

# UNITEDHEALTHCARE REGULATORY SETTLEMENT WITH IOWA'S INSURANCE COMMISSIONER

## Summary of Settlement Terms

Prepared by the Iowa Medical Society  
September 10, 2007

(View the Settlement Agreement at <http://www.iid.state.ia.us>)

### **Parties to the settlement:**

*United:* UnitedHealthcare (“UHC”) Insurance Company, named affiliates (including UnitedHealthcare of Midlands) and UHC affiliates that utilize the UHC claims processing platform that was the focus of this market analysis and settlement. UHC Medicare, Medicaid, and self-funded products and services are not included.

*Regulators:* Iowa’s Insurance Commissioner and the insurance commissioners of 35 other states and the District of Columbia (“Signatory Regulators”). The signatures of at least 30 states were needed by August 27 for the Agreement to go into effect. Additional states can elect to join as Signatory Regulators but must do so within 60 days from the Execution Date unless waived by the Lead Regulators and UHC.

### **Lead regulators**

Five of the state regulators negotiated the settlement agreement (“Agreement”) with UHC and will monitor UHC’s compliance with the Agreement on behalf of all Signatory Regulators. The “Lead Regulators” are the insurance commissioners of Iowa, Arkansas, Connecticut, Florida and New York. UHC must meet with the Lead Regulators at least quarterly to provide progress reports on implementation of settlement terms.

### **Execution date**

August 27, 2007

### **Settlement term**

Ends December 31, 2010

### **Basis for the settlement**

A multi-state analysis of UHC’s claims processing platforms for compliance with state laws and regulations was conducted by the Market Analysis Working Group (MAWG-X) of the National Association of Insurance Commissioners (NAIC). The MAWG-X identifies and reviews insurance companies with potential market regulatory issues impacting multiple jurisdictions. Current vice chair of the MAWG-X is Iowa’s Deputy Insurance Commissioner, Rosanne Mead.

Complaints filed in several states regarding repeated errors in UHC’s claims payment processes – i.e., failure to apply fee schedules and deductibles correctly and violating

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state prompt pay laws – as well as UHC’s failure to correct such errors when directed to do so by the regulators led to MAWG-X’s analysis. UHC cooperated in this review. MAWG-X focused on UHC’s utilization of UNet and Cosmos, two multi-state national platforms that provide administrative services, including claims payment services.

Upon completion of MAWG-X’s review and issuance of findings, the Lead Regulators were asked to negotiate a regulatory settlement with UHC addressing multi-state areas of concern and to develop a system for measuring UHC’s compliance performance against agreed-upon standards.

### **Settlement terms**

*Fines.* UHC will pay regulatory fines to each of the Signatory Regulators based on a per capita UHC membership formula set forth in Exhibit B of the Agreement. If all states become signatories, UHC’s payment obligation would be \$20 million. With the 36 states and the District of Columbia as current signatories, UHC must pay more than \$13 million. Iowa will receive \$140,000 (which will be paid to the state’s general fund). New York will receive the largest assessed amount, nearly \$4 million.

Additional fines of up to \$20 million could be paid by UHC for failure to comply with settlement terms.

*Restitution.* There is no monetary limit on the dollar amounts that UHC is obligated to pay to providers and persons insured by UHC for claims errors resulting from the UHC platform’s installation of provider contracts and fee schedules, eligibility files, product and case installation, and any other claim processing errors.

The Agreement recognizes several ways in which restitution to physicians and others due to such errors might occur, including 1) in the ordinary course of business through reprocessing of claims; 2) through implementation of the Process Improvement Plan where it is determined that less than appropriate claims payments were made; or 3) through internal review by UHC of systemic errors in claims payment.

The Agreement, itself, provides little detail on processes and procedures for restitution. IMS will continue to seek information regarding this settlement term.

### **Process Improvement Plan**

The core of the settlement Agreement is its three-year Process Improvement Plan with specifically identified goals and measurement benchmarks to assure UHC claims processing consistent with laws and regulations in each of the signatory states. In agreeing to this Process Improvement Plan, UHC admits no wrongdoing.

UHC must begin its process improvements within 60 days of the Agreement’s effective date. Further, it must retain an independent examiner approved by the Lead Regulators to assist the Lead Regulators in monitoring UHC compliance. The examiner will, among other things, conduct three (3) annual compliance reviews and prepare written compliance reports for the Lead Regulators and UHC.

Exhibit C of the Agreement sets forth the Process Improvement Plan and actions steps to be taken by UHC. Identified areas for improvement include:

- Claims accuracy and timeliness
- Coordination of benefits
- Appeals, grievances & complaints
- Explanation of benefits
- Contracted entities
- Utilization review
- Operations management
- Provider networks.

Exhibit D sets forth benchmarks and compliance tolerance levels.

Exhibit E establishes requirements for UHC reports and monitoring.

### **Compliance processes**

This Agreement is a regulatory settlement subject to the oversight jurisdiction of each of the Signatory Regulators. (The monitoring of UHC compliance constitutes an ongoing investigation by the state of Iowa.) To the extent provided by law, work papers and other documents produced by, obtained by, or disclosed to the Signatory Regulators shall be confidential.

In the event the Lead Regulators find, after reasonable consultation with UHC, that UHC has intentionally and materially breached the Agreement or engaged in business practices constituting an unfair insurance or claims settlement practice under the laws of one or more of the states of the Signatory Regulators, any penalty or fine imposed as a result of such finding shall not be limited by the assessment provisions of the Agreement.

### **Closing**

IMS will monitor the implementation and will apprise its members of new information of relevance to them.

*Please note:* This regulatory settlement is *not* related to the federal multi-district class action litigation (MDL) line of cases and settlements involving Aetna, Cigna, Humana, the Blues, and others. The MDL class action claims against United and Coventry were dismissed by the federal court on grounds that evidence was insufficient to support a conspiracy under federal racketeering statutes. Those two dismissals are on appeal; the outcome of those appeals will not affect this regulatory settlement.