Market Conduct Report

Oxford Health Insurance, Inc.
Oxford HealthPlans (CT), Inc.
UnitedHealthcare Insurance Company

July 30, 2020

Connecticut Insurance Department

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I. INTRODUCTION

Oxford Health Insurance, Inc., Oxford Health Plans (CT), Inc., and UnitedHealthcare Insurance Company (hereinafter collectively referred to as the "Companies") have their home offices in New York, New York, Shelton, Connecticut and Hartford, Connecticut. By authority granted under §38a-15 of the Connecticut General Statutes, this examination was conducted by Market Conduct examiners of the State of Connecticut Insurance Department at the Companies' offices in Hartford, Connecticut.

II. SCOPE OF EXAMINATION

From September 4, 2018 through January 28, 2020, the Market Conduct Division of the Connecticut Insurance Department examined the market conduct practices of Oxford Health Insurance, Inc., Oxford Health Plans (CT), Inc. and UnitedHealthcare Insurance Company using a sample period of January 1, 2015 through December 31, 2017. The examination was limited to Connecticut business.

The purpose of the examination was to evaluate the Companies' market conduct practices and treatment of policyholders in the State of Connecticut. The examination focused on the solicitation of new business, marketing and sales, agent licensing and appointment, underwriting and rating, policyholder service, complaint handling, network adequacy, provider credentialing, claim processing and company operations.

The Market Conduct examination was conducted pursuant to Connecticut Insurance Department policies and procedures, and the standards proposed in the NAIC Market Regulation Handbook.

III. COMPANY PROFILE

The Companies are wholly owned subsidiaries of UnitedHealth Group Incorporated (UHG), the ultimate Parent Company. Oxford Health Plans (CT), Inc. is domiciled in the State of Connecticut and commenced business on October 1, 1993; Oxford Health Insurance, Inc., is domiciled in the State of New York and commenced business on July 1, 1987; UnitedHealthcare Insurance Company is domiciled in the State of Connecticut and commenced business on December 10, 1974. Oxford Health Plans (CT), Inc. is licensed in Connecticut as a health care center, Oxford Health Insurance, Inc. is licensed in Connecticut to write accident and health

insurance, and UnitedHealthcare Insurance Company is licensed to write life, accident and health insurance in Connecticut.

Direct premiums written as of December 31, 2017 were as follows:

Oxford Health Insurance, Inc.

	Connecticut	Total (All States)
Accident & Health	275,706,160	7,273,910,502

Oxford Health Plans (CT), Inc.

	Connecticut	Total (All States)
Accident & Health	28,284,988	28,284,988

UnitedHealthCare Insurance Company

	Connecticut	Total (All States)
Life	2,577,904	126,599,822
Accident & Health	704,310,069	49,617,903,198

IV. MARKET CONDUCT REPORTS

The examiners reviewed copies of all market conduct examination reports that had been issued to the Companies by other state insurance departments during the examination period. The reports were reviewed to ensure that corrective actions were taken regarding all recommendations made by the respective Insurance Departments.

V. AGENCY ORGANIZATION

The Companies market new business through the offices of independent agents as well as direct sales staff.

The Companies maintain ongoing training programs for their agents. The Companies supply new agents with a product portfolio, which provides detailed descriptions of products and coverages. Changes in coverage are mandated by statute or the Companies' policies and are communicated through written notices as they occur. In addition, the Companies host periodic training seminars for agents.

VI. RECORDS SELECTED FOR REVIEW

The Companies supplied a listing of all individual and group health new business produced, terminations, declinations, complaints/appeals, and claims denied during the period under review. The examiners selected a random sample of files using a sampling methodology described in the NAIC Market Regulation Handbook. A sample of nine hundred two (902) new business contracts, terminations and declinations and seven hundred seventy-two (772) claims were selected for review.

The new health business files were reviewed to evaluate the solicitation and sales practices of producers and agents. In general, applications were examined for completeness, appropriate signatures and dates of application. The application process was reviewed to assure that medical underwriting was applied equitably and to verify that adverse selection had not occurred.

In addition, the producer licensing history and the application date for each policy in the samples were noted in order to identify any individuals or organizations that were not licensed or appointed at the time of sale. The licensing and appointment review is described in more detail in Section VII. Producer Licensing and Appointment.

VII. PRODUCER LICENSING AND APPOINTMENT

The lists of the new business written during the sample period, identifying the producer for each policy, were compared to the Department's licensing records to determine whether each producer was licensed in the State of Connecticut and whether each agent was appointed by the Companies.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Companies' records of licensed and appointed producers agree with Insurance Department's records.

Standard 2: Producers are properly licensed and appointed in the jurisdiction where the application was taken.

The following information was noted in conjunction with the review of these standards:

- The Companies maintain an automated producer database that interfaces with new group health business processing, policy maintenance and producer compensation.

- The Companies perform due diligence procedures on individuals prior to contracting with them.

- The Companies' appointment procedures are designed to comply with the Department's requirements, which mandate that an agent must be appointed within 15 days from the date that the Company receives the application.

Findings:

Comparisons were made between the Companies' records of licensed and appointed producers and the Insurance Department's records. No exceptions were noted.

Standard 3: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

The Companies have procedures to provide notification of termination to the Department.

Findings:

The examiners reviewed the Companies' termination lists and verified that no producers were terminated for cause during the examination period.

Standard 4: The Companies' policies of producer appointments and terminations do not result in unfair discrimination against policyholders.

Findings:

The examiners noted no evidence of unfair discrimination against policyholders as a result of producer appointments and terminations.

Standard 5: Records of terminated producers adequately document reasons for terminations.

The examiners reviewed the Companies' terminated producer files to ensure that records are documented sufficiently.

Findings:

The examiners verified the listing of terminated agents and reviewed the reasons for termination for each agent.

VIII. UNDERWRITING AND RATING

The new group health business underwriting files were reviewed to determine the use and accuracy of rating methodology, accuracy of issuance, consistent (non-discriminatory) practices and use of proper forms. The Companies' policies, forms and rates were reviewed for proper filing with the Insurance Department and compliance with applicable statutes and regulations.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The rates charged for the policy coverages are in accordance with filed rates, if applicable, or the Companies' rating plans.

The following information was noted in conjunction with the review of this standard:

- Rates are systematically computed based on applicant information and rating classification assigned.
- The Companies have written underwriting policies and procedures.
- The Companies provided copies of Department approved rates for the new group health business submissions reviewed during the examination period.

Findings:

The examiners reviewed four (4) small group rating files and no exceptions were noted.

Standard 2: The Companies do not permit illegal rebating, commission cutting or inducements.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures to pay producers' commissions in accordance with Companies' approved written contracts.

Findings:

The examiners reviewed the Companies' policies and procedures and verified that controls are in place to monitor and prevent illegal rebating, commission cutting and inducements.

Standard 3: All forms, including contracts, riders, endorsement forms and certificates, are filed with the Insurance Department, if applicable.

The following information was noted in conjunction with the review of this standard:

- The Companies have compliance policies and procedures in place to review and track all forms, rates, contract riders and endorsements.

- The Companies have a process to log and document Department approved forms, rates, contract riders, endorsements and content of summary of benefits and coverage (SBC) in accordance with Connecticut requirements.

Findings:

The examiners reviewed the Companies' policy forms through a review of the new group health business files and no exceptions were noted.

Standard 4: The Companies' underwriting practices are not to be unfairly discriminatory. The Companies adhere to applicable statutes, rules and regulations and Companies' guidelines in selection of risks.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies and procedures prohibit unfair discrimination.

- Written underwriting guidelines are designed to reasonably assure consistency in rating of policies.

- The Companies have policies and procedures in place for the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials, dependent coverage for individuals to age 26, lifetime/annual limits on the dollar amounts of essential health benefits and PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.

- The Companies have established policies and procedures to ensure compliance with restrictions on establishing lifetime/annual limits on the dollar amounts of essential health benefits for any individual.

- The Companies have established policies and procedures regarding compliance with PPACA-related restrictions on the assessment of cost-sharing upon insured's for preventative items and services.

Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

Standard 5: File documentation adequately supports decisions made.

Findings:

See Section VIII. Underwriting and Rating, Additional Concerns.

Standard 6: Policies and endorsements are issued or renewed accurately, timely and completely.

The examiners reviewed the sample new group health business and renewal files to ensure that the Companies' underwriting policies and procedures were consistently applied for each sample file reviewed.

Findings:

The Companies' practices for the issuance of policies and endorsements had no exceptions noted.

Standard 7: Applications rejected and not issued are not found to be discriminatory.

The Companies' underwriting policies and procedures prohibit unfair discrimination.

Findings:

No exceptions were noted.

Standard 8: Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

The Companies have procedures in place for the issuance of cancellation and renewal notices.

Findings:

The examiners selected one hundred eighty (180) cancellation files for review. The examiners reviewed the sample files selected and no exceptions were noted.

Standard 9: Pertinent information on applications that form a part of the policies is complete and accurate.

Findings:

The examiners reviewed the Companies' sample new health business files, and no exceptions were noted.

Standard 10: Companies comply with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

The examiners reviewed the Companies' procedures for providing information pertaining to continuation of benefits, for processing applications and for notification to policyholders of the beginning and termination of benefit periods and premium notices.

Findings:

The examiners reviewed the Companies' underwriting procedures and sample new business files and no exceptions were noted.

Standard 11: The Companies comply with the provisions of HIPAA regarding limits on the use of pre-existing exclusions.

The Examiners reviewed the Companies' policies and procedures for provisions related to applicants/proposed insured under the age of 19 to verify that coverage is not denied based on a pre-existing condition.

Findings:

The Companies' pre-existing conditions were found to be in compliance with the requirements of HIPAA and Connecticut statutes and regulations, and no exceptions noted.

Standard 12: The Companies issue coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of 1 to 50.

The Examiners reviewed the Companies' policies and procedures regarding guaranteed availability and renewability of individual and small group health insurance coverage in accordance with statutes and regulations.

Findings:

The Companies' small group business appears to comply with Connecticut requirements.

Standard 13: The Companies refer eligible individuals entitled to portability under the provisions to HRA.

Findings:

The examiners verified that the Companies have procedures in place for individuals eligible for HRA. No exceptions were found for the small group new health business sample files reviewed.

Additional Concerns:

The examiners noted, through a review of the new business sample files, where the Company was unable to provide one (1) UnitedHealthcare new business file for regulatory review, out of three hundred seventy four (374), UnitedHealthcare new business files produced for the examination. The Department is concerned that the Companies could not provide documentation for regulatory review.

In Summary:

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

IX. POLICYHOLDER SERVICE

New business, underwriting files and policy transactions were reviewed for accuracy and timeliness of handling.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Premium notices and billing notices are sent out with an adequate amount of advance notice.

The following information was noted in conjunction with the review of this standard:

- Verification that billing notices are generated automatically based on contract renewal dates and payment cycles.
- If premiums are not received, as required, an overdue premium notice is mailed, noting that non-payment will cause the policy to lapse.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Standard 2: Policy issuance and insured requested cancellations are timely.

The following information was noted in conjunction with the review of this standard:

- When the policyholder requests cancellation, the cancellation is processed and any premium due is provided to the policyholder.
- The Companies provide written notice to the policyholders when a policy cancels.

Findings:

The examiners verified that the Companies have procedures in place to process policyholder requested cancellations and Company cancellations, and that such transactions appear to be processed timely in compliance with statutory requirements.

Standard 3: All communication directed to the Companies is answered in a timely and responsive manner by the appropriate department.

The following information was noted in conjunction with the review of this standard:

- The Companies have a customer call center to respond to policyholder and member concerns.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted. It is recommended that policyholder call center policies and procedures be reviewed to ensure that all member and provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

Standard 4: Reinstatement is applied consistently and in accordance with policy provisions.

The Companies have standardized reinstatement guidelines in place to ensure that requests are reviewed and either approved or denied by underwriting.

Findings:

The examiners reviewed the Companies' policies and procedures and sample underwriting files. No exceptions were noted.

Standard 5: Policy transactions are processed accurately and completely.

The Companies have policies and procedures in place for processing policyholder transactions including conversions, plan changes and enrollment updates.

Findings:

The examiners reviewed the Companies' policies and procedures and sampling of new business files. No exceptions were noted.

Standard 6: Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

The Companies have policies and procedures in place for tracking and issuing evidence of creditable coverage.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

X. MARKETING AND SALES

The Companies provided samples of all marketing and sales materials used in Connecticut during the period under examination. The marketing and sales materials were analyzed to identify any pieces that had a tendency to mislead or misrepresent any aspect of the Companies' products or benefits to policyholders. In addition, the marketing and sales materials were reviewed to verify compliance with statutes and regulations related to the disclosure of certain information regarding the Companies' identity, financial standing and organization.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the advertising and sales material process.
- All advertising and sales materials are reviewed in a consistent format through an online submission and tracking process.
- All advertising and producer generated material is subject to compliance review.
- Prior to final approval, all advertising and sales materials are reviewed to ensure that any necessary changes identified during the initial review were made.
- Approved submissions are endorsed for use for a specific period, which is incorporated into the approval number on the piece.

Findings:

The companies were found to be in compliance.

Standard 2: The Companies' internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Companies have developed training programs for their producers.

Findings:

The examiners reviewed the Companies' training programs and established policies and procedures. The Companies' internal producer training materials appear to be adequate and in compliance.

Standard 3: The Companies' communications to producers are in compliance with applicable statutes, rules and regulations.

The Companies maintain an extensive on-going training program. Written policies and procedures govern that all communications are reviewed and approved by the Companies' compliance units.

Findings:

The examiners verified that the Companies have communication procedures in place for all producers.

Standard 4: Outline of coverage is in compliance with applicable statutes, rules and regulations.

Findings:

The examiners reviewed the Companies' outlines of coverage and no exceptions were noted.

XI. COMPLAINTS

The examiners reviewed a sample of ninety-four (94) Department complaint files and three hundred forty-five (345) sample Non-Department Complaints, Grievances and Appeal files during the examination period. Included in our review were grievances and appeals involving mental health and substance abuse disorders.

See concerns identified through a review of complaints and appeals in Section XII. Claims.

Department Complaint Handling

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All complaints or grievances are recorded in the required format on the Companies' complaint registers.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the complaint handling process.
- All complaints are recorded in a consistent format in the complaint log.
- An automated tracking database is used to record and maintain complaint information.

Findings:

- The examiners verified the Companies' complaint logs for the examination period. No exceptions were noted.

Standard 2: The Companies have adequate complaint handling procedures in place and communicate such procedures to policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' Plan Descriptions have been reviewed and approved by the Department's Life and Health Division.
- The complaint handling procedures are included in the Plan Descriptions.

Findings:

The examiners verified that the Companies' Plan Descriptions include all complaint handling procedures as required by statute.

Standard 3: The Companies should take adequate steps to finalize and dispose of Department complaints in accordance with applicable statutes, rules and regulations and contract language.

Findings:

- The examiners noted during a review of the UnitedHealthcare Insurance Company Insurance Department Complaints, one (1) instance out of forty-three (43) cases reviewed where the Company incorrectly ended dependent coverage prior to the end of the policy year when the dependent turned 26. The Department is concerned that the Company provided notification which tended to be misleading and insufficient for covered members. In addition, see concerns identified through a review of complaints and appeals in Section XII. Claims.

Non-Department Complaints (Grievance/Appeal/Concerns)

The Companies have established the following complaint and appeal policies that are available to members and providers as outlined in the Plan Descriptions:

A. Inquiry/Complaint

A member or provider may contact the Companies' member relations to question problems or concerns.

B. Grievance

A complainant, who has not been satisfied at the inquiry/complaint level, may request a review of the previous decision. A complainant has one hundred eighty (180) days. Notification of the decision must occur within thirty (30) days of receipt of the grievance by the Companies.

C. Appeal

A complainant has sixty (60) days from receipt of notification of the Grievance decision to appeal. Appeals are acknowledged within three (3) business days of receipt. The member will be notified of the Committee's decision within twenty business (20) days.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 4: The time frame within which the Companies respond to complaints, grievances and appeals is in accordance with applicable statutes, rules and regulations.

Findings:

The examiners verified that the Companies responded to complaints, grievances and appeals in a timely manner.

Standard 5: The health carriers document complaints, grievances and appeals and establish and maintain grievance/appeal procedures in compliance with statutes, rules and regulations.

Findings:

The examiners verified that the Companies' complaint, appeal and grievance logs for the examination period were complete and found no exceptions.

Standard 6: The health carriers file, with the Commissioner, a copy of their complaints, grievances and appeals, including all forms.

Findings:

The examiners verified that the plan descriptions filed with the Department appear to be in compliance.

Additional Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

In Summary:

It is recommended that the Companies review their complaint, grievance and appeal policies and procedures to ensure they are investigated and resolved pursuant to required complaint and claim handling procedures.

XII. CLAIMS

The Companies provided a listing of all claims submitted during the period under examination. The review consisted of a sampling of seven hundred seventy-two (772) denied claims. The files were reviewed to determine the accuracy and timeliness of claim and interest payments.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The initial contact by the Companies with the claimant is within the required time frame and claims are settled in a timely manner.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the claim handling process.
- All claim notifications are logged into the claim system.
- Claim management monitors claim accuracy and timeliness.

Findings:

Pursuant to §38a-816(15) of the Connecticut General Statutes, the Companies are required to pay clean claims within twenty (20) days for claims filed electronically and sixty (60) days for claims filed in paper format. The Department requested that the Companies provide a listing of all clean claims paid in excess of twenty (20) and sixty (60) days for the examination period. The examiners found eight hundred eighty-six (886)) claims that were not paid within twenty (20) and sixty (60) days, and failed to include interest.

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated and resolved pursuant to required claim settlement practices.

Standard 2: Claim files are adequately documented.

The following information was noted in conjunction with the review of this standard:

- copy of the HCFA form or electronic proof of loss
- applicable clinical/other investigative correspondence
- written communication, telephone or other communication
- proof of payment

Findings:

See additional concerns identified through a review of claims in Section XII. Claims.

Standard 3: The Companies have appropriate policies in place for the archival and disposal of claim forms.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found.

Standard 4: The Companies' claim forms are appropriate for the type of product.

Findings:

The examiners noted that the claim forms were appropriate and in accordance with the Companies' policies and procedures.

Standard 5: Canceled benefit checks and drafts reflect appropriate claim handling practices.

The following information was noted in conjunction with the review of this standard:

- Claim procedures were verified to ensure that the check/draft claim process was handled accurately and was appropriate.

Findings:

The examiners verified that processes were in place and no exceptions were noted.

Standard 6: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

The following information was noted in conjunction with the review of this standard:

- All litigated claims were reviewed for the examination period.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found. Specific claim errors are identified below.

Standard 7: The group health plan complies with the requirements of Federal and State law for Mental Health Parity, (including PPACA and HIPAA).

The following information was noted in conjunction with the review of this standard:

- A review of the Companies' responses to the Mental Health Parity Annual Compliance Survey for the period under review.
- A review of the Companies' responses to Consumer Report Cards on Health Insurance Carriers in Connecticut for the period under review.
- A review of the Companies MCAS (Market Conduct Annual Statement) Health Data submission to I-Site for 2017 and 2018.

Findings:

The examiners reviewed the Companies' Mental Health Parity Annual Compliance Survey, which included the Companies' responses to the analysis and testing for any cost share features, penalties and benefit limitations and classifications (inpatient in and out-of-network, outpatient in and out-of-network, emergency and prescription drugs) that apply to mental health and substance abuse disorders vs. medical/surgical conditions. In addition, the examiners reviewed the Companies' responses in the Survey regarding non-quantitative treatment limitations (medical management, prior authorization and step therapy). Also, the examiners reviewed the Companies MCAS Health Data submissions. Finally, the examiners also reviewed the Companies' response to the Consumer Report Card on Health Insurance Carriers in Connecticut, for the period under review.

The Department findings and areas of concern are noted below.

- The examiners noted, through a review of the 2017 Consumer Report Card submission, that several areas with regards to the Mental Health Utilization requests noted significant increase from the prior year's Report Card. The Company indicated that the utilization review data was not accurately being reported, for Oxford Health Insurance, Inc., Oxford Health Plans (CT), Inc. and UnitedHealthcare Insurance Company. In particular, it was noted that all utilization review data should be reported regardless of who performs the review, including all delegated entities. The Company did contact the Department and submit the correct data for the 2018 Consumer Report Card, however, the Department is concerned that incomplete utilization review data was submitted to the Department for several years, including the period under review.

- In addition, the examiners noted through a review of the total claim data submitted for the 2018 Consumer Report Card for Oxford Health Plans (CT), Inc. and Oxford Health Insurance, Inc., that the Companies submitted incomplete claim data for the Consumer Report Card, in the following areas, total claims received, total claims denied and total claims approved. The Department is concerned that the Companies submitted incomplete information for regulatory review.

- The examiners noted, through a review of the 2017 Consumer Report Card, that Oxford Health Plans (CT), Inc., Oxford Health Insurance, Inc. and UnitedHealthcare Insurance Company, reported zero (0) or very few external appeals for the past 2 years, when in fact the number of external appeals that the Department recorded appears somewhat higher. A review by the Companies indicated that the external appeals numbers reported to the Department were in error, as they did not include external appeal information from all appropriate data owners. The Department is concerned that that the Companies did not provide complete information on the Consumer Report Card.

- The Department acknowledges that 2017 data reportable in 2018 was the first year for the health MCAS and that reportable data elements for the second year health MCAS increased substantially. However the examiners noted, through a review of the 2017 and 2018 MCAS Health Data submissions by UnitedHealthcare Insurance Company, significant differences in several of the ratios from 2017 to 2018 data years, including claim denial data, adverse determination overturns, and final adverse determinations overturned upon request for external review. Based on its review, the Department is concerned that the Company did not provide complete information on the 2017 MCAS Data submission. The Department acknowledges that the Companies have made revisions to their MCAS data reporting submissions, to more accurately and completely report required data, commencing with the 2018 Reporting Period,

Specific claim errors are identified below.

Additional Concerns:

In addition to the standards reviewed in this section, the examiners have the following concerns:

- The examiners noted, through a review of UnitedHealthcare Insurance Company denied claims, there were many instances where the Company is using a denial code, (G1), when asking for additional information, as a result, claims are being reported as denied claims even when the additional information is received and the claim is paid. The Department recommends

the Company not use a denial code, but a pend code, when additional information is requested.

- The examiners noted, through a review of Oxford Health Plans (CT), Inc. denied claims, two (2) instances where the claims were incorrectly denied as not authorized, when in fact, authorization were on file for the dates of service. The Department is concerned that the Company did not properly investigate the claim when originally received.

- The examiners noted, through a review of Oxford Health Plans (CT), Inc. denied claims and denied mental health claims, three (3) instances of incorrect denial codes being used. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted through a review of Oxford Health Plans (CT), Inc. and Oxford Health Insurance, Inc., nine (9) instances where claims were incorrectly denied as an out-of-network provider or not a covered benefit were reprocessed, but failed to include interest. At the request of the Department, an additional $2,500 in interest was paid. The Department t is concerned that the Companies did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review Oxford Health Insurance, Inc., mental health denied claims, three (3) instances where speech therapy services were incorrectly denied as not covered when billed with an autism diagnosis. At the examiners request, the claims were reprocessed for a total of $2,357, including interest. The examiners recommend the Company review its policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted, during the examination period of Oxford Health Insurance, Inc. mental health denied claims, one (1) instance where two (2) non-physician health care specialties were not being mapped correctly, resulting in claims being denied as ineligible provider. The Company updated the system on August 12, 2015, and conducted a review of prior claims. A total of six hundred eighty-seven (687) claims were adjusted, however they failed to include interest. At the request of the Department, an additional ninety-five (95) interest payments were made, along with the Department's letter for a total of $4,898. The examiners recommend that the Company review its policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted, through a review of Oxford Health Insurance, Inc., and Oxford Health Plans,(CT), Inc., denied health claims, the Companies were

incorrectly denying claims rather than forwarding them to the delegated vendors. The examiners requested a review of all claims that were denied in error. The review revealed that Oxford Health Plans (CT), Inc. failed to process eighteen (18) claims and Oxford Health Insurance, Inc. failed to process one hundred seventy-one (171) claims, representing a total of $75,329, including interest. The Companies reprocessed these claims with interest and letters were sent to the policyholders acknowledging the Department's findings. The Department is concerned that the Companies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted that there were several instances where the Companies conducted claim reviews and remediation projects during the examination period, which failed to include interest, until the Department became involved. The Department is concerned that the Companies did not properly investigate the claims at the time they were originally received.

- In addition, when reviewing the sample claim files for Oxford Health Plans (CT), Inc., and Oxford Health Insurance, Inc., there were numerous instances where the files contained insufficient, incomplete and incorrect information for regulatory review. At the Department's request, the Company's re-reviewed a number of sample claim files to provide additional information to allow the Examiners to complete our review. The Examiners are concerned that the Companies did not provide sufficient document for regulatory review of claim sample files, when originally received, resulting in a delay in the examination process.

In addition, the examiners have identified the following concerns through a review of the complaints and appeals:

- The examiners noted that during a review of UnitedHealthcare Insurance Company appeals, one (1) instance where a claim was overturned during the appeals process, in which no new additional information was provided. The Department is concerned that the Company failed to properly investigate claims at the time they were originally received.

- The examiners noted that during a review of UnitedHealthcare Insurance Company appeals, one (1) instance where the Company was applying a cost share on a claim for newborn audiology exams. Under the ACA, coverage was required for certain preventative care screenings without cost shares. The examiners requested that the Company conduct a claims review and the results determined that an additional thirty six (36)) claims for UnitedHealthcare Insurance Company needed to be reprocessed. The Company issued additional payments in the amount of $8,119, including interest. In addition, the examiners requested the Companies conduct a claims review of Oxford Health

Plans (CT) and the results were an additional two (2) claims were improperly charged cost shares. The Companies issued additional payments in the amount of $490, including interest. The examiners recommend that the Company review its claim and appeal policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted that during a review of UnitedHealthcare Insurance Company Insurance Department Complaints, one (1) instance where a claim for lab work for a preventative exam was denied in error. The Company indicated that this was an individual claim processing error, and no other individuals were affected. The examiners recommend that the Companies review their policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted that during the examination period, UnitedHealthcare Insurance Company Insurance Department Complaints, there were many instances where members were being informed that their coverage was terminated for non-payment, when in fact the company acknowledged that there were errors that caused payments not to be posted timely to member's accounts on the individual exchange. The Company has implemented a fix to their system, and the Company no longer participates in the individual exchange as of the end of 2016.

- The examiners noted during a review of the UnitedHealthcare Insurance Company Insurance Department Complaints, one (1) instance where the Company incorrectly ended dependent coverage prior to the end of the policy year when the dependent turned 26. The Department is concerned that the Company provided notification which tended to be misleading and insufficient for covered members.

- The examiners noted during a review of the Oxford Health Insurance, Inc., Non-Department Complaints, one (1) instance where a claims sweep was not completed by the Company. At the request of the Department, two (2) claims were identified as processed incorrectly at the non-network benefit level for a participating provider. The Companies reprocessed these claims and letters were sent to the policyholders acknowledging the Department's findings.

- The examiners noted during a review of the Oxford Health Insurance, Inc., Non-Department Complaints, one (1) instance where the maximum out-of pocket, (MOOP), was over applied due to the timing of the claims being processed for the members' medical and pharmacy plan. These separate services are processed on separate claim systems.

- The examiners noted during a review of Oxford Health Insurance, Inc., Non-Department Complaints, three (3) instances for claims for psychotherapy

services were incorrectly paid in the absence of required medical information, and sixty-one (61) claims were denied with the incorrect reason code. The examiners recommend that the Companies review their policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted during a review the Oxford Health Plans (CT), Inc. Insurance Department Complaints, one (1) instance where eye refractions and office visits were incorrectly bundled and double copayments applied. At the Department's request, the examiners had the Company perform a claims review, for Oxford Health Insurance, Inc. and UnitedHealthcare Insurance Company, as well, and it was determined that there was a total of one thousand seven hundred sixty-six (1,766) claims, totaling $21,885, including interest. The Companies reprocessed these claims and letters were sent to the policyholders acknowledging the Department's findings. The examiners recommend that the Companies review its policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted during a review of Oxford Health Insurance, Inc., appeal files, one (1) instance of certain lab codes where cost shares were incorrectly being applied as part of a preventative physical. As noted in additional findings involving other preventative services noted above, the Department has concerns that the Company failed to properly investigate appeal files related to claims for certain preventative services and wellness visits where cost shares were applied in error. The Department recommends the Company review its appeal policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted that during the examination period, UnitedHealthcare Insurance Company, Insurance Department Complaints, one (1) instance where The Company was incorrectly applying Medicare estimation of Medicare Part B related services, in violation of Connecticut law. The Company conducted a review as requested by the Department and identified three (3) impacted members affected. The Company reprocessed a total of 3 claims for a total of $7,391 including interest. The Department recommends the Company review its appeal policies and procedures to ensure that claims are properly investigated and paid.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements. In addition, the examiners noted that The Companies did not report complete information on the Consumer Report Card and MCAS data submissions.

XIII. NETWORK ADEQUACY

Standard 1: The health carrier demonstrates, using reasonable criteria that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

The following information was noted in conjunction with the review of this standard:

- ratios of providers, both primary care providers and specialty providers, to covered persons
- geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons
- waiting times for appointments, hours of operation, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care

The examiners reviewed the Connecticut Insurance Department Network Adequacy Survey, which included the Companies' responses to the ratio of providers, both primary care and specialty care to members. In addition, the examiners reviewed geographic accessibility of participating providers to the business or members personal residences, and wait times for scheduling in-network appointments for the period under review.

Findings:

The Companies submitted the 2017 Network Adequacy Survey that reported wait times in excess of the timeframe requirements for non-urgent appointments for primary care, specialist care and non-physical mental health. The Companies worked with the Department's Life and Health Division to correct the flaws in the survey design, (i.e. remove duplicates and non-eligible providers), and the results were satisfactory to the Department.

Standard 2: The health carrier files a quality assurance plan with the Commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan. The carrier makes the quality assurance plans available to regulators.

The following information was noted in conjunction with the review of this standard:

- the health carrier's procedures for making referrals within and outside its network

- the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services

- the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

Standard 3: The carrier has provided documentation to the Commissioner that it is currently NCQA and URAC accredited.

Standard 4: The health carrier files, with the Commissioner, all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Standard 5: The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week, within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the Managed Care Plan Network Adequacy Model Act.

Standard 6: The health carrier executes written agreements with each participating provider that are in compliance with statutes rules and regulations.

Standard 7: The health carrier's contracts with intermediaries are in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Intermediaries and participating providers, with whom they contract, shall comply with all applicable Requirements for Health Carriers and Participating Providers as indicated in the Managed Care Plan Network Adequacy Model Act and accompanying regulations.

- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

- Each contract between a health carrier and participating provider or provider group shall contain a "hold harmless" provision specifying protection for covered persons from being billed by providers. The language of the "hold harmless" provision shall be substantially similar to the language of the Managed Care Plan Network Adequacy Model Act

Standard 8: The health carrier provides notice to members advising them of Primary Care Physicians who have terminated with the plan as required by Connecticut Statute.

The following information was noted in conjunction with the review of this standard:

- The health carrier shall develop selection standards for primary care professionals and each health care professional specialty

- The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries, and any provider networks with which it contracts.

Standard 9: The health carrier provides, at enrollment, a Provider Directory listing of all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

The following information was noted Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems

Findings:

The examiners noted, through a review of the Oxford Health Insurance, Inc. Insurance Company on-line provider directory, that the Company failed to include mental health psychologist and psychiatrist providers for non-members. The Department is concerned that the Company failed to include a required listing of certain providers in its on-line provider directory.

In Summary:

It is recommended that the Companies review their policies and procedures with regards to maintaining and updating their on-line provider directory according to Connecticut requirements.

XIV. PROVIDER CREDENTIALING

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carriers establish and maintain programs for credentialing and re-credentialing in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies have established written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carriers contract and shall apply those standards consistently.
- The Companies have assured that the carriers' medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.
- The Companies have established a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documentation.

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 2: The health carriers verify the credentials of a health care professional before entering into a contract with that health care professional.

The following information was noted to ensure providers are properly credentialed prior to appearing in the provider directory:

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 3: The health carriers require all participating providers to notify the health carriers' designated individual of changes in the status of any information that is required to be verified by the health carriers.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carriers provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XV. COMPANY OPERATIONS

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies have up-to-date, valid internal or external audit programs.

The following information was noted in conjunction with the review of this standard:

- The Companies have an internal audit department that has performed reviews of a variety of operational functions.

- Audit reports are distributed to all relevant operational and management personnel.
- External audits are performed on a regular basis.

Findings:

The Companies have performed a number of audits during the examination period. The examiners reviewed the audit reports provided and found no exceptions during the examination period.

Standard 2: The Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures in place for all operational functions.
- System tests are performed on a regular basis.

Findings:

The examiners reviewed and verified that the Companies have programs in place to protect the integrity of computer information and appear to be in compliance.

Standard 3: The companies have anti-fraud plans in place.

The following information was noted in conjunction with the review of this standard:

- The Companies have written anti-fraud plans.
- The Companies have a Special Investigative Unit (SIU) dedicated to the prevention and handling of fraud.
- Potential fraud activity is tracked by the SIU and investigated. Activity is reported to the regulator, as necessary.

Findings:

The examiners reviewed the written anti-fraud plans and investigative policies and procedures. For the examination period, the Companies had no reportable incidents.

Standard 4: The Companies have valid disaster recovery plans.

Findings:

The examiners reviewed and verified that the Companies have valid disaster recovery programs in place and no incidences were reported during the examination period.

Standard 5: Records are adequate, accessible, consistent and orderly and comply with record retention requirements.

Findings:

The Companies appear in compliance.

Standard 6: The Companies are licensed for the lines of business that are being written.

The examiners reviewed the Certificates of Authority for the Companies and compared them to the lines of business that the Companies write in the State of Connecticut.

Findings:

The examiners verified that the Companies are duly authorized for the lines of business being written.

Standard 7: The Companies have procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies allow for sharing customer and personal information with affiliates, but do not share such information with non-affiliates.
- The Companies' policies require a consumer privacy notice to be provided to policyholders on an annual basis.
- The Companies have developed and implemented information technology security practices to safeguard the customer's personal and health information.

- The Companies' internal audit function conducts reviews of privacy policies and procedures.

Findings:

The examiners reviewed and verified that the Companies have valid programs in place. No incidences were reported during the examination period.

Standard 8: The Companies have a comprehensive written information security program for the protection of non-public customer information.

The examiners reviewed and verified that the Companies have a written security program in place for the protection of non-public customer information. In addition, the examiners verified that the Companies have proper cyber security policies and procedures in the areas of breach notification, administrative, physical and technical safeguards to protect consumer information and security incident response procedures.

Standard 9: The Companies cooperate on a timely basis with examiners performing the examinations.

Findings:

The Companies complied in good faith with the examiners' requests including those that were very complex. At times during the examinations, there was a delay in responding to requests in order to coordinate the availability of subject matter experts and compile the relevant information to appropriately respond to the examiners' requests and follow-up questions. The examiners noted that there were a number of instances where the Department did not receive adequate or complete responses to the Department's exceptions as well as frequent requests for extensions to response due dates.

XVI. SUMMARY OF RECOMMENDATIONS

Report
Section

VIII. Underwriting and Rating

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

XI. Complaints:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements

XII. Claims:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements. In addition, the examiners noted that The Companies did not report complete information on the Consumer Report Card and MCAS data submissions.

XIII. Network Adequacy:

It is recommended that the Companies review their policies and procedures with regards to maintaining and updating their on-line provider directory according to Connecticut requirements.

XVII. ACKNOWLEDGMENT

Stephen DeAngelis, Meg Salamone, Karen Mayer, Shannon Gonska and Robert Chester participated in the preparation of this report.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Market Conduct Report

of

UnitedHealthcare Insurance Company, Inc.
Oxford Health Insurance, Inc.
Oxford Health Plans (CT), Inc.

July 22, 2020

On August 7, 2019, through July 1, 2020, The Market Conduct Division of the Connecticut Insurance Department examined by targeted review the Mental Health Parity practices of UnitedHealthcare Insurance Company, Inc., Oxford Health Insurance, Inc. and Oxford Health Plans(CT), Inc., (hereinafter referred to as the "Companies".), for the sample period of January 1, 2017 through December 31, 2017.

The evaluation was based on a series of questions, in which the companies provided responses, involving MHPAEA "in-operation" NQTL predominant disparities and their "in-practice" standards applied between three healthcare plan benefits: (1) Medical/Surgical Benefits, (2) Substance Use Disorder Benefits and (3) Mental Health Benefits. Insurers must apply nonquantitative treatment limitations (NQTL) both "as-written" and "in-operation" in a manner that is comparable and not more stringent for MH/SUD benefits than for Med/Surgical benefits in the same classification. The targeted review was limited to Connecticut Health Insurance business.

United Healthcare Insurance Company, Inc. has its home office in the State of Connecticut. Oxford Health Insurance, Inc. has its home office in the State of New York, and Oxford Health Plans (CT), Inc. has its home office in Connecticut. By authority granted under §38a-15 of the Connecticut General Statutes, this targeted review was conducted by Market Conduct examiners of the State of Connecticut Insurance Department (the Department) at the Department offices in Hartford, Connecticut.

The purpose of the examination survey was to evaluate the Company's Mental Health Parity Non-Quantitative Treatment Limitation practices and activity in the State of Connecticut. The examiners reviewed the Company's response, which included information requested for the examination period.

The Department's findings are as follows:

- The Respondent imposed nonquantitative treatment limitations with respect to mental health and SUD benefits and was, therefore, required to provide detailed explanations of how its analysis of its underlying processes, strategies, standards and other factors used to apply

NQTL to MH/SUD and to medical surgical benefits have led the Respondent to conclude that the NQTLs were applied, as written and in operation, in a manner that was comparable and not more stringent for MH/SUD than for medical/surgical services and was, consequently, in conformance with legal requirements.

- The Respondent was unable to provide adequate documentation demonstrating compliant parity analyses, despite numerous requests and guidance from examiners, notwithstanding that it was noted that during the period under examination, the Respondent's application of the NQTLs was contributing to operational outcomes that produced non-comparative predominant disparities.

- The following areas of concern were also noted, between the rate at which SUD providers and Medical Surgical Providers were accepting new patients in the out-of-network claims rate between MH, SUD and Med/Surg benefits, in the claims denial rate between SUD benefits and Med/Surg benefits, in the rate of fail-first and step therapy programming, applied utilization review management required and pre-authorizations between MH, SUD and Med/Surg benefits, in the average In-Patient stay rate and outpatient treatment/rehabilitation visit rate between SUD benefits and Med/Surgical benefits, in the rate of required pre-authorizations within the drug formularies between SUD Rx benefits and Med/Surgical Rx benefits, and, in the reimbursement rates between Med/Surgical providers, MH providers and SUD providers

It is required that the Companies review their NQTL standards and operational practices impacting and contributing to these predominant operational disparities between Mental Health Benefits, Substance Use Disorder Benefits and Medical/Surgical benefits.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matters of:

Docket Nos. MC 20-13, MC 20-27, MC 20-52

Oxford Health Insurance, Inc.,
Oxford Health Plans (CT), Inc.,
UnitedHealthcare Insurance Company, and
United Behavioral Health

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STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Oxford Health Insurance, Inc., Oxford Health Plans (CT), Inc., UnitedHealthcare Insurance Company, and United Behavioral Health (hereinafter collectively referred to as "the Companies"), and the State of Connecticut Insurance Department (the "Department") by and through Andrew N. Mais, Insurance Commissioner, to wit:

I.

WHEREAS, United Behavioral Health, (hereinafter referred to as "UBH") is a utilization review company, incorporated under the laws of the State of California with its principal business in California;

WHEREAS, pursuant to Conn. Gen. Stat. §38a-16, the Insurance Commissioner conducted an investigation of UBH's practices related to behavioral health care services ("UBH Investigation") to determine if Connecticut members may have been adversely affected by coverage and/or reimbursement determinations utilizing criteria or guidelines that were not consistent with the American Society of Addiction Medicine Patient Placement Criteria ("ASAM Criteria");

WHEREAS, pursuant to the UBH Investigation, the Insurance Commissioner alleges that UBH failed to comply with Conn. Gen. Stat. §38a-591c, by failing to demonstrate that the criteria developed and used by UBH between July 1, 2015 and January 31, 2019 were consistent with the most recent edition ASAM Criteria;

WHEREAS, pursuant to the UBH Investigation, the Insurance Commissioner alleges that UBH violated Conn. Gen. Stat. §38a-591 when it failed to utilize criteria consistent with ASAM Criteria;

WHEREAS, the Commissioner alleges that UBH misrepresented to the Department that the criteria and guidelines it used to determine coverage for behavioral health care services and for reimbursement determinations in Connecticut were equivalent to and consistent with the ASAM criteria;

WHEREAS, UBH cooperated with the Insurance Commissioner's review of this matter;

WHEREAS, UBH denies that it has violated the aforementioned Connecticut statutes or any other applicable state or federal law, and that it made any misrepresentations to the Department regarding its behavioral health care services coverage determination criteria, guidelines and reimbursement determinations, but in order to avoid the expense and time-consuming process of formal administrative proceedings or future litigation, UBH voluntarily waives:

a) any right to a hearing,

b) any requirement that the Commissioner's decision contain a statement of findings of fact and conclusions of law, and

c) any and all rights to object to or challenge before the Commissioner or in any judicial proceeding any aspect, provision, or requirement of this Stipulation and Consent Order;

WHEREAS, nothing contained in this Stipulation and Consent Order, nor any action taken by UBH in connection with the UBH Investigation or the payment of any monetary penalty and any recitations set forth in this Stipulation and Consent Order, shall constitute, or be construed as, an admission of liability or evidence of unlawful conduct, or be admissible in any judicial or other proceeding for the purpose of proving liability or unlawful conduct against the Companies or any of its past or present parents, affiliates or subsidiaries.

II.

WHEREAS, Oxford Health Insurance, Inc. is domiciled in the State of New York; Oxford Health Plans (CT), Inc. and UnitedHealthcare Insurance Company are domiciled in the State of Connecticut (collectively referred to as "Oxford");

WHEREAS, from August 7, 2019 through February 1, 2020, the Department conducted an examination of Oxford's market conduct practices in the State of Connecticut covering the period from January 1, 2017 through December 31, 2017 (the "Targeted Market Conduct Exam");

WHEREAS, pursuant to the Targeted Market Conduct Exam, the Insurance Commissioner alleges the following with respect to Oxford:

1. Licensed insurers are required to provide mental health and substance abuse (MH/SUD) benefits in parity with medical/surgical benefits.

2. For nonquantitative treatment limitations (NQTL), licensed insurers may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification.

3. The Insurance Commissioner alleges Oxford imposed nonquantitative treatment limitations with respect to MH/SUD benefits and was, therefore, required to provide detailed explanations of how its analysis of its underlying processes, strategies, standards and other factors used to apply NQTL to MH/SUD and to medical/surgical benefits have led Oxford to conclude that the NQTLs were applied, as written and in operation, in a manner that was comparable and not more stringent for MH/SUD than for medical/surgical services and was, consequently, in conformance with legal requirements.

4. The Insurance Commissioner alleges that Oxford was unable to provide to the Department's satisfaction, documentation demonstrating compliant parity analyses, notwithstanding that it was noted that during the period under examination, Oxford's application of the NQTLs appeared to be contributing to operational results that produced differing outcomes:

    a. in the claims denial rate between SUD benefits and medical/surgical benefits,

    b. in the rate of fail-first and step therapy programming, applied utilization review management required and pre-authorizations between MH, SUD and medical/surgical benefits,

    c. in the average in-patient stay rate and outpatient treatment/rehabilitation visit rate between SUD benefits and medical/surgical benefits,

d. in the rate of required pre-authorizations within the drug formularies between SUD Rx benefits and medical/surgical Rx benefits, and

e. in the reimbursement rates between medical/surgical providers, MH providers and SUD providers;

WHEREAS, the Commissioner finds the conduct as described above violates §§38a-488a, 38a-514 of the Connecticut General Statutes, The Paul Wellstone and Pete Dominici Mental Health Parity and Equity and Addiction Equity Act of 2008, and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2 and 38a-41 of the Connecticut General Statutes;

WHEREAS, during the Targeted Market Conduct Exam, Oxford provided explanations for any alleged disparities in outcome data described in paragraph 4 above, and maintained throughout the exam that the alleged disparities in outcome data are not determinative of non-compliance with parity obligations;

WHEREAS, the Commissioner alleges that the explanations and analysis provided by Oxford were insufficient to support a finding that the NQTLs were applied by Oxford in any classification in such a manner that the processes, strategies, evidentiary standards, or other factors used in applying those limitation to SUD benefits within that classification were comparable to, and were applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification.

WHEREAS, Oxford disagrees with the Commissioner's conclusions and contends the explanations and analysis of comparable processes provided during the exam sufficiently document parity compliance both as written and in operation;

WHEREAS, Oxford denies that it has violated the aforementioned Connecticut statutes or any other applicable state or federal law, but in order to avoid the expense and time-consuming process of formal administrative proceedings or future litigation, Oxford voluntarily waives:

a) any right to a hearing;

b) any requirement that the Commissioner's decision contain a statement of findings of fact and conclusions of law; and

c) any and all rights to object to or challenge before the Commissioner or in any judicial proceeding any aspect, provision, or requirement of this Stipulation and Consent Order;

WHEREAS, nothing contained in this Stipulation and Consent Order, nor any action taken by Oxford in connection with the Targeted Market Conduct Exam or the payment of any monetary penalty and any recitations set forth in this Stipulation and Consent Order, shall constitute, or be construed as, an admission of liability or evidence of unlawful conduct, or be admissible in any judicial or other proceeding for the purpose of proving liability or unlawful conduct against the Companies or any of its past or present parents, affiliates or subsidiaries.

III.

WHEREAS, from September 4, 2018 through January 31, 2020, the Department conducted an examination of Oxford's market conduct practices in the State of Connecticut covering the period from January 1, 2015 through December 31, 2017 (the "Oxford Market Conduct Exam");

WHEREAS, pursuant to the Oxford Market Conduct Exam, the Insurance Commissioner alleges that during the period under examination, Oxford failed to fully follow established practices and procedures to ensure compliance with statutory requirements, resulting in some instances of:

a) failure to maintain sufficient controls to ensure that claims are properly investigated and sufficiently documented,

b) failure to provide sufficient and correct complete documentation for regulatory review, including the Consumer Report Card and Market Conduct Annual Statement,

c) failure to pay claims without conducting a reasonable investigation,

d) failure to maintain proper controls to ensure that all claims for autism treatment are processed timely and sufficiently documented,

e) failure to pay claims in a timely manner,

f) failure to properly investigate certain mental health claims,

g) failure to implement proper controls for making payment of mental health claims that were denied rather than forwarded to the delegated vendor,

h) failure to properly investigate claims for certain preventative services including newborn audiology exams,

i) failure to adopt and implement reasonable standards for conducting the prompt investigation of eye refraction claims,

j) failure to properly investigate psychotherapy claims,

k) failure to maintain an adequate online provider directory for certain mental health providers, and

l) failure to take corrective action for the prompt payment and investigation of claims required under Docket MC 14-71 executed on June 29, 2015;

WHEREAS, the Insurance Commissioner alleges that the conduct as described above violates §§38a-514b, 38a-543 and 38a-816 of the Connecticut General Statutes, and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2, 38a-41 and 38a-817 of the Connecticut General Statutes;

WHEREAS, Oxford denies that it has violated the aforementioned Connecticut statutes or any other applicable state or federal law, but in order to avoid the expense and time-consuming process of formal administrative proceedings or future litigation, Oxford voluntarily waives:

a) any right to a hearing;

b) any requirement that the Commissioner's decision contain a statement of findings of fact and conclusions of law; and

c) any and all rights to object to or challenge before the Commissioner or in any judicial proceeding any aspect, provision, or requirement of this Stipulation and Consent Order;

WHEREAS, nothing contained in this Stipulation and Consent Order, nor any action taken by Oxford in connection with the Oxford Market Conduct Exam or the payment of any monetary penalty and any recitations set forth in this Stipulation and Consent Order, shall constitute, or be construed as, an admission of liability or evidence of unlawful conduct, or be admissible in any judicial or other proceeding for the purpose of proving liability or unlawful conduct against the Companies or any of its past or present parents, affiliates or subsidiaries.

IV.

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. The Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. The Companies, pursuant to Conn Gen. Stat. §38a-2, shall pay to the Treasurer of the State of Connecticut a monetary penalty of Five Hundred Seventy-Five Thousand Dollars ($575,000) within 21 business days of execution of this Stipulation and Consent Agreement to resolve any purported violations herein above described.

3. The Companies shall place the sum of Five Hundred Thousand Dollars ($500,000) within 21 business days of execution of this Stipulation and Consent Agreement in the Insurance Department Education Fund to be used by a non-profit Connecticut organization agreed to by the Companies and the Commissioner, for the purpose of improving the behavior health system and access to behavioral health services.

4. Within 90 days of the execution of this Stipulation and Consent Order, the Companies must file with the Insurance Commissioner a Corrective Action Plan (the "CAP"). The CAP shall include a process and framework to ensure that current criteria is compliant with ASAM Criteria. In addition, UBH shall develop reasonable procedures and standards as part of a remediation plan for members and providers who may have been harmed when coverage and/or reimbursement denial determinations for levels of care for substance use disorder treatment were made utilizing criteria or guidelines in effect between July 1, 2015 and January 31, 2019 that the Department believes were not consistent with ASAM Criteria. The parties acknowledge the UBH Investigation overlaps with ongoing litigation involving UBH (*Wit v. United Behavioral Health*, USDC, N.D. Ca., Case No. 14-cv-02346). The remediation plan required by this Consent Order shall be consistent with and commenced after a final judgment resolving that litigation (after the exhaustion of appeals). If the Insurance Commissioner determines that UBH has not achieved any or all of the requirements set out in the CAP, the Insurance Commissioner may assess a penalty pursuant to Conn. Gen. Stat. §38a-2 to resolve any purported violation of Conn. Gen. Stat. §§38a-41, 38a-591 or any other Connecticut law.

5. As part of the CAP referenced above, UBH agrees to submit documentation annually for a two-year period to establish that it uses the ASAM criteria to make coverage and reimbursement decisions, as applicable, related to substance use disorder (SUD) benefits. UBH shall employ an independent examiner approved by the Commissioner, to review a random sample of up to 30 files, consisting of denial, authorization or appeal files to confirm use of the ASAM Criteria, and provide the examiner's report to the Department.

6. Oxford agrees to undertake a complete review of its practices and procedures to enhance compliance with Connecticut statutes in the areas of concern, as described in the Oxford Market Conduct Exam, the Targeted Market Conduct Exam, and this Stipulation. Oxford will provide the Insurance Commissioner with a summary of actions taken to comply with the recommendations in the Oxford Market Conduct Exam Report and the Targeted Market Conduct Exam Report within one hundred eighty (180) days of the date of this Consent Order and Stipulation.

7. This Stipulation and Consent Order shall not be construed to limit the authority of the Insurance Commissioner in investigating and taking appropriate action with regard to related undisclosed or unknown matters which may be subsequently identified.

This Stipulation and Consent Order shall not be construed to limit the authority of any other government agency which may have authority in this matter or serve as a release with respect to any other government agency actions.

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 6 day of January 2020 for and on behalf of Oxford Health Insurance, Inc., Oxford Health Plans (CT), Inc., UnitedHealthcare Insurance Company, that he/she is the President or Chair of such companies, and he/she has authority to execute and file such instrument.

By: _____
William J. Golden

State of Connecticut

SS

County of Fairfield

Personally appeared on this 6 day of January 2020 _____ signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____
Cynthia Marcantonio
Notary Public/Commissioner of the Superior Court

CYNTHIA MARCANTONIO
NOTARY PUBLIC
My Commission Expires Aug. 31, 2025

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 5 day of January 2020 for and on behalf of United Behavioral Health, that he/she is the President and Chief Executive Officer of such company, and he/she has authority to execute and file such instrument.

By: _____
Rebecca L. Schechter

State of Massachusetts

SS

County of Middlesex

Personally appeared on this 5 day of January 2020 Karen A McMullen signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____
Notary Public/Commissioner of the Superior Court

Karen A. McMullen
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
April 10, 2026

Section Below To Be Completed by State of Connecticut Insurance Department

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Dated at Hartford, Connecticut this 22 day of January 2021

_____
Andrew N. Mais
Insurance Commissioner