurance Company respectfully recommends that the above finding be revised to indicate that there was no violations of Maine's prompt payment law, 24-A M.R.S.A. § 2436, notwithstanding the late payment of claims because statutory interest was paid on each claim. *(Specifically there is a note on page 20 in the draft report indicating "The Examiners confirmed the Company did pay the appropriate interest on the claims in question".)*

While the examiners correctly noted that claims must be processed within 30 days, Maine's prompt payment law also contemplates situations where claims are not paid within such a time period and imposes a resulting obligation to pay interest. United

HealthCare Insurance Company contends that through the payment of interest on claims, a carrier ultimately meets the requirements of the law.

More specifically, the initial requirement to process claims within 30 days cannot be separated from the subsequent requirement to pay interest on late claims when considering compliance with the prompt payment law. The statute recognizes that there may be situations where a claim is not paid within 30 days and provides an internal remedy for such circumstances - an interest penalty. If a carrier was late in paying a claim and also failed to pay the statutorily mandated interest, there would then be a violation of the law.

United Healthcare Insurance Company respectfully requests that the finding be revised to indicate that while there were five (5) late payments of claims, there was no violation of the law by virtue of the payment of the statutory interest.

Finding #2

The Examiners identified four (4) of 130 denied and zero-paid claims, representing potential violations of Title 24-A Chapter 23 §2164-D(3) of the Maine Insurance Rule concerning Unfair Claims Practices. Specifically, one claim was paid as authorized for out-of-network, when no authorization was included in the file. Another claim was paid with an incorrect benefit amount of 70%, which was in conflict with the correct benefit amount of 50%. Finally, two claims were denied as not having authorizations when upon review, it was determined the file contained an open authorization certification.

Finding #2: Recommended Change

United Healthcare Insurance Company respectfully recommends that the above finding be revised to indicate that there was no violation of Maine's unfair claims practices law, 24-A M.R.S.A. 2164-D (3).

As the examiners have noted, there were four (4) claims processed incorrectly out of the sample population. The four (4) claims were processed incorrectly due to human error.

Under the law, there must be a violation of both subsections 2 and 3. Subsection 2 states that an insurer has committed an unfair claims practice if the act listed in subsection 3 has been committed either in conscious disregard of the statute and any rules under the statute or has been committed with such frequency to indicate a general business practice to engage in that type of practice. Subsection 3 enumerates several unfair claims practices, such as committing knowing misrepresentations or refusing to pay claims without a reasonable investigation.

Based on the facts outlined above, there was neither a conscious disregard of the law nor a frequency of conduct that would indicate a "general business practice." The isolated nature of these claims mistakes is manifested by the error percentage rate of

3.1% of the overall total claims sample. These actions occurred as a result of inadvertent errors.

United Healthcare Insurance Company respectfully requests that the finding be revised to indicate that the four (4) claims were processed incorrectly; however, there was no violation of Maine's unfair claims practices law.

In summary, United Healthcare Insurance Company appreciates the opportunity to provide recommendations. Please do not hesitate to contact me with any questions or comments regarding this response.

Respectfully Submitted,

Valerie K. Brown
Director, Market Conduct Exams and Assessments

Cc: Barry L. Wells, CCLA, MCM
Joseph Stangl
Daniel Silverstein