Final Report Federal Targeted Market Conduct Examination of
UnitedHealthcare of Texas, Inc., HIOS ID #40220
State of Texas as of July 13, 2021

Examination Report: 40220– 2018 – FED – 1

CCIIO/Oversight Group/Compliance and Enforcement

July 13, 2021

In accordance with Title 45 of the Code of Federal Regulations (C.F.R.), section 150.313, the Center for Consumer Information and Insurance Oversight (CCIIO) has completed a targeted Market Conduct Examination (Examination) of UnitedHealthcare of Texas, Inc., HIOS ID #40220 (Issuer). The Examination review period was July 1, 2016 through June 30, 2017. The Examination was called to assess the Issuer's compliance with the requirements of the following:

- Coverage of Preventive Health Services – 42 U.S.C. §300gg-13 and 45 C.F.R. §147.130;
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – 42 U.S.C. §300gg-26, 45 C.F.R. §§146.136 and 147.160;
- Patient Protections – 42 U.S. C. §300gg-19a and 45 C.F.R. §147.138(a)(3); and
- Essential Health Benefits – 42 U.S.C. §300gg-6, 45 C.F.R. §§147.150 and 156.100, et seq.

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I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIIO) has conducted a targeted Market Conduct Examination (Examination) of UnitedHealthcare Insurance Company (Issuer) to assess the Issuer's compliance with the requirements of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended: 42 U.S.C. §300gg-26, 45 C.F.R §§146.136 and 147.160; Coverage of Preventive Health Services: 42 U.S.C. §300gg-13 and 45 C.F.R §147.130; Patient Protections: 42 U.S.C. §300gg–19a and 45 C.F.R. §147.138(a)(3); and Essential Health Benefits: 42 U.S.C. §300gg-6, 45 C.F.R. §§147.150 and 156.100, et seq. The period covered by the Examination was July 1, 2016 through June 30, 2017 (Examination Period).

A random sample of 1,108 Issuer-generated documents and claims were reviewed. Of the selected samples, CCIIO found two violations (based upon the product count in each finding). All violations were found in plan certificates. The violations included a discriminatory benefit design in one product, and a failure to provide benefits that are substantially equal to the Texas EHB-benchmark plan in one product. Through this Examination report, the Issuer is directed to modify certain policies and procedures to ensure future compliance, complete a self-audit to identify any inappropriately denied claims, and re-adjudicate the identified claims, as appropriate.

This report is by exception; therefore, the Examination Results section only indicates areas where findings were noted and includes criticism responses from the Issuer (when provided). In summary, findings were identified for the following Federal requirements:

a. 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125: Essential Health Benefit (EHB) – Prohibition on discrimination; and
b. 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i) and (ii) and 156.115(b): Provision of EHB – Providing EHB Substantially Equal to the Texas EHB-benchmark plan.

Additional details regarding these findings are in the Examination Results section of this report.

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations.

The Issuer is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. When

applicable, corrective actions for other jurisdictions and/or affiliates should also be addressed.

II. Scope of Examination

CCIIO conducted an Examination pursuant to 45 C.F.R. §150.313. The Examination Period was July 1, 2016 through June 30, 2017. The purpose of the Examination was to assess the Issuer's compliance with select applicable Federal requirements.

Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal requirements does not constitute acceptance of such practices.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners and procedures developed by CCIIO. All samples were selected by using a computer-generated, random sample program unless otherwise stated.

Area	Population	Sample Size
MH/SUD* paid claims	2,423	154
MH/SUD denied claims	349	91
MH/SUD paid Rx claims	4,037	108
MH/SUD denied Rx claims	2,788	108
Preventive Service paid claims	15,950	109
Preventive Service denied claims	1,029	105
Preventive Service Rx paid claims	3,696	108
Preventive Service Rx denied claims	1,334	107
Other medical Rx paid claims	42,464	109
Other medical Rx denied claims	17,834	109

*MH/SUD stands for mental health and substance use disorder

The Issuer's responses to criticisms issued during the Examination process appear after the finding in the Examination Results section of this report.

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III. Summary of Findings

Finding #	Summary	Citation	Completed or Required Corrective Actions
1	Failure to provide EHB by implementing a discriminatory benefit design that covered methadone maintenance treatment for pain management and not for opioid addiction.	42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125.	For plan documents, no further action is required as the Issuer's certificates were updated to reflect coverage of methadone maintenance treatment for opioid addiction. The Issuer is directed to conduct a self-audit and re-adjudicate any claims for methadone maintenance treatment for opioid addiction that were improperly denied during the Examination Period. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

2	Failure to provide EHBs that are substantially equal to the Texas EHB-benchmark plan.	42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i), (ii), and 156.115(b).	For plan documents, no further action is required as the Issuer's certificates have been updated to reflect that benefits are provided for: a. Court-ordered medically necessary services; and b. FDA-approved mechanical organs for transplants For court-ordered medically necessary services, the Issuer is directed to conduct a self-audit and re-adjudicate any claims for court-ordered medically necessary services improperly denied during the Examination Period. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication. No further action is required with regard to

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Finding #	Summary	Citation	Completed or Required Corrective Actions
			claims involving transplants of FDA-approved artificial organs since the Issuer confirmed no such claims were denied by the Issuer during the Examination Period.

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IV. Issuer Profile

UnitedHealthcare of Texas, Inc. (UHCTX), is a Texas Corporation, domiciled in Texas, with its principal place of business located at 1311 W. President George Bush Highway, Richardson, Texas 75080. UHCTX is an HMO offering a basic health care service plan and is licensed to conduct business in the state of Texas. UHCTX is a wholly-owned subsidiary of United Healthcare, Inc., which in turn is a wholly-owned subsidiary of United HealthCare Services, Inc. (UHS), a Minnesota general business corporation. UHS is a direct wholly-owned subsidiary of UnitedHealth Group Incorporated (United), the ultimate parent in the insurance holding company system.

V. Examination Results

A. Essential Health Benefit (EHB) – Prohibition on Discrimination

Finding 1 – Violation of 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125.

42 U.S.C. §300gg-6 states in the pertinent part:

> "Comprehensive health insurance coverage
>
> (a) Coverage for essential health benefits package A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title."

42 U.S.C. §18022 states in the pertinent part:

> "In defining the essential health benefits under paragraph (1), the Secretary shall—
>
> (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;"

45 C.F.R. §156.125 states:

> "An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

The Issuer failed to meet the above requirements by implementing a discriminatory benefit design that covered methadone maintenance treatment for pain management but excluded coverage for methadone maintenance treatment for opioid addiction.

EHB Findings – Prohibition on Discrimination

For one product in the small group market, the corresponding certificates for off-Exchange health plans (NQHPs) excluded coverage for methadone for opioid addiction, but provided such coverage for treatment of pain management.

On page 39 of its National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015), the American Society of Addiction Medicine (ASAM) states:

> "Pregnant women with opioid use disorder are candidates for opioid agonist treatment if a return to opioid use is likely during pregnancy. Methadone is the accepted standard of care for use during pregnancy. Buprenorphine mono-product is a reasonable and recommended alternative to methadone for pregnant women."

The identified product provided coverage for buprenorphine, which is approved for the treatment of pregnant women, but excluded coverage for methadone for opioid addiction. However, methadone remains the favored treatment for opioid addicted pregnant women. By failing to provide coverage for methadone maintenance treatment for opioid addiction, the Issuer is limiting access to clinically appropriate and effective treatment for opioid addiction. This limits access to the preferred method of treatment for pregnant women, a particularly vulnerable segment of the population, and could have a severe impact on the health of the mother and unborn child. For these individuals, the choice between buprenorphine treatment and methadone should be made based on the needs and condition of the pregnant patient and clinical opinion of the treating physician.

Methadone has FDA-approved indications for drug detoxification and maintenance therapy of opioid abuse, and also pain management. Providing coverage for methadone when used for pain and denying coverage when used for opioid abuse discriminates against individuals based upon their health condition (opioid addiction).

The Issuer agreed stating, "The Company acknowledges this Criticism. However, we would like to clarify that the forms filed in 2016 for the 2017 plan year were already revised to remove this exclusion."

Area Reviewed	Population	Sample Size
MH/SUD paid claims	2,423	154
MH/SUD denied claims	349	91
MH/SUD paid Rx claims	4,037	108
MH/SUD denied Rx claims	2,788	108
Preventive Service paid claims	15,950	109
Preventive Service denied claims	1,029	105

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Area Reviewed	Population	Sample Size
Preventive Service Rx paid claims	3,696	108
Preventive Service Rx denied claims	1,334	107
Other medical Rx paid claims	42,464	109
Other medical Rx denied claims	17,834	109

Required Action:

No further action with respect to plan documents is required as the Issuer indicated it updated its certificates to address this finding beginning with the 2017 plan year. A random sample of 2017 certificates was reviewed to verify the exclusion for methadone maintenance treatment for opioid addiction had been removed.

However, the Issuer is directed to conduct a self-audit of denied claims during the Examination Period to identify and re-adjudicate all improperly denied claims involving methadone maintenance treatment for opioid addiction. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Issuer Response: The Company conducted a self-audit of claims incurred during the examination period, between July 1, 2016 and June 30, 2017 and did not identify any claims related to methadone maintenance treatment for opioid addiction that were improperly denied.

CCIIO concurs with the Issuer's position.

B. Essential Health Benefits – Failure to Provide Benefits Substantially Equal to the Texas EHB-Benchmark

Finding 2 – Violation of 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i), (ii) and (b).

42 U.S.C. §300gg-6 states in the pertinent part:

> "Comprehensive health insurance coverage
>
> (a) Coverage for essential health benefits package A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title."

42 U.S.C. §18022 states in the pertinent part:

> "Essential Health Benefits
>
> (a) Essential Health Benefits Package. — In this title, the term "essential health benefits package " means, with respect to any health plan, coverage that—
>
> (1) provides for the essential health benefits defined by the Secretary under subsection (b);
> (2) limits cost sharing for such coverage in accordance with subsection (c); and
> (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).
>
> (b) Essential Health Benefits.
>
> (1) In general—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
>
> (A) Ambulatory patient services.
> (B) Emergency services.
> (C) Hospitalization.
> (D) Maternity and newborn care.
> (E) Mental health and substance use disorder services,

including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care."

45 C.F.R. §156.115 states in the pertinent part:

"Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits; [and],
(ii) Limitations on coverage including coverage of benefit amount, duration, and scope...

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:
(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;
(ii) Is made only within the same essential health benefit category; and
(iii) Is not a prescription drug benefit.
(2) Submits evidence of actuarial equivalence that is:
(i) Certified by a member of the American Academy of Actuaries;
(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
(iii) Based on a standardized plan population; and
(iv) Determined regardless of cost-sharing."

The Issuer failed to meet the above requirements because it failed to provide EHBs that were substantially equal to the Texas EHB-benchmark plan.

EHB Findings – Not Substantially Equal

For one product in the small group market, the corresponding certificates did not provide EHBs that were substantially equal to the Texas EHB-benchmark plan. The 2016 Texas EHB-benchmark plan (page 37) and the 2017 Texas EHB-benchmark plan (page 50) provide coverage for FDA-approved artificial devices for transplants, with no exclusions for court-ordered medically necessary services. The Issuer's certificates excluded coverage for court-ordered medically necessary services and/or Food and Drug Administration (FDA) approved artificial devices for

transplants. The Issuer also did not submit evidence that an actuarially equivalent substitution was provided for either of the two EHBs that are the basis for the finding.

Finding 2.a.

Court-ordered medically necessary services.

One product in the small group market failed to provide the benefit covered by the EHB-benchmark plan.

The Issuer agreed with the finding stating, "The Company acknowledges this Criticism. However, we would like to clarify that the forms filed in 2017 for [plan year] 2018 implementation were already revised to reflect 'This exclusion does not apply to services determined to be medically necessary.'"

Area Reviewed	Population	Sample Size
MH/SUD paid claims	2,423	154
MH/SUD denied claims	349	91
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Required Action:

No further action is required with respect to plan documents as the Issuer indicated it had updated its certificates to address this finding beginning with the 2018 plan year. A random sample of 2018 certificates was reviewed to verify coverage of medically necessary court-ordered services.

However, the Issuer is directed to conduct a self-audit of denied claims processed during the Examination period to identify and re-adjudicate all improperly denied claims involving medically necessary court-ordered services. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Issuer Response: The Company conducted a self-audit of claims incurred during the examination period, between July 1, 2016 and June 30, 2017 and did not identify any claims for court-ordered medically necessary services that were improperly denied.

CCIIO concurs with the Issuer's position.

Finding 2.b.

Food and Drug Administration (FDA) approved artificial devices for transplants.

One product in the small group market failed to provide the benefit covered by the EHB-benchmark plan.

The Issuer agreed with the finding stating:

> "The Company acknowledges this Criticism. However, we would like to clarify that the exclusion related to health services for transplants involving permanent mechanical organs has already been under review. Subsequently, revisions to the documents were made in the 2018 filing for the 2019 plan year submitted on 6/19/18 under submission IDs 402200009 and 988090050. Upon approval, they will go into production in 2019."

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Area Reviewed	Population	Sample Size
MH/SUD paid claims	2,423	154
MH/SUD denied claims	349	91
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Preventive Service Rx paid claims	3,696	108
Preventive Service Rx denied claims	1,334	107
Other medical Rx paid claims	42,464	109
Other medical Rx denied claims	17,834	109

Required Action:

No further action is required with respect to plan documents as the Issuer indicated it had updated its certificates to address this finding beginning with the 2019 plan year. A random sample of 2019 certificates verified coverage of FDA-approved artificial organs was included.

No further action is required with respect to the re-adjudication of claims as the Issuer was asked to provide a list of all denied claims involving transplants of artificial organs that occurred during the Examination Period. In response the Issuer stated, “We have reviewed our denied claim records related to artificial organ transplant claims. The results of this review indicate there were no denied claims involving permanent mechanical organs for members covered under United Healthcare of Texas during the Examination Period.” CCIIO conducted a search of the related claims data for claims for artificial transplant devices. There were no claims paid or denied, confirming the Issuer’s statement.

VI. Closing

A total of 1,108 randomly selected Issuer-generated documents and claims were reviewed. Of the samples selected, CCIIO found two violations related to two areas reviewed. Both violations were found in plan certificates and included a failure to provide EHB by implementing a discriminatory benefit design in one product and a failure to provide benefits that are substantially equal to the Texas EHB-benchmark plan in one product.

Violations included:

- Failure to provide EHB by implementing a discriminatory benefit design by providing coverage of methadone maintenance treatment for pain management while excluding coverage of methadone maintenance treatment for opioid addiction.

- Failure to provide EHBs that are substantially equal to the Texas EHB-benchmark plan by failing to provide coverage of court-ordered medically necessary services and FDA-approved artificial devices for transplants which are covered by the EHB-benchmark plan.

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VII. Examination Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Examination are hereby acknowledged.

Mary M. Nugent -S

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Compliance and Enforcement Division
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In addition, the following individuals participated in this Examination and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Mary Nugent, CIE, FLMI, AIRC, MCM, ACS – Compliance and Enforcement Division Director
- Darshell Shepphard, MCM
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