MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

RICKY DAVIS
State Chief Deputy Fire Marshal

MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
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MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
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March 7, 2018

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Joe Ochipinti, CEO Gulf States Region
United Healthcare
3838 N. Causeway Blvd., Suite 2600
Metairie, LA 70002

RE: Target Market Conduct Exam Report as of December 31, 2016

Dear Mr. Ochipinti:

In accordance with Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011), an examination of your Company has been completed. Enclosed herewith is the Order adopting the report and a copy of the final report as adopted.

Pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2011), the Mississippi Department of Insurance shall continue to hold the content of said report as private and confidential for a period of ten (10) days from the date of the Order. After the expiration of the aforementioned 10-day period, the Department of Insurance will open the report for public inspection.

If you have any questions or comments, please feel free to contact me.

Sincerely,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY _____
Christina J. Kelsey
Senior Attorney

MC/CJK/bs
Encls. Order w/exhibit

BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF MISSISSIPPI

RE: TARGET MARKET CONDUCT EXAM REPORT OF
UNITED HEALTHCARE INSURANCE COMPANY
UNITED HEALTHCARE OF MISSISSIPPI **CAUSE NO. 18-7262**

ORDER

THIS CAUSE came on for consideration before the Commissioner of Insurance of the State of Mississippi ("Commissioner"), or his designated appointee, in the Offices of the Commissioner, 1001 Woolfolk Building, 501 North West Street, 10th Floor, Jackson, Hinds County, Mississippi, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011). The Commissioner, having fully considered and reviewed the Target Market Conduct Exam Report together with any submissions or rebuttals and any relevant portions of the examiner's work papers, makes the following findings of fact and conclusions of law, to-wit:

JURISDICTION

I.

That the Commissioner has jurisdiction over this matter pursuant to the provisions of Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011).

II.

That United HealthCare of Mississippi, Inc. is a Mississippi-domiciled health maintenance organization ("HMO") which was initially certified as an HMO by the Mississippi State Department of Health on June 1, 1992, under the name Complete Health of Mississippi, Inc. ("CHM"). Effective May 1, 1996, the Articles of Incorporation of CHM resolved to change the name of the corporation to United HealthCare of Mississippi, Inc. Effective December 22, 2010, the Company changed its name to United HealthCare of Mississippi, Inc.

That United HealthCare Insurance Company is domiciled in the State of Connecticut. The Company is a wholly-owned subsidiary of UHIC Holdings, Inc. and its ultimate parent

company is United Health Group, Incorporated, a publicly traded corporation in the State of Delaware. The Company is licensed to sell life and accident and health insurance in most states in the United States and primarily issues group accident and health insurance contracts to employers and associations.

FINDINGS OF FACT

III.

That the Commissioner, or his appointee, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2011), called for an examination of United Healthcare Insurance Company and United HealthCare of Mississippi, Inc. and appointed Joseph R. May, Examiner-In-Charge, to conduct said examination.

IV.

That on or about November 10, 2017, the Target Market Conduct Exam Report concerning United Healthcare Insurance Company and United HealthCare of Mississippi, Inc. for the period of January 1, 2007, through December 31, 2016, was submitted to the Mississippi Department of Insurance by Examiner-In-Charge, Joseph R. May.

V.

That on or about December 1, 2017, pursuant to Miss. Code Ann. § 83-5-209(2) (Rev. 2011), the Department forwarded to the Company a copy of the Target Market Conduct Exam Report and allowed the Company a 30-day period, and later was given an extension until January 19, 2018, to submit any rebuttal to the report. The Company responded by an email dated January 18, 2018 with a rebuttal. A revised report was provided to the Company on February 16, 2018. The Company responded to the revised report on February 23, 2018.

CONCLUSIONS OF LAW

VII.

The Commissioner, pursuant to Miss. Code Ann. § 83-5-209(3) (Rev. 2011), must consider and review the report along with any submissions or rebuttals and all relevant portions of examiner work papers and enter an Order: (1) adopting the Report of Examination as final or with modifications or corrections; (2) rejecting the Report of Examination with directions to reopen; or (3) calling for an investigatory hearing.

IT IS, THEREFORE, ORDERED, after reviewing the Target Market Conduct Exam Report and all relevant examiner work papers, that the Target Market Conduct Exam Report of United Healthcare Insurance Company and United HealthCare of Mississippi, Inc. attached hereto as Exhibit "A", should be and same is hereby adopted as final, with modifications.

IT IS FURTHER ORDERED that a copy of the adopted Target Market Conduct Exam Report, accompanied with this Order, shall be served upon the Company by certified mail, postage pre-paid, return receipt requested.

IT IS FURTHER ORDERED that the Mississippi Department of Insurance shall continue to hold the content of this report as private and confidential information for a period of ten (10) days from the date of this Order, pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2011).

IT IS FURTHER ORDERED, pursuant to Miss. Code Ann. § 83-5-209(4) (Rev. 2011), that within thirty (30) days of the issuance of the adopted report, United Healthcare Insurance Company and United HealthCare of Mississippi, Inc. shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

IT IS FURTHER ORDERED that United Healthcare Insurance Company and United HealthCare of Mississippi, Inc. take the necessary actions and implement the necessary procedures to ensure that all recommendations contained in the Target Market Conduct Exam Report are properly and promptly complied with.

SO ORDERED, this the 7th day of March 2018.

MIKE CHANEY
COMMISSIONER OF INSURANCE

CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the above and foregoing Order and a copy of the final Target Market Conduct Exam Report, as adopted by the Mississippi Department of Insurance, was sent by certified mail, postage pre-paid, return receipt requested, on this the 7th day of March 2018, to:

Mr. Joe Ochipinti, CEO Gulf States Region
United Healthcare
3838 N. Causeway Blvd., Suite 2600
Metairie, LA 70002

Christina J. Kelsey
Senior Attorney

Christina J. Kelsey
Senior Attorney
Counsel for the Mississippi Department of Insurance
Post Office Box 79
Jackson, MS 39205-0079
(601) 359-3577
Miss. Bar No. 9853

MISSISSIPPI INSURANCE DEPARTMENT

Target Market Conduct Examination Report

of

United HealthCare Insurance Company
185 Asylum Street
Hartford, Connecticut 06103

and

United HealthCare of Mississippi, Inc.
795 Woodland Parkway, Suite 301
Ridgeland, Mississippi 39157

As of December 31, 2016

NAIC COMPANY CODES: 79413, 95716

NAIC MATS Nos: MS-MS099-10, MS-MS099-11

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EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

State of Mississippi,

County of Madison,

Joseph R. May, being duly sworn, states as follows:

1. I have authority to represent the Mississippi Insurance Department in the target market conduct examination of United HealthCare Insurance Company and United HealthCare of Mississippi, Inc. as of December 31, 2016.

2. The Mississippi Insurance Department is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.

3. I have reviewed the examination work papers and examination report, and the examination of United HealthCare Insurance Company and United HealthCare of Mississippi, Inc. was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners and the Mississippi Insurance Department.

The affiant says nothing further.

Joseph R. May
Examiner's Signature

Subscribed and sworn before me by Joseph May on this 15th day of March, 2018.

April D. McDonald
Notary Public

(SEAL)
STATE OF MISSISSIPPI NOTARY PUBLIC ID # 103679 APRIL D. McDONALD Commission Expires Oct. 10, 2020 RANKIN COUNTY

My commission expires October 10, 2020 [date]

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT
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FAX: (601) 576-2568

November 10, 2017

Honorable Mike Chaney
Commissioner of Insurance
Mississippi Insurance Department
1001 Woolfolk Building
501 North West Street
Jackson, Mississippi 39201

Dear Commissioner Chaney:

Pursuant to your instructions and authorization and in compliance with statutory provisions, a target market conduct examination has been conducted of the affairs of:

United HealthCare Insurance Company
185 Asylum Street
Hartford, Connecticut 06103

United HealthCare of Mississippi, Inc.
795 Woodland Hills Parkway, Suite 301
Ridgeland, Mississippi 39157

License #	NAIC Group #	NAIC #	MATS #
7700418	707	79413	MS-MS099-10
9500034	707	95716	MS-MS099-11

The target market conduct examination was commenced under the provisions of Miss. Code Ann. §83-1-27, §83-41-337, and §83-5-201 *et seq*., and in accordance with the National Association of Insurance Commissioners *Market Regulation Handbook*, as amended. The examination was conducted in various locations with the majority of time spent in Ridgeland, Mississippi. The target market conduct examination report is herewith submitted.

FOREWORD

This examination report is a report by exception. As a result, files or material reviewed containing no improprieties have been omitted from the examination report. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* as adopted by the National Association of Insurance Commissioners ("NAIC") and consistent with the pre-determined market conduct examination program presented to and approved by the Mississippi Insurance Department ("MID").

This report is not intended for any purpose other than to communicate to the Commissioner of Insurance of the State of Mississippi the findings and results of test work performed during the course of this target market conduct examination. This report should not be used by the company examined or any other entity or person(s) for purposes of advertising.

PURPOSE AND SCOPE

In November 2016, Carr, Riggs & Ingram, LLC ("CRI") was appointed by the MID to conduct a target market conduct examination (the "Examination") of United Healthcare Insurance Company ("UHIC") and United HealthCare of Mississippi, Inc. ("UHCMS") (collectively referred to as "UHC" or the "Companies"). In addition, the law firm of Gilchrest Donnell was retained by the MID to assist in portions of the Examination including the analysis of network adequacy. The Examination covers the period from January 1, 2007 through December 31, 2016. The MID has authority for performing this Examination pursuant to, but not limited to, Miss. Code Ann. §83-1-27, §83-41-337 and §83-5-201 *et seq*.

The purpose of this Examination was to review UHC's claim payment and other practices to determine compliance with applicable market conduct standards and statutory provisions. Specifically, this target examination was designed to review and make a determination of facts regarding the claims payment dispute between the Companies and North Mississippi Health Services ("NMHS"). Additionally, the Examination plan was designed to conduct a review to determine compliance with applicable network adequacy requirements pursuant to Miss. Code Ann. §83-41-409 and Regulation 19 Miss. Admin. Code, Part 3, Chapter 14, due to the anticipated departure of NMHS from UHC's network.

This Examination was conducted in accordance with procedures consistent with the NAIC *Market Regulation Handbook* and approved by the MID during planning for this Examination. The procedures developed and used during this Examination were designed to specifically address those areas noted above, and should not be considered a full scope examination or applied in any other context. Other areas of the Companies' market conduct and financial condition were not considered within the scope of this Examination.

COMPANY OPERATIONS

UHIC is domiciled in the State of Connecticut. The company is a wholly-owned subsidiary of UHIC Holdings, Inc. and its ultimate parent company is United Health Group, Incorporated ("UHG"), a publicly traded corporation in the State of Delaware. The company is licensed to sell life and accident and health insurance in most states in the United States and primarily issues group accident and health insurance contracts to employers and associations.

UHCMS is domiciled in the State of Mississippi. The company is a wholly-owned subsidiary of United Healthcare, Inc. and its ultimate parent company is UHG. UHCMS is a for-profit health maintenance organization ("HMO") that offers its enrollees a variety of managed care programs and products through

contractual arrangements with health care providers. UHCMS also offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions. The Notes to the December 31, 2016 financial statements, as filed with the MID, indicate that UHCMS contracted with the State of Mississippi, Division of Medicaid ("MS DOM") to provide health care services to Medicaid eligible beneficiaries in Mississippi. The program, referred to as the Mississippi Coordinated Access Network ("MS CAN"), targets high risk Medicaid beneficiaries. UHCMS also has a contract with the MS DOM to provide health care services to eligible beneficiaries under the Children's Health Insurance Program ("CHIP") in Mississippi.

EXECUTIVE SUMMARY

As indicated in the Purpose and Scope section of the report, this Examination was conducted in accordance with procedures recommended by the NAIC Market Regulation Handbook and approved by the MID during planning for this Examination. The procedures developed and used during this Examination were designed to review and make a determination of facts regarding the claims payment dispute between the Companies and NMHS. Additionally, the Examination plan was designed to conduct a review to determine compliance with applicable network adequacy requirements pursuant to Miss. Code Ann. §83-41-409 and Regulation 19 Miss. Admin. Code, Part 3, Chapter 14, due to the anticipated departure of NMHS from UHC's network. On May 1, 2017, a resolution was reached regarding the dispute between UHC and NMHS in which the hospital would be considered in-network. As such, the MID suspended the network adequacy portion of the Examination.

As further discussed in the General Procedures and Findings section of the report, the general approach used was categorized as follows:

- Planning and Administration
- Understanding of Systems
- Zero-Pay Claims
- Claim Denials
- Takebacks
- Network Adequacy

The general procedures, other work performed, and findings deemed noteworthy for report purposes in each of the above sections are discussed in detail in the General Procedures and Findings section of this report. In order to streamline this report, only those issues that were either systemic and/or deemed appropriate to highlight are included in this section. Other individual issues are addressed in the appropriate section as indicated above.

During the course of this Examination, it was noted that the data files provided to the examination team did not have an indicator that would allow for identification of those claims that were considered adjustments and/or re-opened claims (i.e. claims that required outside development). When a claim was "closed" for outside development and the information requested was subsequently received by UHC, a new claim number was assigned to the claim, even though it was just additional information required on the original claim. There were no subsets of numbers within the claim number or other related field to associate the two claims. This issue along with additional issues further discussed in subsequent sections of this report, impeded the Companies' ability to demonstrate compliance with relevant Mississippi Code Sections, as there were no separate fields maintained that were included in the data files provided indicating when a claim was pended for outside development and when the additional information was received that would allow for proper adjudication of the submitted claim. In order to ensure full

compliance with both Miss Code Ann. §83-9-5 and § 83-5-207 and in order provide adequate records to evidence the transactions and operations of the Companies, it is recommended that the Companies closely review their record retention and documentation requirements and ensure that all documents are maintained that are necessary to provide adequate documentation regarding the transactions and operations of the Companies. Additional comments and recommendations regarding the above noted issues are included in the relevant sections of this report and summarized in the Comments and Recommendations section.

GENERAL PROCEDURES AND FINDINGS

The purpose of this Examination was to review UHC's claim payment and other practices to determine compliance with applicable market conduct standards and statutory provisions. Specifically, this Examination was designed to review and make a determination of facts regarding the claims payment dispute between the Companies and NMHS. Additionally, the MID initially planned to conduct a review to determine compliance with applicable network adequacy requirements pursuant to Miss. Code Ann. §83-41-409 and Regulation 19 Miss. Admin. Code, Part 3, Chapter 14, due to the anticipated departure of NMHS from UHC's network. However, as discussed above, on May 1, 2017, a resolution was reached regarding the dispute between UHC and NMHS in which the hospital would be considered in-network. As such, the MID suspended the network adequacy portion of the target market conduct exam. In order to address UHC's claim handling practices and review the Companies' network adequacy, the examiners divided the exam into the following sections based on the demand letter which was submitted by NMHS to UHC on October 13, 2016:

- Planning and Administration
- Understanding of Systems
- Zero-Pay Claims
- Claim Denials
- Takebacks
- Network Adequacy

The general procedures and other work performed in each of the above-mentioned areas are discussed in the applicable sections as follows:

Planning and Administration

On November 10, 2016, an Examination commencement meeting between various NMHS personnel and the MID Examination team was held onsite at NMHS in Tupelo, Mississippi. During this meeting, NMHS provided the examiners an overview of the claims processing issues that they had been facing with UHC and provided documentation supporting the issues for the examiners to review. On November 29, 2016, an Examination commencement meeting between UHC representatives and the MID Examination team was held at the MID to discuss the UHC's claims processes related to NMHS and the Examination process. The examiners also determined the point of contact for any requests from UHC.

Through the initial Examination data request ("EDR"), the Examination team gained a greater understanding of the systems used to process claims. As part of the EDR, the Examination team obtained a data file from NMHS that included substantially all claims submitted to UHC during the period under examination. This data file was segregated into the two main scopes of the Examination: zero-pay claims and claim denials. CRI tied the zero-pay and denial details to the demand letter submitted by NMHS to UHC on October 13, 2016 to verify the completeness and accuracy of the file and selected a sample of

claims for an initial walkthrough of UHC's claims processes. Upon submission of this sample to UHC, it was determined that the NMHS data file included claims for Administrative Services Only ("ASO") and Medicaid, which are considered out of scope for this Examination. As a result, certain changes were required and limitations were applied to the testing procedures due to the inclusion of ASO and Medicaid. These changes are further discussed in subsequent sections of this report.

Sampling methodology used during the course of this Examination was performed primarily using ActiveData (file interrogation software) via Microsoft Excel and was on a random or statistical basis, as required by Chapter 14 of the NAIC *Market Regulation Handbook*.

Understanding of Systems

The Examination approach involved incorporating procedures into the Examination that provided a good understanding of the systems used for processing claims. The procedures involved meetings and discussions with UHC representatives regarding these processes, and obtaining information regarding UHC's policies and procedures in order to assist in reviewing and making a determination of facts regarding the claims payment dispute between the Companies and NMHS. Information obtained included documentation such as claims administration systems manuals, personnel training documentation and other information related to the claims payment systems. Procedures performed on sample items selected include but are not limited to tests ensuring that the claim files were processed in accordance with the policies and procedures in place, and as documented during the Examination.

UHC had various claims processing systems for the different types of claims (i.e. standard medical, pharmacy, vision, etc.). The two major standard medical processing platforms that were used by the Companies during the time period covered by this Examination were the UNET and TOPS systems. One systemic issue noted was the inability to capture key information in separate fields that would allow for automated testing and demonstration of compliance with timely pay requirements as contained in Miss. Code Ann. §83-9-5.

Some claims do not meet the definition of a "clean claim" and require outside development or additional information in order to be processed and paid by UHC. Miss. Code Ann. §83-9-5 requires that these claims, referred to by the Companies as "reopened claims", be paid within twenty (20) days of receipt of the requested additional information. However, it was noted that the data files provided to the examiners did not have an indicator that would allow for identification of those claims that were considered adjustments and/or re-opened claims (i.e. claims that required outside development). As such, it was not possible to perform statistical analysis on the data sets provided that could determine compliance with the twenty (20) day time requirement in accordance with Miss Code Ann. § 83-9-5. Also, when a claim was "closed" for outside development (i.e. additional information is needed) and information was subsequently received by UHC, a new claim number was assigned to the claim, even though it was just additional information required on the original claim. There were no subsets of numbers within the claim number to associate the two claims. There was no separate field maintained that was included in the data files provided that indicated when a claim was pended for outside development and when the additional information was received that would allow for proper adjudication of the submitted claim.

Per review of the UNET Claim Life Cycle document provided by the Companies, it was noted that a claim was defined in part as (1) claims resubmitted for missing information are counted as new claims, and (2) claims resubmitted for rework are not counted as new claims. However, as discussed above there was not a separate field that captured the required information that would provide a clear audit trail to the Examination team by the Companies to provide evidence of compliance with Miss Code Ann. § 83-9-5 as

it related to claims that were closed and reopened for outside development.

Zero-Pay Claims

On October 10, 2016, NMHS submitted a letter to UHC outlining issues the hospital had been experiencing with UHC's claim payment practices. According to NMHS, from 2007 through 2016, approximately 51,000 claims were submitted to UHC for total charges of approximately $86 million. According to UHC remittance advices, all of these claims had processed to pay $0 to the provider due to various adjustments to the claim. As previously stated in the Planning and Administration section of this report, on November 10, 2016, an Examination commencement meeting between various NMHS personnel and the MID Examination team was held onsite at NMHS in Tupelo, Mississippi. During this meeting, NMHS provided the examiners an overview of the claims processing issues that they encountered with UHC and provided documentation supporting the issues for the examiners to review. On November 29, 2016, an Examination commencement meeting between UHC representatives and the MID Examination team was held at the MID to discuss the UHC's claims processes related to NMHS and the Examination process. During this meeting, UHC provided the claim lifecycle overviews for both paper and electronic submission.

Following the Examination commencement meeting with UHC, the examiners informally requested a webinar with UHC to gain an understanding of the claims systems. UHC selected three random Mississippi claims in order to provide an overview of the claims systems without including any disputed claims. After the walkthrough was completed, the examiners submitted an EDR to set up a second walkthrough using in-scope claims.

As discussed in the Planning and Administration section of this report, the Examination team obtained a data file from NMHS that included substantially all claims submitted to UHC during the period under examination. This data file was segregated into the two main scopes of the Examination: zero-pay claims and denied claims. CRI tied the zero-pay and denial details to the demand letter submitted by NMHS to UHC on October 13, 2016 to verify the completeness and accuracy of the file and selected a sample of claims for walkthrough of UHC's claims processes using in-scope claims.

Upon submission of the in-scope sample to UHC, it was determined that the NMHS data file included claims for Administrative Services Only ("ASO") and Medicaid, which are considered out of scope for this Examination. It was also noted that the claim number provided in the aforementioned file did not match any reference number in UHC's claims systems. CRI communicated with UHC to identify a field that could be used to properly locate the claim. The examiners held a webinar with UHC representatives to perform a general walkthrough of the Companies' claims systems and procedures related to the processing of claims submitted by NMHS. During this webinar, CRI reviewed only the in-scope claims sent in the sample.

Following this webinar, CRI obtained information from both UHC and NMHS in order to filter out the ASO and Medicaid claims from the data file. Per the sampling methodology in the NAIC *Market Regulation Handbook*, CRI selected a sample of sixty (60) zero-pay claims from the adjusted claims detail to review the treatment and payment of each claim. This sample selection was submitted to UHC, who provided a response indicating that only seven (7) of the sample of sixty (60) items were actually fully insured. The others were primarily ASO business with some Medicaid claims that were not identified in the extraction above. Upon review of the response, the Examination team inquired of UHC to assist in properly identifying and carving out the ASO and Medicaid claims, noted above, from the file provided to us by NMHS. Because the file obtained from NMHS was extracted directly from the 835

files submitted to NMHS by UHC, the Examination team expected the file to be reconcilable with data maintained in UHC's systems. However, upon review of the file information, UHC was unable to effectively carve out the ASO and Medicaid business from this file. In order to provide a proper population from which to pull samples, the examiners requested a file from UHC with the same date parameters as the file obtained from NMHS. Once this file was obtained, CRI selected an additional fifty-three (53) sample items, which provided for the total original sample size of sixty (60). CRI attempted to reconcile the UHC data file to the NMHS data file for accuracy and completeness but, without identifiers for the ASO and Medicaid claims, was unable to completely reconcile the two files. Additionally, upon receipt of the additional sample items, UHC communicated that multiple claims had been purged from the claims processing systems and would take additional time to collect documentation to review the processing of those purged items.

CRI held multiple webinars to review the claims sample with UHC representatives. During these webinars, there were claims in which UHC could not identify the date when additional information requested from the provider was received by UHC. As such, The Companies could not demonstrate compliance with Miss Code Ann. §83-9-5, as there was no clear audit trail maintained that was included in the data files provided that indicated when a claim was pended for outside development and when the additional information was received that would allow for proper adjudication of the submitted claim. Additionally, in one instance, it was noted that the contracted rate did not match allowable rate due to the timing of new contract being loaded into UHC's system. If contracts were loaded late, it would create inconsistencies in pricing of services.

Claim Denials

As previously stated in the Zero-Pay Claims testing section of this report, NMHS submitted a letter to UHC outlining issues the hospital had been experiencing with UHC's claim payment practices. In this letter, NMHS stated that during the 2015 fiscal year, approximately 3,000 claims totaling approximately $9.2 million in unpaid charges were denied by UHC's systems. The Examination team utilized the same approach and processes in testing Claim Denials as was used in testing Zero-Pay claims. The same issues regarding the inclusion of ASO and Medicaid business were encountered with both Zero-Pay Testing and Claim Denials.

As discussed in the Zero-Pay Claims testing section of this report, following a claims webinar with UHC, CRI obtained information from both UHC and NMHS in order to filter out the ASO and Medicaid claims from the data file. Per the sampling methodology in the NAIC *Market Regulation Handbook*, CRI selected a sample of twenty (20) denied claims from the adjusted claims detail to review the treatment and payment of each claim.

This sample selection was submitted to UHC, who provided a response indicating that only five (5) of the sample of twenty (20) items were actually fully insured. The others were primarily ASO business with some Medicaid claims that were not identified in the extraction above. Upon review of the response, the Examination team inquired of UHC to assist in properly identifying and carving out the ASO and Medicaid claims, noted above, from the file provided to us by NMHS. Because the file obtained from NMHS was extracted directly from the 835 files submitted to NMHS by UHC, the Examination team expected the file to be reconcilable with data maintained in UHC's systems. Upon review of the file information, UHC was unable to effectively carve out the ASO and Medicaid business from this file. In order to provide a proper population from which to pull samples, the examiners requested a file from UHC with the same date parameters as the file obtained from NMHS. Once this file was obtained, CRI selected an additional fifteen (15) sample items, which provided for the total original sample size of

twenty (20). However, upon submission of the new sample items to UHC, it was determined that only four (4) of the fifteen (15) items were true denials. All other sample items selected included claims in which the claim was paid at $0. Upon researching the denied claims file parameters, it was determined that the outcome definition was inaccurately programmed to result in a file containing only true denied claims. The outcome was requested based on remark code when it should have been "billed equals not covered" in order to get only denied claims. UHC pulled a new report with the correct information. CRI pulled the remaining eleven (11) sample items from the revised denial report provided by UHC.

CRI attempted to reconcile the UHC data file to the NMHS data file for accuracy and completeness but, without identifiers for the ASO and Medicaid claims, was unable to completely reconcile the two files. Additionally, upon receipt of the additional sample items, UHC communicated that multiple claims had been purged from the claims processing systems and it would take additional time to collect documentation to review the processing of those purged items.

CRI held multiple webinars to review the claims sample with UHC representatives. During these webinars, there were multiple claims in which UHC could not identify the date when additional information requested from the provider was received by UHC. As such, The Companies could not demonstrate compliance with Miss Code Ann. §83-9-5, as there was no clear audit trail maintained that was included in the data files provided that indicated when a claim was pended for outside development and when the additional information was received that would allow for proper adjudication of the submitted claim. Additionally, CRI noted an instance in which it appeared that a new contract for NMHS was loaded into UHC's systems late, resulting in an error in the rate at which the contract was paid.

Takebacks

In its October 13, 2016 demand letter to UHC, NMHS alleged that UHC's recoupment of several million dollars was in direct violation of Miss Code Ann. §83-41-219, which limits the timeframe in which the insurer can request reimbursement for payment of an invalid claim or overpayment of a claim. NMHS' position is that, because UHC limits the time for NMHS to file a claim to 120 days, UHC has 120 days to conduct post-payment audits and request reimbursement. In November 2016, UHC responded and denied that any of the recoupments violated the statute or the Facility Participation Agreement ("Agreement") between UHC and NMHS. As part of the Examination, the examiners requested documents from the parties, conducted multiple interviews, and analyzed relevant legal authority. It was determined that UHC recoupments based on audits completed more than 120 days after payment were in violation of Miss. Code Ann. §83-41-219. It is undisputed that UHC requires NMHS to submit claims within 120 days of service or discharge under the Agreement. UHC therefore had 120 days to complete its post-payment audits for requesting reimbursement under the statute.

Additionally, the examiners found that the statute does not apply to audits opened prior to July 1, 2012, or claims submitted by NMHS to UHC in its role as Coordinated Care Organization for Mississippi Medicaid. To the extent that any of the recoupments at issue fall into one of these exceptions, the 120-day reciprocal time period does not apply.

Finally, it should be noted that the examiners did not identify all of the UHC recoupments that may have violated Miss. Code Ann. §83-41-219. The examiners likewise did not quantify the amount owed to NMHS. Rather, this report focuses on the threshold issue of whether UHC's recoupments were in compliance with the statute.

Network Adequacy

As discussed in the Purpose & Scope section of this report, the MID requested that the examiners determine whether UHC's network in north Mississippi would be in compliance with Miss. Code Ann. §83-41-409 and Regulation 19 Miss. Admin. Code, Part 3, Chapter 14 following the departure of NMHS from UHC's network.

On May 1, 2017, a resolution was reached regarding the dispute between UHC and NMHS in which the hospital would be considered in-network. As such, the MID suspended the network adequacy portion of the target market conduct exam.

COMMENTS AND RECOMMENDATIONS

1. In order to fully comply and appropriately demonstrate compliance with Miss Code Ann. §§ 83-5-207 and 83-9-5, it is recommended that the Companies closely review their record retention and documentation requirements and maintain records in a manner that would allow for adequate documentation of compliance. (Pages 4, 6, 8 and 9)

2. It is recommended that the Companies review their current policies and procedures regarding timely implementation and input of contracted rates for providers and make any necessary adjustments to ensure that all contracts are timely entered into UHC's systems. (Pages 7 and 8)

3. It is recommended that the Companies comply with the 120 day time-frame regarding post payment audits (i.e. "takebacks"). (Page 9)

ACKNOWLEDGEMENT

The examiners representing the Mississippi Insurance Department and participating in this Examination were:

Examiner-in-Charge:	Joseph R. May, CPA, CMA, CFE, CIE, FAHM
Supervising Examiner	R. Dale Miller, CPA, CFE, CFF
Senior Examiner:	Daniel Bryde

In addition, the law firm of Gilchrest Donnell was retained by the MID to assist in portions of the Examination including the analysis of network adequacy.

Respectfully,

Joseph R. May, CPA, CMA, ~~CFE, CIE~~, FAHM
Examiner-In-Charge