State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

UNITEDHEALTHCARE OF WISCONSIN, INC
3100 AMS BLVD
GREEN BAY WI 54313

dated MAY 2, 2008, and served upon the company on July 10, 2008

, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 12th day of July, 2010.

Sean Dilweg
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

UNITEDHEALTHCARE OF WISCONSIN, INC.
WAUWATOSA, WISCONSIN

APRIL 14, 2008 TO MAY 2, 2008

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July 10, 2008

Honorable Sean Dilweg
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conduct April 14, 2008 to May 2, 2008 of:

UNITEDHEALTHCARE OF WISCONSIN, INC.
Wauwatosa, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

UnitedHealthcare of Wisconsin, Inc. (the company), can be described as a for-profit, network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under ch. 185, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers participating in the plan." Under the network model, the HMO insurer provides care through contracts with clinics and otherwise independent physicians operating out of their separate offices.

The company was incorporated on May 8, 1986, and commenced business on June 6, 1986, as the Heritage Health Plan of Wisconsin, Inc. Simultaneously, the company acquired all of the assets, and assumed all of the liabilities of the PrimeCare Health Plan of Wisconsin, pursuant to an asset purchase agreement dated May 8, 1986. By shareholder consent dated May 11, 1987, the name of the company was changed to PrimeCare Health Plan, Inc. On

March 1, 1990, UnitedHealth Care Corporation (United), a Minnesota managed care holding company, acquired Heritage Holding Company, Inc. (HHC), through purchase of all outstanding shares of common stock on March 1, 1990. HHC, which owned 100% of the company's outstanding common stock at the time of the purchase, was subsequently dissolved, and the ownership interest in the company was transferred to UHC Management Company (UMC). UMC is a wholly owned subsidiary of United. UMC subsequently changed the name to United HealthCare Services (UHS). On August 1, 1991, the company merged with an affiliate, Samaritan Health Plan, which was also a wholly owned subsidiary of UMC. Samaritan, which was the surviving corporation, changed the name to PrimeCare Health Plan, Inc., pursuant to the merger. On July 17, 1996, the company merged with an affiliate, MetraHealth Care Plan of Wisconsin, Inc. PrimeCare Health Plan, Inc., was the surviving corporation. On June 30, 2000, the company became a wholly owned subsidiary of UnitedHealthcare, Inc. (UHC), pursuant to a transfer of 100% of the company's outstanding shares to UHC by UHS. UHC is a Delaware corporation and wholly owned subsidiary of UHS designed to be the holding company for all of the companies that are part of the UnitedHealth Group. UnitedHealth Group Incorporated (United) is the ultimate controlling entity in the insurance holding company system.

On October 9, 1999, the company's board of directors amended the articles of incorporation to change the corporate name to the current name, UnitedHealthcare of Wisconsin, Inc. The name change was effective December 31, 1999.

At the time of the examination, the company did business in twenty-six Wisconsin counties. The company's service area was mainly in focused on the eastern portion of the state along with five counties in the mid northwest portion of the state.

The company has had a contract with the Centers for Medicare and Medicaid Services (CMS) since August 1, 1995 to offer a Medicare HMO through the marketing name of SecureHorizons by UnitedHealthcare. UnitedHealthcare Insurance Company, the parent company has had a contract with CMS to offer Medicare Advantage (MA) special needs plans (SNP) since April 1, 2004 under the marketing name of Evercare Senior Care Options.

The parent company also has contacted with CMS to offer its Private Fee for Service (PFFS) plans since September 1, 2004 under the marketing name of Secure Horizons Medicare Direct.

The parent company also offered Part D plans in all counties under the marketing plan names of AARP Medicare RX (AARP Enhanced, AARP Preferred & AARP Saver) and UnitedHealth RX (UnitedHealth RX Value and UnitedHealth Basic).

The company did not offer a Medicare Supplement plan however, the parent company offered Medicare Supplement plans in all Wisconsin counties under the plan name AARP Medicare Supplemental Insurance and SecureHorizons PLHIC (PacifiCare Life and Health Insurance Company).

The majority of the premium written by the company in 2005 and 2006 was in group accident and health. In 2006, the company ranked as the third largest writer of group accident and health in Wisconsin with 7.7% of the market share. In addition, the company ranked as the largest writer of small employer health Insurance with 18.3% of the market share.

In 2005, the company ranked as the fourth largest writer of group accident and health in Wisconsin with 6.5% of the market share. The company ranked as the third largest writer of small employer health insurance with 10.2% of the market share.

The following tables summarize the premiums earned in Wisconsin for 2005 and 2006 broken down by lines of business.

Premium and Loss Ratio Summary

	2006			
Line Of Business	Direct Premiums Earned	% of Total Premium	Direct Losses Incurred	Pure Loss Ratio
Comprehensive	$290,052,712	44.77%	$236,327,921	81.48%
All Others	$357,823,256	55.23%	$305,306,069	85.32%
Total	$647,875,968	100%	$541,633,990	

	2005			
Line Of Business	Direct Premiums Earned	% of Total Premium	Direct Losses Incurred	Pure Loss Ratio
Comprehensive	$402,591,492	61.74%	308,657,132	76.67%
All Others	$249,484,753	38.26%	$208,519,006	83.58%
Total	$652,076,245	100%	$517,176,138	

Complaints

The Office of the Commissioner of Insurance (OCI) received 123 complaints against the company from January 1, 2007 to December 31, 2007. A complaint is defined as "a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent." The company ranked 16th on the 2006 complaint summary for group accident and health, with a complaint ratio of .03 compared to a Wisconsin average of .02 complaints per $1,000,000 written premium. In 2007, the company ranked 13th on the complaint summary for group accident and health with a complaint ratio of .04 compared to a Wisconsin average of .02 complaints per $1,000,000 written premium.

The company received the majority of the complaints in group accident & health. The majority of the complaints involved denial of claims and claim delays.

The following table summarizes the complaints received broken down by coverage type and reason type. There may be more than one type of coverage and/or reason for each complaint.

2007						
Reason Type	Total	Under writing	Marketing & Sales	Claims	Plcyhlder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H						
Group A&H	7			6		1
HMO	101	1	5	91	3	1
PPO	13			12		1
Other	2			1		1
Total	123	1	5	110	3	4

2006						
Reason Type	Total	Under writing	Marketing & Sales	Claims	Plcyhlder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H						
Group A&H	14			9	4	1
HMO	82	1	9	67	4	1
PPO	10			9	1	
Other	7			6	1	
Total	113	1	9	91	10	2

Grievances

The company submitted the annual grievance summary reports to OCI for 2005 and 2006, as required by s. Ins. 18.06, Wis. Adm. Code. A grievance is defined "as any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed writing to the insurer by, or on behalf of, an insured."

The company's grievance report for 2005 indicated the company received 667 grievances, 403 grievances or 60.42% were reversed. The majority of the grievances filed with the company in 2005 were related to plan administration.

The company's grievance report for 2006 indicates the company received 326 grievances, 204 grievances or 62.57% were reversed. The majority of the grievances filed with the company in 2006 were related to plan administration.

The following table tables summarize the grievances for the company for 2005 and 2006. There may be more than one type of coverage and/or reason for each complaint.

Category	2005 No.	2006 No.
Access to Care	2	4
Continuity of Care	0	0
Prescription Drug	63	40
Emergency Services	11	0
Experimental Treatment	53	18
Prior Authorization	0	0
Noncovered Benefit	131	40
Not Medically Necessary	10	0
Other	133	66
Plan Administration	284	153
Request for Referral	0	0
Plan Providers	11	0
Total	698	326
Resolution Categories		
Plan Administration	386	219
Benefit Denial	274	107
Quality of Care	7	0
Total	667	326

Independent Review Organization

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the OCI annual reports for the prior calendar year's experience indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent review include adverse and experimental treatment determinations. The IRO reports indicate that for 2005 the company had five IRO requests files and for 2006 the company had two IRO requests filed involving the company.

The following tables summarize the IRO review requests for the company for the last two years:

2006

Independent Review Organizations				Number of Decisions		
Review Requests Received	IPRO	Maximus-CHDR	Permedion	Upheld	Reversed	Average Number of Days to Resolve
2	1	0	1	2	0	23

2005

Independent Review Organizations				Number of Decisions		
Review Requests Received	IPRO	Maximus-CHDR	Permedion	Upheld	Reversed	Average Number of Days to Resolve
5	0	3	2	3	2	26

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine compliance with the previous market conduct examination, and whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2006 through December 31, 2007. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of the company's operations and practices in the areas of claims, policyholder services and complaints, grievances and internal review, small employer health insurance, privacy and confidentiality, managed care, electronic commerce, company operations and management and marketing and sales of senior products, and producer licensing.. The examination included a review of the company's Medicare Advantage and Medicare Part D agent marketing activities.

The targeted examination was also conducted to determine compliance with the 2003 market conduct examination report recommendations and to verify compliance with the 2005 Stipulation and Order.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted April 14, 2004, contained 36 recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Claims

1. It is recommended that the company develop a written procedure specific to Wisconsin chiropractic claims for handling of claim and coverage issues related to limiting or terminating chiropractic services as required by s. 632.875, Wis. Stat.

   Action: Compliance

2. It is recommended that the company modify the form letters it sends to treating chiropractors and patients regarding Wisconsin chiropractic claims to contain all of the information required by s. 632.875 (2) (a) (b) (c) (d) (e) (f) (g) and (h), Wis. Stat.

   Action: Compliance

3. It is recommended that the company correct the identified system problem so that ANSI codes are printed on generated EOB forms for Wisconsin certificate holders as required by s. Ins 3.651 (4) (a) 5. f, Wis. Adm. Code.

   Action: Compliance

4. It is recommended that the company develop a written procedure and corresponding letters to ensure that requests from Wisconsin certificate holders for information related to the specific methodology used by the company in adjudicating claims are answered as required by s. Ins 3.60 (6), Wis. Adm. Code.

   Action: Compliance

Policyholder Services and Complaints

5. It is recommended that the company revise the manner in which it maintains a record of complaints so that it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with s. Ins 18.06 (1), Wis. Adm. Code.

   Action: Non-Compliance

6. It is recommended that the company revise its complaint procedures involving the handling of OCI complaints to reflect its stated practice of contacting the complainant within 10 days of receiving the complaint per OCI referral instructions in order to comply with s. 601.42, Wis. Stat.

Action: Compliance

Grievances and Internal Review

7. It is recommended that the company revise the definition of complaint in its written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code and to handle as grievances all written communications that meet the definition of a grievance in s. Ins 18. 01, (4) Wis. Adm. Code.

   Action: Non-Compliance

8. It is recommended that the company revise its definition of an appeal (grievance) to comply with the requirements of s. Ins 18.01 (4), Wis. Adm. Code.

   Action: Compliance

9. It is recommended that the company revise its procedures to handle as grievances written expressions of dissatisfaction involving quality of care issues as required by s. Ins 18.01 (4) and s. Ins 18.03, Wis. Adm. Code.

   Action: Compliance

10. It is recommended that the company revise its appeal/grievance procedures to schedule all unfavorable 1st Level Appeal grievances for hearing by the grievance committee rather than requiring the grievant to request a 2nd Level formal hearing as required by s. Ins 18.03 Wis. Adm. Code.

    Action: Compliance

11. It is recommended that the company revise its WI 1st Level Admin Denial Letter and WI 1st Level Clinical Denial disposition letter to not require that the grievant request a hearing in order for the grievance to proceed to the 2nd Level Appeal and be heard by the grievance committee as required by s. Ins 18.03, Wis. Adm. Code.

    Action: Compliance

12. It is recommended that the company improve its existing procedures and provide staff training to better ensure the prompt handling of grievances in compliance with the time frames required by s. Ins 18.03 (6), Wis. Adm. Code.

    Action: Compliance

13. It is recommended that the company improve its existing procedures to ensure that all documentation related to a grievance is maintained in the grievance file for a period of 3 years as required by s. Ins 18.06 (1), Wis. Adm. Code.

    Action: Compliance

14. It is recommended that the company submit an amended grievance experience report to OCI for 2002 deleting those grievances that were included to comply with federal regulations and that the company revise its grievance reporting procedures so that in future reports grievances will be limited to those items that

meet the definition of a grievance in s. Ins 18.01 (4), Wis. Adm. Code and reported to OCI as required by s 18.06, Wis. Adm. Code.

Action: Compliance

15. It is recommended that the company amend its provider agreements to include a provision that requires the contracting entity to promptly respond to complaints and grievances filed with the company to facilitate resolution as required by s. Ins 18.03 (2) (c) a. Wis. Adm. Code.

Action: Compliance

16. It is recommended that the company submit to OCI documentation that all members who had received an adverse determination or an experimental treatment determination on or after December 1, 2000 and prior to June 15, 2002, and who had completed the HMO's internal grievance process were provided with a notice that they had the right to request an independent review, as required by s. Ins 18.11 (2) (a), Wis. Adm. Code.

Action: Compliance

17. It is recommended that the company modify the external review provisions in its policy to include an explanation of how to obtain a current listing of IROs, as required by s. 632.835 (2) (bg) 1, Wis. Adm. Code.

Action: Non-Compliance

18. It is recommended that the company develop and implement procedures to ensure that its customer service staff provides its members with complete information on the independent review process, as required by s. 632.835 (2) (bg), 1, Wis. Stat.

Action: Compliance

19. It is recommended that the company develop and implement a procedure that ensures that it accepts independent review requests without requiring a written release from the member in compliance with s. Ins 18.11 (3) (b), Wis. Adm. Code.

Action: Compliance

20. It is recommended that the company develop and implement a procedure whereby a member may request and obtain an independent review of an adverse determination, as defined by s. Ins 18.10 (1), Wis. Adm. Code, or an experimental treatment determination, as defined by s. 18.10 (2), Wis. Adm. Code.

Action: Compliance

21. It is recommended that the company develop and implement a procedure for handling expedited independent review requests that complies with s. 632.835 (3) (g), Wis. Stat.

Action: Compliance

22. It is recommended that the company develop and implement a procedure to submit the additional information requested by an IRO or an explanation within 5 business days after receiving a request, as required by s. 632.835 (3) (c), Wis. Stat.

    Action: Compliance

Small Employer Health Insurance

23. It is recommended that the company revise the termination letters used in cases where a small employer group has fallen below the minimum participation requirements of the policy and specifically offer to continue the coverage for 60 days after the nonrenewal or termination date to allow the small employer to increase the number of eligible employees to the required number as required by s. Ins 8.54 (4) (a) 2., Wis. Adm. Code.

    Action: Compliance

24. It is recommended that the company revise its procedures to record the date it receives a request for a small employer health plan price quote.

    Action: Non-Compliance

25. It is again recommended that the company establish procedures to ensure that a separate written notice is provided to the policyholder, upon issuance of the policy, which discloses to the policyholder, that the protections afforded by ch. 635, Wis. Stat., will cease to apply and the policy terminated if the employer moves his business outside the state or if the employer no longer meets the definition of small employer, as required by s. Ins 8.44 (2), Wis. Adm. Code.

    Action: Compliance

26. It is recommended that the company revise its procedure, Adding Newborns (COSMOS Adding Newborns_tt 9/28/00) to specify and comply with the requirements of s. 632.895 (5), Wis. Stat.

    Action: Compliance

Privacy and Confidentiality

27. It is recommended that the company include as a revision to its applications the ability to date the form and limits the length of time the authorization is valid to the policy term or the pendency of a claim for benefits in order to comply with s. 610.70 (2) (a) 2 and (b) 2, Wis. Stat.

    Action: Compliance

28. It is recommended that the company develop and implement a process for providing to individuals access to recorded personal medical information in order to document compliance with s. 610.70 (3), Wis. Stat.

Action: Compliance

Managed Care

29. It is recommended that the company draft summaries of its quality assurance plan for inclusion in its marketing materials and certificate of coverage or enrollment materials and submit the summaries to OCI with 60 days of the adoption of the examination report in order to comply with s. Ins 9.40 (7) (a) and (b), Wis. Adm. Code.

    Action: Compliance

30. It is again recommended that the company amend its provider agreements to include a provision addressing reimbursement for services provided in continuity of care situations, as required by s. 609.24 (1) (e), Wis. Stat.

    Action: Compliance

31. It is recommended that the company amend its provider contracts to include a provision regarding the responsibility of the provider specialist to post in-office notice of termination, as required by s. Ins 9.35 (1) (a) 3, Wis. Adm. Code and s. 609.24, Wis. Stat.

    Action: Compliance

32. It is recommended that the company improve its compliance program, including documenting its oversight of its contractors, providers and vendors, in order to meet the requirements of s. Ins 9.42, Wis. Adm. Code.

    Action: Compliance

Electronic–Commerce

33. It is recommended that the company develop and implement a process for identifying company advertisements on the Internet, and for monitoring agent websites to ensure that all advertisements used by agents are approved by the company, are included in the company's advertising file, and are compliant with s. Ins 3.27, Wis. Adm. Code.

    Action: Compliance

Company Operations and Managem*ent*

34. It is recommended that the company improve existing procedures to ensure that current copies of active provider agreements are maintained in order to comply with s. 601.42, Wis. Stat.

    Action: Compliance

35. It is recommended that the company operate a process to ensure that it makes periodic and necessary amendments to provider agreements for Wisconsin providers as required by Wisconsin insurance law.

Action: Compliance

36. It is recommended that the company designate a management level person familiar with Wisconsin insurance law to be responsible for oversight of Wisconsin claims, grievances and complaints, and for communicating with OCI.

Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claim procedure manuals, explanation of benefit (EOB) and remittance advise (RA) forms, claim adjustment (ANSI) codes and claim payment methodology. The company contracted with ACN Group for care management services for chiropractic, physical therapy, occupational and speech therapy providers.

The company's insurance policies provided benefits based on whether a subscriber used network or non-network providers. The company reimbursed participating providers based on a negotiated fee-for-service basis. The company paid for emergency services and approved services rendered by non-network providers at the network providers benefit level,

The examiners reviewed a random sample of 125 paid and 125 denied claims processed during the period of review. The sample included 50 claims specific to the coordination benefits; 110 claims for mandated benefits; 30 mental health mandated benefits claims and 30 claims specific to chiropractic services. The examiners selected the sample from the company data files for the entire population of claims submitted between January 1, 2006 to December 31, 2007. For the mandated benefits claim sample, the examiners randomly pulled claims with applicable CPT codes. No exceptions were noted regarding the mandated benefit claim review.

The examiners reviewed the company's compliance with prior market conduct examination recommendations and found that the company was not in compliance with the formatting requirements of s. Ins. 3.651, Wis. Adm. Code, for its EOBs and RAs. The examiners

noted that the company used a form titled "Provider Explanation of Benefits" (EOB) for statements sent to the provider of services, which under s. Ins 3.651 (3), Wis. Adm. Code, meets the definition of remittance advice (RA). The examiners requested that the company demonstrate compliance with s. Ins. 3.651 (3), Wis. Adm. Code. The company stated that it respectfully disagreed that the naming format on the provider document to reflect provider remittance advice (RA) rather than provider explanation of benefits (EOB) conflicted with Ins. 3.651 (3), Wis. Adm. Code. The company's position was that "Remittance Advice" and "Explanation of Benefits" had the same meaning.

The examiners found that although the company used the ANSI codes required by s. Ins. 3.651 (5), Wis. Adm. Code, the company's placement of the ANSI codes in both the provider RA and the member EOB forms did not comply with the formatting requirements of s. Ins. 3.651 (3) and (4), Wis. Adm. Code. The company admitted that it had not reformatted its member EOBs to meet the requirements of s. Ins. 3.651 (3) and (4), Wis. Adm. Code, and stated it would submit a system enhancement request to reformat the member EOB form. However, the company disagreed that its provider EOB did not comply with the reformatting requirements of s. Ins. 3.651 (3) and (4), Wis. Adm. Code. The ANSI code columns were to the left of the amount paid column as outlined in the requirement. However, when the examiners reviewed a random sample of 25 unpaid claims involving coordination of benefits, the examiners found that the provider RA for two claims did not list all the ANSI codes in the ANSI code column, but had all the ANSI codes in the paragraphs below the column. Further, the examiners found that in 14 of the 25 claims, the company re-worded the ANSI code on its provider RA form. For ANSI code 23, which stated "payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments", the company worded the ANSI code 23 to read "payment adjusted because charges have been paid by another payer".

1. **Recommendation:** It is recommended that the company correctly word the provider explanation of benefits as remittance advice as required by s. Ins 3.651 (3), Wis. Adm. Code.

2. **Recommendation:** It is recommended that the company place ANSI codes in the ANSI code column on the remittance advice form, to meet the requirements of s. Ins. 3.651 (3) (b) (4) (i), Wis. Adm. Code.

The examiners found that the explanation of benefits (EOB) form did not display CPT-4, HCPCS and CDT codes as required by s. Ins. 3.651 (4) 5. c, Wis. Adm. Code. The company stated that the codes described specific procedures performed, that from the codes a diagnosis could be inferred, and that this detail information was protected health information (PHI) as defined by the federal HIPAA privacy regulations. The company maintained it included a description of the service that was sufficient to accomplish the purpose of enabling the subscriber to determine whether benefits have been paid correctly. Section Ins. 3.651 (4) (a) 5. c., Wis. Adm. Code, requires for each patient to list on a single line for each procedure or service the CPT, HCPCS or CDT-1 code to meet the requirements of s. 632.725, Wis. Stat.

3. **Recommendation:** It is recommended that the company revise the member EOB forms to include CPT or like codes to satisfy the minimum requirements of s. Ins 3.651 (4) (a) 5. c., Wis. Adm. Code.

The examiners reviewed a random sample of 100 claims not paid. The examiners found that one claim file indicated the company did not coordinate the benefits with Medicare. The company admitted that the claim was not handled appropriately. The company stated that the claim would be reconsidered, and if applicable, interest would be issues at time of payment. The 2005 Stipulation and Order addressed the coordination of benefits therefore, the examiners requested an additional 25 random unpaid coordination of benefit claim sample. The examiners noted no problems in the 25 unpaid claim sample.

Company Operations/Management

The examiners reviewed the company's response to OCI's company operations and management interrogatory and the provider agreements.

The examiners reviewed a random sample of 50 provider agreements and credentialing files. The examiners found four providers covered under the same provider agreement that did not

contain the, Wisconsin Regulatory Requirements Appendix document, which the company used to satisfy the notification requirement that complaints and grievances be referred to the company for handling and that in certain situations a terminated provider is subject to Wisconsin's continuity of care requirements. To determine compliance with the 2003 market conduct examination recommendation, OCI requested that the company demonstrate that it improved its existing procedures to ensure that current copies of active provider agreements were maintained in order to comply with s. 601.42, Wis. Stat. The company provided the policy and procedures for contract retention and storage that specifically addressed the procedures to ensure that current copies of active provider agreements were maintained in both electronic and hard copy formats. However, the company could not locate the Wisconsin Regulatory Appendix for four files in the provider sample. Section Ins 6.80 (4) Wis. Adm. Code, requires domestic insurers to maintain corporate records for three years and to be available to the commissioner.

The examiners requested copies of internal audit reports that were generated during the period of review. The company stated, "Due to audit scope revisions, UHC is currently in process of completing and issuing the final WI Findings and Summary Report (2007). The target issuance date of the final report is scheduled for June 2008 and will be available". Subsequent to field work the company provided the audit reports.

Managed Care

The examiners reviewed the company's response to the managed care interrogatory, the policies and procedures regarding plan administration, quality assurance and improvement, credentialing and recredentialing, enrollee access, continuity of care, compliance program, patient protection, and provider agreements. The company received an excellent accreditation outcome as a result of the review by the National Association of Quality Assurance (NCQA), with an expiration date of December 16, 2008. The examiners documented that the company had filed

with OCI the certification of managed care plan type as required by s. Ins 9.40 (8), Wis. Adm. Code, the certification of access standards as required by s. Ins. 9.34 (1), Wis. Adm. Code, and the quality assurance plan as required by s. Ins. 9.40 (2) & (3), Wis. Adm. Code.

The examiners reviewed the company's compliance plan, which was required under s. Ins. 9.42, Wis. Adm. Code, and its Internal Assessment Work Plan. Schedule 1.5b of the work plan stated that EOB's were audited annually. The examiners requested a copy of the EOB audit reports for any audits conducted during the period of review. The company responded that an internal preliminary review of EOBs was completed as part of the 2006 Audit Plan, however, no formal audit report specific to EOBs was prepared and a subsequent internal audit of EOBs was in progress for 2007. The examiners then requested all work documents associated with this internal review of EOB's. The company responded that an initial review was completed to determine final audit scope parameters and work plan protocols. Based on a preliminary review activities corrective action activities and requirements were already underway. These activities would be included in formal audit scope plans.

The examiners also requested that the company demonstrate compliance with the 2003 market conduct recommendation that the company improve the compliance program, including documenting the oversight of the contractors, providers and vendors, in order to meet the requirements of s. Ins 9.42, Wis. Adm. Code. The examiners requested a copy of the audit report for the vendor ACN Group conducted during the period of review to demonstrate compliance with s. Ins. 9.42 (3), Wis. Adm. Code. The company stated that UHC was presently completing a review of ACN Group activities and that the outcomes from the review would be made available upon completion.

4. **Recommendation:** It is recommended that the company provide a copy of the A.C.N. Group audit report in order to document compliance with s. Ins 9.42 (3), Wis. Adm. Code.

5. **Recommendation:** It is recommended that the company audit the EOB's annually as stated in the company's compliance plan to demonstrate compliance with s. Ins. 9.42 (3), Wis. Adm. Code.

Marketing Sales & Advertising

The examiners reviewed the company's response to the marketing, sales and advertising interrogatory for Medicare Advantage and Medicare Part D Prescription Drug plans, and the company's use of telemarketers. The examiners also interviewed company management responsible for these activities. The company contracted with Ovations Inc., a subsidiary of UnitedHealth Group (UHG), for the sales and marketing of the Medicare Advantage product/plans offered through SecureHorizons and marketed through the company. Ovations was comprised of four business units: Evercare, SecureHorizons, Ovations Insurance and Medicare Part D. For the 2008 enrollment year, the company offered eleven plans to Wisconsin residents, including PFFS Medicare Advantage with and without prescription drugs, a special needs plan, Medicare Part D prescription drug plans and plans marketed for AARP.

The company did not provide complete answers to 25 of the 39 questions in OCI's marketing, sales and advertising interrogatory. The company stated that the OCI did not have jurisdiction because the interrogatory questions pertained to its agreement with CMS. UHG indicated that its State Product Advocacy (STA) section of Ovations insurance regulatory affairs department was responsible for reviewing all proposed and enacted laws including legislation and regulation such as OCI bulletins in the 50 states. Once the analysis was completed, STA distributed pertinent law updates to the states and/or producers by email.

The company indicated that UHG' compliance investigations unit was responsible for the receipt, investigation and resolution of complaints regarding Medicare Advantage sales agents. The company stated that it had a departmental database to record investigational information on agent complaints. The company's investigation unit was responsible for determining whether an escalated approach was necessary or whether the case should proceed through the normal investigation process. When the company found no credible allegation that an agent violated CMS marketing guidelines, statutes, company policy or other laws, the complaint was categorized as

non-complaint. When the complaint was valid, the investigator requested an agent statement and copy of the application. The examiners found that the company did not typically contact the Medicare beneficiary when it was investigating agent complaints since CMS advised the company not to contact the Medicare beneficiary. The company stated that after it gathered the facts and reviewed the evidence, it categorized the complaints in accordance with CMS guidelines as substantiated, unsubstantiated, inconclusive or non compliant. The disciplinary action committee (DAC) or the corrective action committee (CAC) reviewed the case summary and determined the disciplinary action or corrective action. The more serious matters were referred to the DAC, who then determined whether an agent would be terminated for cause or not cause.

The distribution compliance team also managed several different compliance monitoring programs for the agents, such as outbound education and verification, secret shopping, sales event reporting, provider contact form tracking, enrollment form completion, onsite monitoring, telephonic auditing, and sale files audits. In addition, the company stated information was received from complaint handling data from the compliance investigations unit and rapid disenrollment data from finance department. Each monitoring program had an acceptable threshold based upon CMS requirements and company standards. The agents who exceeded the established thresholds were reviewed in one of two committees (either the DAC-disciplinary action committee or the CAC-corrective action committee) to determine what the best course of corrective or progressive or disciplinary action should be taken.

The examiners requested that the company provide a listing of agents that had complaints made against them when selling Medicare Advantage or Medicare Part D plans. The company provided a list of 41 complaints involving 28 agents. The complaint categories, as defined by CMS, were unsubstantiated (10), inconclusive (18), non-complaint (7), substantiated (3) and 3 complaints were for agents that the company indicated were previously terminated. The examiners found of the three previously terminated agents, the OCI records indicate that one agent was terminated and the other two agents were still active. In the list provided by the company,

three of the agents had five complaints made against them. The examiners found that 10 of the 28 agents were not appointed with the company, although the company's policies and procedures state that agents were to be licensed and appointed with the company.

The examiners requested that the company list and describe the steps for training its agents and the time spent and cost of the training. The examiners also requested training manuals and any other materials used in the training. The company did not provide the OCI with the information, stating that the context of its marketing Medicare Advantage products in Wisconsin was subject to the jurisdiction of the CMS who had jurisdiction over the plan, and had established marketing, sales, advertising and compliance plan standards. However, the examiners did learn that the company had online certification modules that agents had to pass to sell the Medicare Advantage products.

> **6. Recommendation:** It is recommended that the company document a process for providing information requested regarding Wisconsin Medicare beneficiaries and Wisconsin insurance agent per s. 601.42, Wis. Stat.

The external company sales force was developed as a hierarchy. Each level of agent was dependent upon the other. The company had an account manager assigned to each field marketing organization (FMO) to assist the FMO in making sure the process worked. The company had no direct contract with the producers (solicitors). The levels were:

> **FMO** (Field Marketing Organization) who contracted directly with producers (solicitors) or had a contract with Super General Agents
>
> **SGA** (Super General Agent) – non captive contracted agents, supervised by FMO and Internal broker department. The company contracted directly with producers (solicitors) or contracted directly with Managing General Agents, General Agent or agents.
>
> **MGA** (Managing General Agent)- non captive contracted agent who contracted with producers (solicitors) or contracted with General Agents or Agents.

The internal sales force consisted of:

> Internal Sales Representatives (ISR), employees of the company, salaried, supervised by company sales managers, had sales territories they were responsible for.
>
> Internal Career Agents (ICA), captive agents contracted with the company, supervised by company sales managers

Telesales – internal salaried staff and the company used a vendor (Connextions) for overflow calls.

The examiners requested that the company describe the use of agents and brokers in obtaining Medicare Advantage and Medicare Prescription Drug business. The company stated that it used broker/agents who were contracted with the company. The company used FMO, MGA, SGA and GA. The company also used external solicitors who were not contracted with the company but were contracted through the FMO. The company required the solicitors to sign an agreement that outlined the company's expectations regarding representing the company. The company also used ICA's, who were contracted with the company and were supervised by company sales managers. Internal sales representatives (ISR) and internal and contracted telesales representatives were employees of the company and both were supervised by company sales managers.

The company provided a list of the FMO's, SGA's, MGA's and GA's., consisting of 26 agents and six agencies. The examiners were not able to determine if the principals of the six agencies were licensed to do business in Wisconsin as agencies may be licensed by OCI but the licensure does not provide the agency with the authority to act as an agent. The examiners found that of the 26 agents, 22 were not appointed by the company even though the contracts used during the period of review indicated that all contracted agents were to be appointed by the company for Medicare Advantage plans and Medicare Prescription Drug Plans.

The company also provided a list of 365 external solicitor agents for 2006 and 140 solicitor agents for 2007. The examiners found that four of the solicitor agents were not licensed in Wisconsin and one solicitor agent was as an insurance agency.

In the Medicare meeting on May 1, 2008, with company management, the examiners asked how the company verified that agents were licensed in Wisconsin when the agent electronically enrolled a Wisconsin Medicare beneficiary in a Medicare Advantage or Medicare Prescription drug plan. The company stated the system tracked agent licensing and it mirrored the agent contract. Each agent was given an identification number that would trigger the licensing

credentials and if the agent identification number did not match the licensing credentials the agent did not receive commissions. However, the company processed the Medicare enrollment application based on CMS guidelines. The examiners requested the company procedure on how the company conducts follow-ups with an unlicensed agent submitting the application. The company responded that it conducted no direct outreach to the agent about licensure status; but that the agent would not be paid commissions without a valid Wisconsin license.

Following the on-site portion of the examination, the examiners became aware as the result of an OCI complaint that the company also had a referral broker program. This program paid a one-time commission to licensed referring agents based on enrollment applications subsequently written by the company's agent. The company did not pay for leads under this program only for completed enrollment applications. Additionally, the company required that the new business stay in effect for at least 90 days as required by CMS guidelines in order to earn the commission. The company terminated the referral broker program effective November 15, 2008, as part of the company's Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) implementation.

> **7. Recommendation:** It is recommended that the company have a system or procedure in place to monitor the licensing and appointment of agents that solicit, negotiate or place business or that are paid compensation per s. 628.03 (1), Wis. Stat.

The company also utilized telemarketers for its Medicare Advantage and Part D business. The company stated that its non-licensed telemarketers offered basic plan information but were not allowed to compare benefits, do needs assessment, make recommendations or conduct enrollments. Its licensed telemarketers conducted needs assessments, educated on plan options, compared plans, made recommendations and completed telephonic enrollments. The company further stated that its licensed agents and non-licensed telemarketers accepted inbound telephone calls, confirmed appointment requests with field agents, RSVP Medicare beneficiaries to community seminars or/and completed a telephonic enrollments. The company provided a copy of the Secure Horizons telesales manual. This manual required that all telesales agents be licensed

and did not address the non-licensed telesales agent. The company provided a new procedure called telephonic enrollment, document number MCR-TS-A005. The company stated that although the procedure was not approved until 2008, the procedure did represent the company's practice for 2007. The document included a definition of agent that stated "A global term to refer to any licensed, certified and appointed individual soliciting and selling Ovations products, including but not limited to FMO, SGA, MGA, GA, ICA, ISR, AE, Broker or Telesales representative." The document also included a definition of a TeleSales Agent as "a licensed, certified, and appointed Agent who solicits and sells Ovations and AmeriChoice products over the telephone, by using a CMS-approved script. Or an unlicensed representative who solicits for Ovations and AmeriChoice products using a CMS-approved script, sets appointments and community meetings for field agents, gives basic benefits statements per CMS regulations, and transfers requests for enrollment to a licensed Agent." The examiners were not able to verify that the company consistently used only licensed, certified and appointed telesales agents during the period of review to enroll Medicare beneficiaries. The examiners found that the company did not have a system or procedure specific to Medicare plans for monitoring and ensuring that only licensed and appointed telemarketers enroll Medicare beneficiaries in its Medicare plans.

> **8. Recommendation**: It is recommended that the company have a system or procedure in place to monitor the licensing and appointment of its telemarketers who solicit or market telephonic enrollments.

Producer Licensing

The examiners reviewed the company's response to the producer licensing interrogatory for the Medicare Advantage and Medicare Prescription Drug plans, agency agreements, producer listing and terminations and the company's licensing and appointment of telemarketers. The examiners also interviewed company management responsible for these activities. In addition, the examiners reviewed a random sample of 50 appointed and 50 terminated agent files; 50 small employer files issued; 50 small employer quotes, and conducted

an analysis of agent data provided in response to the data call. The examiners found that four of the procedures and documents provided by the company in response to the interrogatory questions were new. Three of the documents were in draft form and one document was effective July 1, 2007, but approved on March 28, 2008.

The company's internal distribution operations department was responsible for the management of agent contracts, agent appointment and terminations in Wisconsin. The department received, processed and executed contracts; processed state appointments and terminations; requested and reviewed background investigation reports and maintained current license and appointment information. The company contracted with a vendor, CHCS, to process the listing and appointment verification for contracted agents, as well as the terminations. The company contracted with Innovative IT Solutions to process appointments for company employees such as telesales agents.

The examiners requested from the company a listing of all Wisconsin agents who represented the company as of the end of the examination period. The examiners compared these records with the agent database maintained by the OCI. The examiners found that: the company's database included the names of 244 agents that OCI records indicated were not licensed in Wisconsin. The company stated that the records it used to provide the data for commercial agents included additional data that was not specifically requested such as terminations and commission eligibility. The records included agents representing the company within the time frame of the examination period, but not all agents represented the company at the end of the examination period. Of the 31 commercial agents on the list, the examiners found that four were licensed but never appointed with the company; 11 had been licensed but were cancelled in the OCI database over ten years ago but cancelled in the company system in 2006; 18 had wrong social security numbers in the company database of which 14 were active appointed agents with the company and four had been cancelled prior to the examination period.

The examiners found 47 commercial agents who were not appointed with the company. The company stated that its database identified active appointments and in all cases the discrepancies involved company processing errors, which resulted in the OCI not receiving appropriate appointment information. The company stated that none of the agents were paid commissions for business submitted and were appointed with United Healthcare Insurance Company. Section Ins 6.57 (1), Wis. Adm. Code, states that submission of an application for an intermediary-agent appointment shall initiate the appointment. The application shall be submitted to the OCI and entered in the OCI licensing system within 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted.

9. Recommendation: It is recommended that the company appoint agents within 15 days after the earlier of the date of the agent contract is executed or the first application is submitted to comply with s. Ins. 6.57 (1), Wis. Adm. Code.

The examiners found that the OCI database indicated 83 agents were currently appointed with the company, but the company did not show the agents as appointed. The company stated that:

a) It did not have a record of ever appointing 21 agents.
b) It attempted to terminate four agents but due to processing errors, it never completed the termination process.
c) It did a clean up project of the agent system in 2003 and as a result did not have tax id's or social security numbers of 40 agents so it was not able to terminate them in the OCI system.
d) It had incorrect social security numbers for five agents in its system and it failed to correct the numbers.
e) It terminated five agents in its system in the past but it did not have verification that the terminations were processed in the OCI database.
f) Its system showed three agents were terminated due to lack of continuing education credits but the OCI database showed them as still licensed and appointed.
g) It tried to appoint one agent and due to a system error, the appointment was not completed.

Section Ins 6.57 (2), Wis. Adm. Code, provides that notices of termination of appointment of individual intermediaries in accordance with s. 628.11, Wis. Stat. are to be filed prior to or within 30 calendar days of the termination date with the office of the commissioner of insurance.

10. Recommendation: It is recommended that the company develop a process to ensure that its written procedures for the termination of agents are implemented and

that the company rewrite the agent termination letters to include a statement that the agent is to return all indicia of agency and that the company sends the notice of agent termination of appointment to the agent within 15 days of the termination as required by s. Ins 6.57 (2), Wis. Adm. Code.

The examiners found 72 agents whose license numbers in the company database did not match the agent license number in the OCI database. The company agreed that the agent license number in its database was not correct and made the correction. The examiners compared the last names of agents from the company's data and the last names in the OCI database. The examiners found that the OCI database included 44 commercial and Medicare Advantage agents whose last name did not match that in the company database. For the 27 commercial agents the company stated that the agents failed to notify the company of the name change or that the company found an error when the name was entered into the company's system.

The examiners found that the company's system had 190 agents appointed with the company as of the end of the examination period although their Wisconsin agent license was cancelled. The company stated that none of the agents represented or sold any business as of the end of the examination period. The agent's licenses were terminated prior to December 31, 2007, and data was provided in error. The examiners reviewed data regarding these agents who wrote the company's commercial business and found that:

a) 32 commercial agents had an inactive license status with OCI but remained active in company's system
b) 31 commercial agents had their license terminated by the company, but company failed to notify OCI within 30 calendar days of the termination date
c) 1 commercial agent had an inactive license status by OCI for failure to pay but company did not terminate agent in its system and continue to pay commission

11. Recommendation: It is recommended that the company revise its procedure and conduct an internal audit within 90 days of the adoption of the report to make sure all OCI requests for intermediary's license termination regarding agents writing its commercial business are done without delay in order to comply with s. 628.10 (2) (am), Wis. Stat.

The examiners reviewed the small employer quotes provided by the company in response to the data request. The examiners were not able to review 564 of the quotes noted in the data as direct sales because the data did not contain the agent's social security number. The

company stated the original data contained quote data that was not applicable to the examination review. The company's quote issuance system (UnitedeServices) was used for issuing quotes by licensed agents and brokers, as well as, testing proper product loads and for staff to provide quotes to agents/brokers at their request that were noted in the quote system as direct-sale quotes. The company explained that:

a). 195 of the 564 quotes were test quotes and should not have included in the data.

b) 114 quotes were made by five agents. One of the agents who provided two quotes was licensed but had never been appointed with the company.

c) 190 of the quotes were not identified in the quote system with an agent name.

c) quotes were sent to agent/brokers by staff members as direct sales. Four quotes were not identified with an agent name; one quote was submitted by an agent who was licensed but not appointed at the time of the initial quote and one agent was not licensed or appointed with the company at the time of the quote.

The examiners compared the company's small employer quote data with the OCI agent licensing data base. The examiners found 33 agents and 224 quotes that the quote issue date was prior to the date of the agent's Wisconsin insurance license. The company stated that the small employer quotes were issued in error. The examiners found that 22 agents were not licensed. The examiners also found that 20 of the 22 agents were not appointed with the company in a timely manner and two agents were not appointed with the company. Section Ins 6.57 (5), Wis. Adm. Code, provides that no insurer shall accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent with that insurer. Section Ins 6.57(1), Wis. Adm. Code, provides that submission of an application for an intermediary agent shall be submitted to the office of the commissioner of insurance and entered in the OCI licensing system within 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted.

The examiners requested that the company verify for 50 groups in the small employer business data call that the agent who sold the group policy was licensed in Wisconsin. The examiners found 15 agents who were licensed but who were appointed after the sale of the group; seven agents who were licensed but never appointed with the company; one group had the wrong state, and 14 groups were sold by unlicensed and unlisted agents. Section 628.03, Wis. Stat., provides that no natural person may perform, offer to perform or advertise any service as an intermediary in this state unless the natural person obtains a license under s. 628.04 or 628.09, Wis. Stat. and no person may utilize the services of another as an intermediary if the person knows or should know that the other does not have a license as required by law. Section Ins 6.57 (5), Wis. Adm. Code, provides that no insurer shall accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent appointed with that insurer.

12. **Recommendation:** It is recommended that the company develop written procedures and a process to ensure it does not accept small employer quotes from agents who are not licensed in the state of Wisconsin to ensure compliance with s. 628.03, Wis. Stat., and s. Ins 6.57 (5), Wis. Adm. Code.

13. **Recommendation:** It is recommended that the company develop a process to appoint all agents marketing small employer insurance to ensure compliance with s. Ins 6.57 (1) and (5), Wis. Adm. Code.

The examiners reviewed a random sample of 50 active agent files. The examiners found that five of the agent files did not include applications for appointments for these agents, which the company indicated was part of the contracting packet that agents submitted to the company. Section Ins 6.80, Wis. Adm. Code, provides that domestic insurers shall provide records of insurance company operations and other financial records reasonably related to insurance operations for the preceding 3 years shall be maintained and be available to the commissioner.

14. **Recommendation:** It is recommended that the company develop a process to ensure that its agent files are complete in order to show compliance with s. Ins 6.80 (4), Wis. Adm. Code.

The examiners found that the company failed to appoint 24 agents within 15 days of the execution of the agent contract. Section Ins 6.57 (1), Wis. Adm. Code, states the application shall

be submitted to the office of the commissioner of insurance 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted. The company responded that, "Agents are appointed as licenses are received, therefore the WI license may have been submitted to the Company 1 day to several years after the original contract was signed. However, no agent can sell without an appointment. The date an agent can begin selling in a particular state was not the contract start date, but rather the appointment date. An agent's contract start date was the date an agent signed the company's contracts; agents are not authorized to sell until the appointment and certification are completed."

The examiners reviewed a random sample of 50 terminated agent files. The company provided a copy each agent termination letter giving the notice of termination of appointment stating that the agent was no longer appointed as a representative and may not act as a representative of the company. The notice did not include a formal demand for the return of all indicia of agency as required. The company stated that even though this information was not included in its letter, at the time of appointment, agents were required to sign a UnitedHealthcare producer contract, which clearly stated that the agent must promptly return or destroy all marketing and enrollment materials provided by UnitedHealthcare to UnitedHealthcare when the contract terminates, or sooner upon UnitedHealthcare's request. Section Ins 6.57 (2), Wis. Adm. Code, states that prior to or within 15 days of filing termination notice with the OCI, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative of the company and that he or she may not act as its representative. This notice shall also include a formal demand for the return of all indicia of agency.

The examiners found seven agent files where agents were not notified of the termination within 15 days of the date of termination. The company stated that although the agents did receive termination letters, it agreed that the letters were not within the 15 days of termination as required.

The examiners requested copies of the company's procedures for agent termination that were in effect during the period of review. The company provided a copy of procedure agent termination and appointments, document MCR-CLA008, with a revision date of March 10, 2008. The examiners re-requested a copy of the procedures in effect during the period of review. The company provided the same document form number with an approval date of 1/26/07 and an effective date of 2/1/07. Both sets of procedures indicated that the distribution operations certification and contract/licensing manager or supervisor were responsible for conducting audits for cause and not for cause terminations to ensure that CHCS, its delegated vendor, had mailed the appropriate letter, that termination transactions were completed and to ensure the DOI terminations were done. Page three of the procedures indicated that the company conducted audits within 30 to 90 days after the request for termination was submitted to CHCS. The examiners requested copies of audits for 2007. The company stated that no audits were conducted during 2007.

The examiners reviewed the small employer issued data provided by the company in response to the data request and found 178 files where no information regarding the agent was provided. The examiners found three small employer issued groups were sold by agents who were not licensed or appointed with the company; four groups that the agents were appointed more than 15 days after the group had been issued and one group that the agent had never been appointed with the company. Section 628.03, Wis. Stat., states that "no natural person may perform, offer to perform or advertise any service as an intermediary in this state, unless the natural person obtains a license under s.628.04 or 628.09, and no person may utilize the services of another as an intermediary if the person knows or should know that the other does not have a license as required by law."

15. Recommendation: It is recommended that the company develop and implement a procedure and process for ensuring that all types of agents have a valid insurance license to be in compliance with s. 628.03 (1), Wis. Stat.

16. Recommendation: It is recommended that the company develop a process to ensure that the language in its agent contracts regarding appointing agents and in its written procedures is being followed.

The examiners discussed with the company ways in which it could audit and maintain current and accurate agent licensing and appointment information. The company indicated that the annual agent billing statement reconciliation was a manually intensive process. The examiners found that as the company did not completely reconcile all agent records in its system with the records obtained from NIPR's producer database and the OCI data, and numerous errors existed it must develop a process for periodically auditing its agent records. Section Ins 6.57 (3), Wis. Adm. Code, provides that each insurer shall pay once each year the annual appointment fee within 30 days after the mailing of a payment notice to each insurer showing the amount due for all individuals serving as agents for such insurer, according to the commissioner's records as of the notice date.

17. Recommendation: It is recommended that the company develop and implement procedures and processes which include an annual audit to reconcile the annual agent billing statement sent by the OCI with the company records to ensure compliance with s. Ins 6.57 (3), Wis. Adm. Code.

Medicare Advantage Agent Licensing

The examiners requested from the company a listing of all Wisconsin agents who represented the company as of the end of the examination period, which included agents licensed for its Medicare Advantage and Medicare Part D business. The examiners also requested commission and enrollment application data specific to agents writing Medicare Advantage and Part D that the company declined to provide alleging that only CMS had jurisdiction. The examiners compared these records with the agent database maintained by the OCI. The examiners found that the company's database included the names of 244 agents that OCI records indicated were not licensed in Wisconsin. The company stated that for the 213 Medicare Advantage agents, many processes were performed manually due to system constraints of its third party administrator (CHCS) and were subject to human error. While procedures had been put into place to minimize errors, some remained undetected in the system. The company stated it was in

the process of developing a fully automated system to manage licensure and appointments, which would remedy many of the errors that occurred. The examiners found that 141 of the 213 Medicare Advantage agents were on the company list with agency names, not licensed individual agent names. The files either did not include social security numbers, had numbers that did not correspond with individual agent social security numbers or the social security number were incorrectly entered in the company database. As a result, the examiners were not able to document that the 141 agents selling Medicare Advantage products to Wisconsin Medicare beneficiaries during the period of review, were licensed to do business in Wisconsin.

> **18. Recommendation:** It is recommended that the company submit the application for agent appointment to the OCI and entered into the OCI licensing system in a format specified by the commissioner of insurance within 15 days after the earlier of the date of the agent contract is executed or the first application is submitted to comply with s. Ins. 6.57 (1), Wis. Adm. Code.

As part of the data match of agent license numbers and agent names in the company database with those in the OCI database, the examiners found 15 company Medicare agent names did not match the OCI data. The company's database indicated eight agents with errors in the spelling or changes to their last names, and seven agents who were listed as agencies in database and individuals in the OCI database. The company stated that it contracted with agencies and entered the contracted entity into its database. It indicated it appointed the principal of the agency on behalf of the agency but the main name in its system was the agency.

The examiners reviewed the 190 agents that the company's system showed as appointed but whose Wisconsin agent license was cancelled specific to applications written for the company's Medicare Advantage business and found that:

a) 1 Medicare Advantage agent had his license terminated by the company, but company failed to notify OCI within 30 calendar days of the termination date

b) it appeared that the company accepted Medicare advantage business from 60 terminated but licensed agents; however, company stated no commissions were paid

c) 27 Medicare Advantage agents were appointed with PacifiCare but not with UnitedHealthcare of Wisconsin

d) 2 Medicare Advantage agents were never appointed with the company

The examiners requested that the company provide a list of the agents that marketed the Medicare Advantage and Medicare Prescription Drug plans and to indicate if during the period of review the company required agent appointments and listings. The company stated that during the period of review it required agent appointments. The examiners found one agent in the company data that was not licensed or appointed with the company and one agent who was licensed but not appointed until after the period of review.

19. Recommendation: It is recommended that the company revise its procedure and conduct an internal audit of agent licensing and appointment records within 90 days of the adoption of the report to comply with s. 628.10 (2) (am), Wis. Stat.

Policyholder Service & Complaints

The examiners reviewed the company's response to OCI's policyholder service and complaints interrogatory, and the written policies and procedures for handling complaints, internal audit reports and record keeping system.

The examiners reviewed a random sample of 50 complaints. The complaint sample contained thirteen complaints that the company received in writing. The examiners found that the 13 complaints met the definition of a grievance and should have been recorded as grievances per s. Ins. 18.03, Wis. Adm. Code. The 13 files included documentation that the company did afford the complainants the grievance process. The company stated it amended its internal Wisconsin compliance grid in March 2006 to direct that all written Wisconsin UHC issues be recorded as grievances. The examiners could document the company's change as the complaints after March 2006 did not contain complaints that were received in writing and that were recorded as grievances.

The company stated that one of the complaints involved the subscriber making an inquiry regarding the status of a claim determination, and the inquiry did not meet the definition of a grievance as defined in s. Ins 18.01, Wis. Adm. Code. The subscriber letter dated January 4,

2006, stated, "I'm writing concerning claim #..., find it, pay me or tell me why you are not." The examiners found that the subscriber was expressing dissatisfaction with the company's provision of services and claim practices, which met the definition of a grievance per s. Ins 18.01, Wis. Adm. Code.

The company also admitted that in one complaint file it did not notify the insured of the right to an independent review as required by s. Ins 18.11 (2), Wis. Adm. Code, and s. 632.835, Wis. Stat.

> **20. Recommendation:** It is recommended that the company recognize a grievance, which is defined as any dissatisfaction with the provisions of services or claim practices of an insurer offering a health benefit plan in order to document compliance with s. Ins 18.01, Wis. Adm. Code.

The policyholder service and complaint interrogatory question number 11 requested that the company explain how and where the information and documents generated as a result of policyholder contact were maintained and to indicate if it was possible to retrieve information or documents generated and to sort the records by state. The company responded that, "All calls received by a Customer Care agent are documented in the Online Routing System (ORS). The On-line Routing System is the mechanism to record, route, and reconcile issues received from external customers, as well as communications from various internal departments including Customer Service, Health Care Networks, Medical Management, and Claims Operations. The call records are retrievable by member identification number. Records under the jurisdiction of the state of Wisconsin cannot be easily isolated." The examiners requested that the company demonstrate compliance with the requirements of s. Ins 18.06 (1), Wis. Adm. Code, and the prior examination recommendation number 5 with the statement "Records under the jurisdiction of the state of Wisconsin can not be easily isolated." The company responded that it was in compliance with the prior examination recommendation and could pull Wisconsin based complaints off the complaint tracking system. However, the complaint data for 2006 was difficult to obtain from the company and the examiners worked with the company in an attempt to obtain a valid sample. When this was not successful, the examiners agreed to a more limited sample to include

complaints from the fourth quarter of 2006 through December 2007. However due to the time involved to pull the fourth quarter of 2006 and the fact that OCI reserved the right to obtain the remaining 2006 complaints, OCI requested all of the entire complaint data for 2006.

The examiners received the complaint data for 2006, which consisted of 79 complaint files: 13 UBH (United Behavioral Health), 65 CEU (Central Escalation Unit), 1 Executive compared to the 85 complaint files in 2007. The examiners question the small number of complaints identified by the company' s grievance numbers as logic would dictate that the number of complaints should be considerably higher than the number of grievances. The grievance data call that the company provided the OCI identified 501 grievances in 2006 and 326 grievances in 2007. No exceptions were noted regarding the complaint files reviewed.

21. **Recommendation:** It is again recommended that the company revise its manner in which it maintains a record of complaints so it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with s. Ins. 18.06 (1), Wis. Adm. Code.

22. **Recommendation:** It is recommended the company ensure records are maintained as required by s. Ins 6.80 (4) Wis. Adm. Code, and can be made available upon request in accordance with provisions of s. 601.42, Wis. Stat.

Small Employer

The examiners reviewed the company's response to OCI's small employer interrogatory, the written policies and procedures for small employer group business, rating practices, underwriting standards, applications, waiver forms, and standardized letters.

The examiners reviewed a random sample of 50 small employer business files for coverage issued during the period of review. The examiners found eight files where the eligible individuals were waiving coverage but waiver forms were not in files for those individuals. The company stated it had procedures in place to ensure compliance with s. Ins 8.65, Wis. Adm. Code, which requires as part of the application process small employers provide documentation to establish that waivers of coverage are voluntary and permitted. The company's procedures stated that its sales operation team reviewed all new case submissions to ensure that applications and

waivers were included. New cases submissions were not installed until wage/tax verification was reviewed to ensure all applications and waivers had been received. However, the company stated that in the eight files the waivers could not be located. Section Ins 8.65, Wis. Adm. Code, requires as part of the application process small employers to provide documentation to establish that waivers of coverage are voluntary and permitted.

23. **Recommendation:** It is recommended that the company revise the procedures to replicate a complete business file for small groups that convert coverage in compliance with the requirements of s. Ins 8.65 (4), Wis. Adm. Code.

The examiners found that four small employer business files did not include a copy of the rating and renewability disclosure form that was required to be completed before an application was completed with a copy given to the employer applicant. Although the company had a written procedure in place that complied with the requirements of s. 635.11, Wis. Stat., as regards the rating and renewability form, the company could not provide documentation that it provided the rating and renewability forms for the four files.

24. **Recommendation:** It is recommended that the company improve its current procedures to ensure that the rating and renewability form is signed by the applicant at the time of application and a copy of the form retained in the small employer's business file maintained by the company in compliance with the requirements of s. 635.11, Wis. Stat.

The examiners found the company's "welcome" letter for new groups did not comply with s. Ins 8.44 (2), Wis. Adm. Code, which requires that information be disclosed by the insurer with a separate written notice that explained under what circumstances the protections of s. 635 Wis. Stat., will cease to exist, i.e. if the employer moves the business out of state or if the employer no longer meets the definition of a small employer. The company agreed that its procedure did not comply with s. Ins 8.44 (2), Wis. Adm. Code, and indicated that it would revise the administrative welcome packet to include the language from the policy.

25. **Recommendation:** It is recommended that the company revise the existing procedures to comply with the requirements of s. Ins 8.44 (2), Wis. Adm. Code, and provide a separate notice to the policyholder when the policy is issued to advise the policyholder that the afforded by Chapter 635 Wis. Stats., will cease to exist if the

employer moves the business out of state or if the employer no longer meets the definition of a small employer.

The examiners found that none of the 50 small employer files reviewed contained evidence to show that supporting documentation was obtained during the application process to verify that a complete list of eligible employees was obtained as required by s. Ins. 8.65 (1), Wis. Adm. Code. The files contained a document titled "prime census", which provided a list of employees. The examiners requested the company provide supporting documentation that it obtained to verify that the census was accurate. The company provided materials used to train staff of the requirement. The examiners found that none of the 50 files reviewed included documentation in the form of a wage and tax statement or other independent documentation to verify compliance with s. Ins 8.65 (1), Wis. Adm. Code. The company provided supporting documentation subsequent to the completion of the field work.

26. **Recommendation:** It is recommended that the company revise its current procedures to obtain independent verification of the employee census provided by the employer that the census is accurate in order to comply with the requirements of s. Ins 8.65 (1), Wis. Adm. Code.

The examiners requested that the company demonstrate compliance with the prior recommendation that the company revise the procedures to record the date it received a request for a small employer health plan price quote. The company provided the examiners with documentation that indicated the company's quote record system was revised as recommended to include the date the request for a quote was made. The examiners reviewed a random sample of 25 small employer quote files and found that the company had modified the system to capture the quote receipt date except for those instances where the request was obtained on-line by the broker/agent. The examiners documented that the company provided quotes within a few days of receiving the request.

27. **Recommendation:** It is again recommended that the company revise its procedures to record the date it receives a request for a small employer health plan price quote.

Grievances & Independent Review

The examiners reviewed the company's response to OCI's grievance and IRO interrogatory, the company's written grievance procedures and policies, provider agreements, grievance reports and summaries, and grievance committee meeting minutes. The examiners also reviewed the company's independent review organization (IRO) process, and interviewed company management regarding its grievance and IRO processes.

Independent Review Organization Process

The examiners reviewed the company's informational material provided to members regarding the IRO process, including the amendment to the group policy, and notices in the denial letters, expedited review procedures and the grievance resolution letter. The examiners also reviewed the company's procedures for providing all documentation to an IRO when the company received a review request.

The company provided a copy of the policy language describing the independent review process and a copy of the external review program provision in the certificate of coverage with form number COC.CPL.H.07.WI and indicated that this form was approved by OCI on February 2, 2007. The examiners found that this provision did not explain how the insured may obtain a current listing of certified independent review organizations. The company stated that certificate language would be amended to include a statement explaining how to obtain a current list of certified IROs.

28. **Recommendation:** It is again recommended that the company modify the independent review provision in the policies and certificates to include a statement explaining how to obtain a current listing of independent review organizations, as required by s. 632.835 (2) (bg) 1, Wis. Stat.

The company provided a copy of its internal appeals state requirements grid for Wisconsin. The definition of adverse determination in the document indicated the denial of a request for a referral for out of network services was considered an adverse determination only for the company's closed panel plans. The examiners requested the company to verify that this was

correct or to provide an explanation of the definition. The examiners also asked if the company's open panel plans, such as the point-of-service plans, included any referral procedures to allow the member to receive services from a non-plan provider at a higher benefit level. The company agreed that the definition of adverse determination in the HMO appeals state grid was inconsistent with the HMO external state requirement grid. The company also stated that enrollees in a point-of-service plan may receive out-of-network benefits at a higher benefit level if services are not available in-plan.

29. **Recommendation:** It is recommended that the company modify the definition of adverse determination in the HMO Appeals State Grid and all material relating to the Wisconsin independent review process to clearly state that an adverse determination includes the denial of the insured's request for out-of-network services because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network, as required by s. Ins 18.10 (1), Wis. Adm. Code.

The examiners reviewed the nine IRO files, in two of the files the insured was appealing the company's coverage denial of non-network services. In each case, the insured maintained that the in-network providers did not have the necessary expertise to provide the covered service. However, the examiners found that neither of the grievance resolution letters appeared to include a notice of the insured's right to request an independent review. The company acknowledged that it did not provide IRO rights with the two grievance resolution letters although it was an adverse determination.

30. **Recommendation:** It is recommended that the company include a notification of the insured's right to request an independent review with every grievance resolution letter when the grievance results in an adverse determination or an experimental treatment determination, as required by s. 632.835 (2), Wis. Stat.

The examiners reviewed the nine IRO files and in three of the files, the insured's initial request for an independent review was returned by the company. The company acknowledged its non-compliance and indicated that in February 2008, the company had changed the denial letters to instruct insureds to send independent review requests to the Duluth address.

31. **Recommendation:** It is recommended that the company establish a procedure to identify independent review requests from Wisconsin insureds in a timely manner in

order to allow the insured to obtain an independent review within the timeframes provided in s. 632.835 (3), Wis. Stat.

The examiners reviewed the nine IRO files and in two of the files did not contain complete documentation on how the company handled the independent review request. The company did not provide copies of the IRO's determination letters for the two files.

32. Recommendation: It is recommended that the company maintain a copy of the IRO's determination letter in the file in order to document that it has complied with the IRO's decision, as required by s. 632.835 (3) (f), Wis. Stat.

The examiners reviewed the nine IRO files and in five of the files did not contain documentation that the company provided a notice to OCI of the receipt of the independent review request within two business days, as required by s. Ins 18.11 (3) (a), Wis. Adm. Code. The company acknowledged that it did not send notice to OCI of independent review request for files three of the files. The company further acknowledged untimely notice of independent review notice to OCI for two of the files.

33. Recommendation: It is recommended that the company provide written notice to OCI of the receipt of an independent review request within two business days, as required by s. Ins 18.11 (3) (a), Wis. Adm. Code.

The examiners reviewed the nine IRO files and in three of the files, it appeared that the company did not submit the file to the IRO within five business days after receiving written notice of an independent review request, as required by s. 632.835 (3) (b), Wis. Stat. The company acknowledged its non-compliance with submitting the file to the IRO within five days

34. Recommendation: It is recommended that the company submit the file to the IRO within five business days after receiving written notice of an independent review request, as required by s. 632.835 (3) (b), Wis. Stat.

Grievance Process

The examiners also reviewed a random sample of 50 grievance files. The examiners found that three of the files did not contain an acknowledgement letter from the company and the company acknowledged the non-compliance with s. Ins. 18.03 (4), Wis. Adm. Code. The examiners reviewed a random sample of 50 complaints. The examiners found that seven of the 50

complaint files indicated the company recorded the grievances as complaints and afforded the grievant with the grievance process. The company admitted that it did not send an acknowledgment letter or send an acknowledgment letter within the five days as required of s. Ins 18.03 (4), Wis. Adm. Code.

35. **Recommendation:** It is recommended that the company send the insured or the insured's authorized representative a written acknowledgement within five business days of the receipt of each grievance confirming the receipt of the grievance, as required by s. Ins 18.03 (4), Wis. Adm. Code.

The examiners reviewed a random sample of 50 grievance files. The examiners found that one file did not satisfy the 7 day notice requirement for the grievance hearing. The company acknowledged it did not comply with the 7 day notice requirement in this case. OCI has met quarterly with the company since May of 2006 to receive status reports on compliance with the 2005 stipulation and order. In the quarterly meetings any deviations from the requirements of the stipulation and order in regards to handling a grievance were discussed and the company reported on the cause and steps taken to correct the deviations.

The examiners reviewed the grievance data provided by the company in response to the data call. The grievance records provided in the data call contained 131 grievances that were not reported to OCI by the company in the grievance logs the 2006 and 2007 grievance experience reports. The grievance experience reports included grievances closed during the calendar year, not those received, therefore, 30 grievances received in 2006 were closed in 2007, and 22 received in 2007 were closed in 2008. The examiners found that the company failed to report 17 grievances in the 2007 grievance experience report because the member had submitted two grievances during the year and only the first was included in the report, due to a processing error eight grievances included in the data call were not the company's enrollees and the data call included Wisconsin residents who had HMO plans, even if the employer was not located in Wisconsin.

36. **Recommendation:** It is recommended that the company submit amended grievance experience reports to OCI for 2006 and 2007 to include all grievances

that the company received during the calendar year that that the company modify the grievance reporting procedures so that future reports will include information on all grievances received during the previous calendar year, as required by s. Ins 18.06 (2), Wis. Adm. Code.

The company provided a copy of a procedure titled urgent appeals review. The introduction of this procedures stated that an urgent appeal must meet one of two criteria; either a delay in treatment could jeopardize the life or health of the insured or in the opinion of a physician with knowledge of the medical condition, a delay could cause severe pain. Section Ins 18.01 (4), Wis. Adm. Code, references in the definition of expedited grievance, in addition to the above two criteria, that an expedited grievance applies if a physician with knowledge of the insured's medical condition determines that the grievance shall be treated as an expedited grievance. The company agreed that its definition did not comply with all criteria in administrative code since the procedure did not state that an expedited grievance applies if a physician stated that the grievance should be expedited. The company provided documentation that it had updated its Wisconsin state requirements document during the examiners' on-site field work.

37. **Recommendation:** It is recommended that the company modify the definition of expedited grievance in the internal procedures to comply with s. Ins 18.01 (4), Wis. Adm. Code.

The examiners requested the company demonstrate compliance with the prior exam recommendation that the company revise the definition of complaint in the written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code, and to handle as grievances all written communications that meet the definition of a grievance in s. Ins 18.01, (4), Wis. Adm. Code. The examiners found that the company's definition of a complaint did not comply with the definition of s. Ins.18.01 (4), Wis. Adm. Code, in that the definition included "written" communications expressing dissatisfaction as complaints. This was apparent during the examiners review of the policyholder service and complaint sample of 50 complaint files that contained "written" complaints.

38. **Recommendation:** It is again recommended that the company revise the definition of complaint in its written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code and to handle as grievances all written

communications that meet the definition of a grievance in s. Ins 18. 01, (4) Wis. Adm. Code.

Privacy and Confidentiality

The examiners reviewed the company's privacy of consumer financial and health information interrogatory response, the privacy policy manual, HIPAA OneSource manual, employee training materials, disclosure authorizations, and agent contracts. The examiners also interviewed the UHG privacy manager.

The company provided a copy of the corporate privacy office privacy manual that was in place and was last updated in 2003. The examiners found that the company did not use the privacy manual, but rather, the privacy office used the HIPAA OneSource manual as a privacy resource guide. Although the company indicated that all privacy policies were developed at the corporate level, the examiners found that there appeared to be no formal communication of the policies within the company or oversight of the company's privacy activities. Even though the corporate privacy office was responsible implementing all privacy-related policies and procedures, the company did not have in place a written policy and procedure for communications between the company and the corporate privacy office. It was not clear how the company ensured that there was active communication between the company and the corporate privacy office or how it ensures that all privacy issues identified by the company were promptly reported to the privacy office for handling. It was also not clear how the company's privacy office ensures that adequate privacy compliance training was provided to employees of the company and that all potential privacy breaches or deficiencies in the privacy policy identified by the company were considered and addressed by the corporate privacy office.

The company indicated that corporate sent an annual compliance mailing including a financial information privacy notice. The company provided a copy the notice

39. Recommendation: It is recommended that the company draft and implement written policies and procedures for communications between the company and the corporate privacy office, including oversight of all privacy-related employee training and

business practices for auditing purposes and to ensure compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

The company provided a disclosure authorization form that included free-text fields that requested the type of information to be disclosed and the purpose of the disclosure. The company indicated that the blank authorization form was mailed to the insured, and the insured was responsible for filling out the free-text fields. If the insured provided incomplete or inaccurate information, the company requested additional information from the insured. The disclosure authorization did not include the nature of the information to be disclosed and the purpose for which the information was being obtained as required by s. 610.70 (2) (a) 4 and 6 Wis. Stat. The company did not have a procedure for ensuring that insureds were aware that they must provide this information in the free-text fields.

40. Recommendation: It is recommended that the company revise the disclosure authorization form to include the nature of the information to be disclosed and the purpose for which the information is being obtained, as required by s. 610.70 (2) (a) 4 and 6, Wis. Stat.

The examiners found that company's corporate privacy policy manual stated that requests by the insured or the insured's authorized representative for access to medical records be acted upon with 30 days of receipt if the information was maintained or accessible on-site, or within 60 days if the information was not maintained or accessible on-site. The examiners found that the privacy policy manual also stated that requests by the insured or the insured's authorized representative for a written accounting of any persons to whom the insurer had disclosed the recorded personal medical information in the company's possession within 2 years prior to the request be fulfilled within 60 days of request, or within 90 days if the company was unable to provide the information with the company in 60 days. Section 610.70 (3), Wis. Stat., provides that requests for access to personal medical information in the company's possession, including an accounting of all disclosures made within two years prior to the request, must be handled within 30 business days of receipt provided the information that is the subject of the request is reasonably easy to locate and retrieve by the insurer.

41. **Recommendation:** It is recommended that the company revise the internal policies and procedures to provide that requests for access to personal medical information in the company's possession, including an accounting of all disclosures made within two years prior to the request, be handled within 30 business days of receipt provided the information that is the subject of the request is reasonably easy to locate and retrieve by the insurer, as required by s. 610.70 (3), Wis. Stat.

The examiners found that company's corporate privacy policy manual included a number of circumstances under which the company could deny requests for access to personal medical information in the company's possession and did not have a policy in place to address the requirements of section 610.70 (3), (b) and (d) Wis. Stat.

42. **Recommendation:** It is recommended that the company implement a written procedure for providing requested personal medical information to a health care provider designated by an individual or under certain circumstances, to ensure compliance with s. 610.70 (3) (b) and (d) Wis. Stat.

The examiners found that the company's corporate privacy policy manual provided that the company act on requests by the insured or the insured's authorized representative to amend personal medical information in the company's possession within 60 days, and that the time frame may be extended by up to 30 days with notice to the requesting individual. Section 610.70 (4), Wis. Stat., provides that requests to correct, amend or delete any personal medical information in the company's possession must be handled within 30 days of receipt.

43. **Recommendation:** It is recommended that the company revise the internal privacy policy and procedure to provide that requests by the insured or the insured's authorized representative to amend personal medical information in the company's possession by handled within 30 days of receipt as required by s. 610.70 (4), Wis. Stat.

Electronic-Commerce

The examiners reviewed the company's response to OCI's electronic commerce interrogatory and the parent company's corporate website www.uhc.com. The company did not maintain a company specific website. The website allowed applicants to obtain a quote, find a broker and to find a physician. The website linked members to www.myuhc.com, a free online tool where members could manage their plan benefits by creating their own personalized homepage.

Members could view a summary of coverage and benefits; claim activity and estimated out of pocket costs; look up benefits and check on co-pays; find a doctor based on a medical condition or procedure needed; refill a prescription; check deductible account balances, view and print statements and chat with a live nurse. The online provider directories were available to the general public via the Physician Directory link located on www.uhc.com and also via the pre-login directory on www.myuhc.com. On both sites the user had to select from the product selection drop-down box for the plan they wanted to search and then that criteria was mapped to the appropriate network of participating providers. According to the company, the online directory data was refreshed weekly and was available on Wednesday mornings.

The website allowed individuals to obtain information only regarding Medicare plans, by selecting a Medicare tab that directed the viewer to www.SecureHorizons.com.

The parent company United Health Group had privacy and security policies to address the protection of personal information along with a security infrastructure.

No exceptions regarding the electronic-commerce review were noted.

Compliance Program Order

Following the April 14, 2004, adoption of the prior examination report of the company, the OCI issued a stipulation and order dated November 9, 2005. The stipulation and order required that the company maintain a Wisconsin compliance program, and specified consumer and insured service matters. The compliance program required measures and controls to ensure that material violations were promptly identified, including management reports, internal audits and periodic evaluation by an outside auditor of the effectiveness of the compliance program. In addition, the OCI held quarterly compliance meetings with the company at which time the company reported and presented documentation regarding its compliance with the stipulation and order.

The examiners reviewed the company's compliance program, responses to interrogatories regarding company operations, company procedures and random file samples. The

examiners also conducted interview with company management responsible for company operations and compliance. The examiners found that the company had made a significant effort to comply with the stipulation and order, including on-going audits of complaints, grievances, IROs and claims involving Wisconsin mandated benefits.

The company contracted with a firm to complete an independent evaluation of the company's compliance with the stipulation and order, and provided to the OCI a copy of the report. The company provided to the OCI quarterly progress reports to document its ongoing efforts to comply with the stipulation and order and the recommendations in the examination report. Therefore, the examiners also found that the company had developed and instituted improvements to its compliance improvement plan.

The examiners found that the external audit report dated December 31, 2008, indicated that the company complied with the specific consumer and insured service matters addressed in the stipulation and order. However, the examiners found that the external audit report was not complete in that it did not include reference to the auditors' findings regarding the effectiveness of the company's compliance program. The company provided a supplement to the external audit on April 7, 2009 providing additional details about the effectiveness of the compliance program.

V. CONCLUSION

The examiners found that the company was not in compliance with four of the thirty-four recommendations made in prior market conduct examination. In addition to repeating these four recommendations, this examination report contains 39 new recommendations in all areas reviewed with the exception of the electronic commerce review. Ten recommendations relate to the licensing and listing of agents and eleven recommendations relate to the company's handling of grievances and IROs.

The examiners found that the company had written procedures in place but it was evident that the company did not consistently follow its procedures.

The examiners' review of the company's oversight of Medicare Advantage and Medicare prescription drug plan agent marketing activities indicated that it did not comply with Wisconsin agent licensing requirements. The examiners were not able to conduct a thorough review of the Medicare marketing activities because the company did not release certain documents. The company stated that these documents were subject to CMS jurisdiction. The company was not able to consistently document the licensing and appointment status of agents taking electronic applications. The examiners also have concerns regarding the company's failure to consistently appoint agents involved in the company's small employer business, includes the submission of applications for quotes.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 14. 1. It is recommended that the company correctly word the provider explanation of benefits as remittance advice as required by s. Ins 3.651 (3) Wis. Adm. Code.

Page 15 2. It is recommended that the company place ANSI codes in the ANSI code column on the remittance advices to meet the requirements of s. Ins. 3.651 (3)(b)(4) (i) Wis. Adm. Code.

Page 15 3. It is recommended that the company revise the member EOB forms to include CPT or like codes to satisfy the minimum requirements of s. Ins 3.651 (4) 5.c. Wis. Adm. Code.

Managed Care

Page 17 4. It is recommended that the company provide a copy of the A.C.N. Group audit report in order to document compliance with s. Ins 9.42 (5) (a) Wis. Adm. Code.

Page 17 5. It is recommended that the company audit the EOB's annually as stated in the company's compliance plan to demonstrate compliance with s. Ins. 9.42 (3) Wis. Adm. Code.

Marketing Sales & Advertising

Page 20 6. It is recommended that the company document a process for providing information requested regarding Wisconsin Medicare Beneficiaries and Wisconsin insurance agents per s. 601.42, Wis. Stat.

Page 22 7. It is recommended that the company have a system or procedure in place to monitor the licensing and appointment of agents that solicit, negotiate or place business or that are paid compensation per s. 628.03 (1), Wis. Stat.

Page 23 8. It is recommended that the company have a system or procedure in place to monitor the licensing and appointment of its telemarketers who solicit or market telephonic enrollments.

Producer Licensing

Page 25 9. It is recommended that the company appoint agents within 15 days after the earlier of the date of the agent contract is executed or the first application is submitted to comply with s. Ins. 6.57 (1), Wis. Adm. Code.

Page 25 10. It is recommended that the company develop a process to ensure that its written procedures for the termination of agents are implemented and that the company rewrite the agent termination letters to include a statement that the agent is to return all indicia of agency and that the company sends the notice of agent termination of appointment to the agent within 15 days of the termination as required by s. Ins 6.57 (2), Wis. Adm. Code

Page 26 11. It is recommended that the company revise its procedure and conduct an internal audit within 90 days of the adoption of the report to make sure all OCI requests for intermediary's license termination regarding agents writing its commercial business are done without delay in order to comply with s. 628.10 (2) (am), Wis. Stat,

Page 28 12. It is recommended that the company develop written procedures and a process to ensure it does not accept small employer quotes from agents who are not licensed in the state of Wisconsin to ensure compliance with s. 628.03, Wis. Stat., and s. Ins 6.57 (5), Wis. Adm. Code.

Page 28 13. It is recommended that the company develop a process to appoint all agents marketing small employer insurance to ensure compliance with s. Ins 6.57 (1) and (5), Wis. Adm. Code.

Page 28 14. It is recommended that the company develop a process to ensure that its agent files are complete in order to show compliance with s. Ins 6.80 (4), Wis. Adm. Code.

Page 30 15 It is recommended that the company develop and implement a procedure and process for ensuring that all types of agents have a valid insurance license to be in compliance with s. 628.03 (1), Wis. Stat.

Page 31 16. It is recommended that the company develop a process to ensure that the language in its agent contracts regarding appointing agents and in its written procedures is being followed.

Page 31 17. It is recommended that the company develop and implement procedures and processes which include an annual audit to reconcile the annual agent billing statement sent by the OCI with the company records to ensure compliance with s. Ins 6.57 (3), Wis. Adm. Code.

Page 32 18. It is recommended that the company submit the application for agent appointment to the OCI and entered into the OCI licensing system in a format specified by the commissioner of insurance within 15 days after the earlier of the date of the agent contract is executed or the first application is submitted to comply with s. Ins. 6.57 (1), Wis. Adm. Code.

Page 33 19. It is recommended that the company revise its procedure and conduct an internal audit of agent licensing and appointment records within 90 days of the adoption of the report to comply with s. 628.10 (2) (am), Wis. Stat.

Policyholder Services & Complaints

Page 34 20. It is recommended that the company recognize a grievance, which is defined as any dissatisfaction with the provisions of services or claim practices of an insurer offering a health benefit plan in order to document compliance with s. Ins 18.01, Wis. Adm. Code.

Page 35 21. It is again recommended that the company revise its manner in which it maintains a record of complaints so it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with s. Ins. 18.06 (1), Wis. Adm. Code.

Page 35 22. It is recommended the company ensure records are maintained as required by s. Ins 6.80 (4) Wis. Adm. Code, and can be made available upon request in accordance with provisions of s. 601.42, Wis. Stat.

Small Employer

Page 36 23. It is recommended that the company revise the procedures to replicate a complete business file for small groups that convert coverage in compliance with the requirements of s. Ins 8.65 (4), Wis. Adm. Code.

Page 36 24. It is recommended that the company improve its current procedures to ensure that the rating and renewability form is signed by the applicant at the time of application and a copy of the form retained in the small employer's business file maintained by the company in compliance with the requirements of s. 635.11 Wis. Stat.

Page 36 25. It is recommended that the company revise the existing procedures to comply with the requirements of s. Ins 8.44 (2) Wis. Adm. Code and provide a separate notice to the policyholder when the policy is issued to advise the policyholder that the afforded by Chapter 635 Wis. Stats., will cease to exist if the employer moves the business out of state or if the employer no longer meets the definition of a small employer.

Page 37 26. It is recommended that the company revise its current procedures to obtain independent verification of the employee census provided by the employer that the census is accurate in order to comply with the requirements of s. Ins 8.65 (1) Wis. Adm. Code.

Page 37 27. It is again recommended that the company revise its procedures to record the date it receives a request for a small employer health plan price quote.

Grievances & IRO

Page 38 28. It is again recommended that the company modify the independent review provision in the policies and certificates to include a statement explaining how to obtain a current listing of independent review organizations, as required by s. 632.835 (2) (bg) 1, Wis. Stat.

Page 39 29. It is recommended that the company modify the definition of Adverse Determination in the HMO Appeals State Grid and all material relating to the Wisconsin independent review process to clearly state that an adverse determination includes the denial of the insured's request for out-of-network services because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network, as required by s. Ins 18.10 (1), Wis. Adm. Code.

Page 39 30. It is recommended that the company include a notification of the insured's right to request an independent review with every grievance resolution letter when the grievance results in an adverse determination or an experimental treatment determination, as required by s. 632.835 (2), Wis. Stat.

Page 39 31. It is recommended that the company establish a procedure to identify independent review requests from Wisconsin insureds in a timely manner in order to allow the insured to obtain an independent review within the timeframes provided in s. 632.835 (3), Wis. Stat.

Page 40 32. It is recommended that the company maintain a copy of the IRO's determination letter in the file in order to document that it has complied with the IRO's decision, as required by s. 632.835 (3) (f), Wis. Stat.

Page 40 33. It is recommended that the company provide written notice to OCI of the receipt of an independent review request within two business days, as required by s. Ins 18.11 (3) (a), Wis. Adm. Code

Page 40 34. It is recommended that the company submit the file to the IRO within five business days after receiving written notice of an independent review request, as required by s. 632.835 (3) (b), Wis. Stat.

Page 41 35. It is recommended that the company send the insured or the insured's authorized representative a written acknowledgement within five business days of the receipt of each grievance confirming the receipt of the grievance, as required by s. Ins 18.03 (4), Wis. Adm. Code.

Page 41 36. It is recommended that the company submit amended grievance experience reports to OCI for 2006 and 2007 to include all grievances that the company received during the calendar year that that the company modify the grievance reporting procedures so that future reports will include information on all grievances received during the previous calendar year, as required by s. Ins 18.06 (2), Wis. Adm. Code.

Page 42 37. It is recommended that the company modify the definition of expedited grievance in the internal procedures to comply with s. Ins 18.01 (4), Wis. Adm. Code.

Page 42 38. It is recommended that the company revise the definition of complaint in its written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code and to handle as grievances all written communications that meet the definition of a grievance in s. Ins 18. 01, (4) Wis. Adm. Code.

Privacy

Page 43 39. It is recommended that the company draft and implement written policies and procedures for communications between the company and the corporate privacy office, including oversight of all privacy-related employee training and business practices for auditing purposes and to ensure compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

Page 44 40. It is recommended that the company revise the disclosure authorization form to include the nature of the information to be disclosed and the purpose for which the information is being obtained, as required by s. 610.70 (2) (a) 4 and 6, Wis. Stat.

Page 45 41. It is recommended that the company revise the internal policies and procedures to provide that requests for access to personal medical information in the company's possession, including an accounting of all disclosures made within two years prior to the request, be handled within 30 business days of receipt provided the information that is the subject of the request is reasonably easy to locate and retrieve by the insurer, as required by s. 610.70 (3), Wis. Stat.

Page 45 42. It is recommended that the company implement a written procedure for providing requested personal medical information to a health care provider designated by an individual or under certain circumstances, to ensure compliance with s. 610.70 (3), (b) and (d), Wis. Stat.

Page 45 43. It is recommended that the company revise the internal privacy policy and procedure to provide that requests by the insured or the insured's authorized representative to amend personal medical information in the company's possession by handled within 30 days of receipt as required by s. 610.70 (4), Wis. Stat.

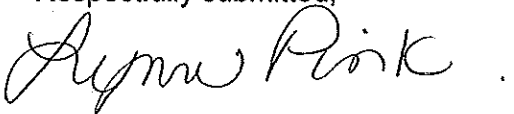
VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

Name	Title
Brian Baird	Insurance Examiner
Barb Belling	Insurance Examiner-Advanced
Stephanie Cook	Insurance Examiner-Advanced
Pam Ellefson	Insurance Examiner-Senior
Linda Low	Insurance Examiner-Senior
Nitza Pfaff	Insurance Examiner

Respectfully submitted,



Lynn Pink
Examiner-in-Charge