

# **OHIO DEPARTMENT OF INSURANCE**

**A**

**TARGETED**

**MARKET CONDUCT EXAMINATION**

**OF**

**UNITED HEALTHCARE INSURANCE COMPANY OF OHIO**

**NAIC #73518**

**As Of**

**December 31, 2001**





**Bob Taft, Governor**

**Ann Womer Benjamin, Director**

2100 Stella Court, Columbus, OH 43215-1067

(614) 644-2658

www.ohioinsurance.gov

Honorable Ann Womer Benjamin  
Director  
Ohio Department of Insurance  
2100 Stella Court  
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare Insurance Company of Ohio

NAIC Company Code 73518

The examination was conducted at the Company's Uniprise Regional Claims Processing Center located at:

4316 Rice Lake Road, Duluth, Minnesota 55811

A report of the examination is enclosed.

Respectfully submitted,

A handwritten signature in black ink that reads "David R. Beck".

David R. Beck

Chief, Market Conduct Division

Date:

A handwritten date in black ink that reads "April 5 2004".



Accredited by the National Association of Insurance Commissioners (NAIC)

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## **SCOPE OF EXAMINATION**

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (the Department).

The purpose of the examination was to determine whether United HealthCare Insurance Company of Ohio, (the Company) had implemented modifications to the Company's health claim practices as ordered April 12, 2001, by the Superintendent.

## **METHODOLOGY**

The Department asked the Company to provide a comprehensive list of health care claims that were closed (paid or denied) between October 1, 2001 and December 31, 2001. The Department pulled a random sample of 100 claims for each month from this population. Claims from capitated providers, self-funded plans, workers compensation, and Medicare, Medicare+Choice, Medicare Supplement and Medicaid claims were excluded.

A series of tests were designed and applied to the sample to determine the Company's level of compliance with Ohio insurance statutes and regulations. The Examiners used the following rules when testing for compliance:

1. The definitions in § 3901.38 (A) ORC were used in constructing and applying all standards and tests. All terms defined in this Section appear in this report in quotes.
2. If the Company's records showed no additional information was needed to "complete" the claim, the date the claim was received was used as the "completed claim" date.

3. If the Company's records showed additional information was needed, and when it was received the claim was not a "completed claim," the date any additional information was received was used as the "completed claim" date.
4. If the Company's records showed additional information was needed from more than one source, the date the last piece of additional information was received was used as the "completed claim" date.
5. The date on which the Company issued a check or draft in payment or advised the provider of the claim denial was used as the date the Company "accepted or rejected" (paid or denied) the claim.
6. Standard business database software was used to calculate the number of days between (1) the date a claim was received and the date any additional information was requested; and (2) the date the claim was complete and the date it was "accepted or rejected" (paid or denied).
7. All calculations were based upon "days" as defined in § 3901-1-60 (C) (9) OAC.
8. An exception was any instance where (1) the number of days to request any additional information exceeded 21 "days" (2) the number of days to "accept or reject" a "completed claim" exceeded 24 "days" (or any applicable contracted time period) or (3) the Company's claim files contained insufficient documentation to test for compliance.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or

- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

### TIMELY INVESTIGATION OF HEALTH CARE CLAIMS

*Standard:* Should a third-party payer determine that additional information is needed to enable it to accept or reject the claim, that information must be requested within twenty-one (21) days of receiving a claim.

*Test:* Did the Company's claim investigation practices conform to § 3901-1-60 (E) (1) OAC ?

*Findings:*

Population	Sample	Yes	No	Standard	Findings
92,609	300	300	0	93%	100%

The standard of compliance is 93%. The Company's claim investigation practices appear to meet acceptable standards.

### TIMELY SETTLEMENT OF HEALTH CARE CLAIMS

*Standard:* A third-party payer shall either deny the claim or tender payment of any amount not in dispute within twenty-four (24) days (or any applicable contracted time period) of receiving a "completed claim."

*Test:* Did the Company's claim settlement practices conform to § 3901.38 (B) (1) of the ORC and § 3901-1-60 (E) (2) OAC?

*Findings:*

Population	Sample	Yes	No	Standard	Findings
92,609	300	275	25	93%	91%

The standard of compliance is 93%. The Company's claim settlement practices do not appear to meet acceptable standards.

### CLAIM FILE DOCUMENTATION

*Standard:* Every third party payer shall maintain claim files with sufficiently detailed documentation to permit reconstruction of the payer's claim settlement activities.

*Test:* Do the Company's claim records conform to §3901-1-60 (H) (2) OAC?

*Findings:*

Population	Sample	Yes	No	Standard	Findings
92,609	300	298	2	93%	99%

The standard of compliance is 93%. The Company's claim file documentation practices appear to meet acceptable standards.

*Examiners' Comments:* The Examiners took exception in two instances where the Company's claim records reflected a "paid" date prior to the "posted" date of the claim. When a claim is "posted" within the Company's claims payment system, the adjudication process has been completed and the claim is released for payment or denial. The "paid date", as defined by the Company, is the date the check physically leaves the Company via U.S. Mail and sent to the provider. Although the Company found this illogical progression of dates to be somewhat suspect as well, a clear explanation was not provided. The Company did surmise that their "payment cycles" (process of issuing batch payments and printing checks) periodically last for more than 24 hours, and that the illogical date progression *may* have resulted from this lengthy process.

**SUMMARY**

The Company's performance in the targeted compliance areas does not appear to meet acceptable standards.

Rodney E. Beetch  
Rodney Beetch  
Examiner in Charge

4-5-04  
Date



UnitedHealthcare  
9200 Worthington Road Westerville, Ohio 43082  
Tel 614 410 7000 Fax 614 410 1011

November 22, 2002

RECEIVED

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OHIO DEPT. OF INSURANCE  
MARKET CONDUCT DIVISION

Mr. David R. Beck  
Chief, Market Conduct Division  
Ohio Department of Insurance  
2100 Stella Court  
Columbus, Ohio 43215-1067

RE: UnitedHealthcare Insurance Company of Ohio  
NAIC Company Code 73518  
Target Market Conduct Examination Report

Dear Mr. Beck:

Thank you for giving us the opportunity to comment on the results of the market conduct examination. It is UnitedHealthcare's policy to pay claims within the timeframe required by state law. As we discussed with you, we agree that we did not meet the claims payment standard for some of the claims in the sample.

Although we recognize the new 30-day standard does not apply to the time period reviewed, the results of the sample would have exceeded 94%, as there were 8 of the 25 exceptions that were paid in less than 30 days, but greater than 24 days. Under current requirements, we would have met the acceptable standard. We will continue to evaluate our current policies and procedures to ensure that our claim settlement practices allow us to pay claims within the timeframe allowed by Ohio law.

Again, thank you for giving us the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Brett Baby".

Brett Baby  
President  
UnitedHealthcare Insurance Company of Ohio