STATE OF MISSOURI

DEPARTMENT OF COMMERCE & INSURANCE

P.O. Box 690, Jefferson City, Mo. 65102-0690

***In Re*:**	)	
	)	
UNITEDHEALTHCARE	)	**Market Conduct Examination No. 386423**
INSURANCE COMPANY	)	
(NAIC #0707-79413	)	

ORDER OF THE DIRECTOR

NOW, on this 17th day of December, 2025, Director Angela L. Nelson, after consideration and review of the market conduct examination report of UnitedHealthcare Insurance Company (NAIC #0707-79413) (hereinafter "UHIC"), examination report number #386423, prepared and submitted by the Division of Insurance Market Regulation (hereinafter "Division") pursuant to §374.205.3(3)(a)[1], does hereby adopt such report as filed. After consideration and review of the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation"), relating to the market conduct examination #386423, the examination report, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such report are deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4). The Director does hereby issue the following orders:

This order, issued pursuant to §374.205.3(4) and §374.046.15 RSMo, is in the public interest.

IT IS THEREFORE ORDERED that the Director does hereby approve the Stipulation as agreed to by UHIC and the Division.

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[1] All references, unless otherwise noted, are to Revised Statutes of Missouri 2016.

IT IS FURTHER ORDERED that UHIC shall not engage in any of the violations of statutes and regulations set forth in the Stipulation, shall implement procedures to place it in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri, shall maintain those corrective actions at all times, and shall fully comply with all terms of the Stipulation.

IT IS FURTHER ORDERED that UHIC shall pay, and the Department of Commerce and Insurance, State of Missouri, shall accept, the Voluntary Forfeiture of $7,000.00, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 17th day of December, 2025.

Angela L. Nelson
Director

IN THE DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF MISSOURI

***In Re*:**	)	
	)	
UNITEDHEALTHCARE INSURANCE COMPANY (NAIC #0707-79413)	)	**Market Conduct Examination No. 386423**
	)	
	)	
	)	

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter the "Division") and UnitedHealthcare Insurance Company (hereinafter "UHIC") as follows:

WHEREAS, the Division is a unit of the Missouri Department of Commerce and Insurance (hereinafter the "Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State of Missouri;

WHEREAS, UHIC has been granted a certificate of authority to transact the business of insurance in the State of Missouri;

WHEREAS, the Division conducted a market conduct examination of UHIC, examination no. 386423; and

WHEREAS, based on the market conduct examination of UHIC, the Division alleges that:

1. UHIC did not adequately monitor the utilization review activities of its Utilization Review Agents (hereinafter "URAs"), in violation of §376.1353[1] and §376.1356.

2. UHIC contracted with a URA that did not have a Missouri Utilization Review Certificate in violation of §374.503.1.

3. UHIC did not provide information responsive to certain requests submitted by the examiner, in

1 All statutory references, unless otherwise noted, are to the 2016 Revised Statutes of Missouri.

violation of §374.205.2 (2) and 20 CSR 100-8.040 (2).

4. UHIC filed inaccurate annual utilization review activities reports as the total number of grievances reported was incorrect, in violation of §376.1375.1.

5. UHIC's annual utilization review activities report for 2018 and 2019 omitted eight URA's conducting reviews and omitted two URA's from its 2020 report, in violation of §374.210.1 (2).

6. In one instance, UHIC did not follow its clinical criteria, in violation of §376.1361.3.

7. Two versions of UHIC's grievance rights templates inaccurately listed 120 days or four months as the period of time members had to file a grievance, in violation of §376.1387 and 20 CSR 400-10.100 (2).

8. Two versions of UHIC's grievance rights templates inaccurately listed the number of days members have to file a grievance with the Department, in violation of §375.936 (6) (a) and §375.934 (2).

9. In six instances, UHIC's first-level grievance outcome templates did not include the toll-free number for the Department, in violation of §376.1378.3.

10. In seven instances, UHIC's "Initial Member Grievance Rights" templates incorrectly state grievances will be resolved within 30 calendar days, in violation of §376.1382.2 (2).

11. In six instances, UHIC's "Initial Member Grievance Rights" templates incorrectly informed recipients that an external review could be requested if the member does not receive a timely decision, in violation of §376.1387 and 20 CSR 100-5.020 (3).

12. In four instances, UHIC's first-level grievance files did not contain an acknowledgment letter acknowledging receipt of the grievance within 10 working days, in violation of §376.1382.2 (1).

13. In three instances, UHIC did not notify enrollees on or before the twentieth working day that additional time was needed to complete a grievance investigation and explain why additional time was needed, in violation of §376.1382.2 (2).

14. In eight instances, UHIC's grievance files referenced another insurance company in its resolution letter, in violation of §375.1007 (1) and §375.1005.

15. In one instance, correspondence in a UHIC second-level grievance resolution letter referenced another insurance company, implicating the provisions of §375.1007 (1).

16. In one instance in a UHIC second-level grievance file, a preliminary panel meeting was not held, and a decision was not rendered prior to submitting the grievance to clinical peers for review, in violation of §376.1385.2.

17. In one instance, a UHIC second-level grievance file involving an adverse determination did not indicate a peer review was conducted, in violation of §376.1385.2.

18. In two instances, UHIC only submitted a grievance to one peer reviewer, in violation of §376.1385.2.

19. In one instance involving a UHIC second-level grievance, the two clinical peer reviewers were not independent reviewers, in violation of §376.1385.2.

20. In two instances, UHIC's second-level grievance reviews were not performed by clinical peers with the same or similar specialty as the medical condition or treatment under review, in violation of §376.1385.1 (3)

21. In two instances, UHIC denied claims even though prior authorization approval was on file, in violation of §376.1361.13 and 20 CSR 400-10.200 (1).

22. In two instances, explanations of benefits issued by UHIC to claimants inaccurately represented that prior approval was not obtained, implicating the provisions of §375.1007 (1).

23. In two instances, UHIC adverse determinations were reviewed by clinical peers not holding the same or similar specialty as the medical condition or treatment under review, in violation of §376.1361.2.

24. In ten instances, UHIC did not send UR determination notices to members, in violation of §376.1363.3 (1).

25. In two instances, UHIC adverse determinations were reviewed by clinical peers not holding the same or similar specialty as the medical condition or treatment under review, in violation of §376.1361.2

26. In 13 instances, UHIC's adverse determination decision did not contain a clinical rationale for the determination, in violation of §376.1363.5.

27. In one instance, a UHIC adverse determination was reviewed by a clinical peer not holding the same or similar specialty as the medical condition or treatment under review, in violation of §376.1361.2

WHEREAS, the Division and UHIC have agreed to resolve the issues raised in the market conduct investigation as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture (hereinafter "Stipulation") embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent that no promise, inducement, or agreement not herein expressed has been made, and they acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** UHIC agrees to take remedial action, bringing it into compliance with the statutes and regulations of Missouri, and agrees to maintain those remedial actions at all times. Such remedial actions shall include the following:

1. UHIC agrees that it will review a statistically credible sample of Missouri files in its future monitoring of utilization review activities of its URA's.

2. UHIC agrees not to utilize URA's lacking a Missouri Utilization Review Certificate in handling Missouri grievances.

3. UHIC agrees to file with the Department complete and accurate utilization review activities reports.

4. UHIC agrees to include correct statutory timeframes for filing grievances, including, but not limited to, grievances filed with the Department, on all correspondence with Missouri members.

5. UHIC agrees to include the toll-free telephone number for the Department in all first-level grievance outcome templates.

6. UHIC agrees to ensure that its "Initial Member Grievance Rights" templates for use in Missouri include the correct statutory time period for grievance resolution and the correct standard for obtaining external review.

7. UHIC agrees to provide acknowledgment letters compliant with §376.1382.2 (1) and conduct investigations compliant with §376.1382.2 (2) whenever a first or second-level grievance is submitted by an enrollee or by someone acting on behalf of an enrollee.

8. UHIC agrees to develop and implement additional procedures, as necessary, to ensure grievances are conducted in full compliance with §376.1385 and §376.1361.2.

9. UHIC agrees to have all second-level grievance reviews, prior authorization reviews, and concurrent or retrospective reviews resulting in adverse determinations on Missouri claims performed by clinical peers with the same or similar specialty as the medical condition or treatment under review.

10. UHIC agrees not to deny Missouri claims for which the member or provider received prior authorization.

11. UHIC agrees to ensure that UR determination notices are sent to Missouri members.

12. UHIC agrees to include the clinical rationale for determination on its written notices of utilization review decisions.

C. **Compliance.** UHIC agrees to file documentation pursuant to § 374.205 with the Division,

in a format acceptable to the Division, within 60 days of the entry of an Order approving this Stipulation of any remedial action taken to implement compliance with the terms of this Stipulation.

D. **Voluntary Forfeiture.** UHIC agrees, voluntarily and knowingly, to surrender and forfeit the sum of $7,000 (seven thousand dollars), such sum payable to the Missouri State School Fund, in accordance with §§374.049.11 and 374.280.2, within fifteen (15) days of the date the Director of the Department (hereinafter "Director") signs the Order approving this Stipulation.

E. **Non-Admission.** Nothing in this Stipulation shall be construed as an admission by UHIC, this Stipulation being part of a compromise settlement to resolve disputed factual and legal allegations arising out of the above-referenced market conduct examination.

F. **Waivers.** UHIC, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights to procedural requirements, including notice and an opportunity for a hearing and review or appeal by any trial or appellate court, which may have otherwise applied to the market conduct examination no. 386423.

G. **Amendments.** No amendments to this Stipulation shall be effective unless made in writing and agreed to by authorized representatives of the Division and UHIC.

H. **Governing Law.** This Stipulation shall be governed and construed in accordance with the laws of the State of Missouri.

I. **Authority.** The signatories below represent, acknowledge, and warrant that they are authorized to sign this Stipulation on behalf of the Division and UHIC, respectively.

J. **Counterparts.** This Stipulation may be executed in multiple counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute a single document. Execution by facsimile or by electronically transmitted signature shall be fully and legally effective and binding.

K. **Effect of Stipulation.** This Stipulation shall not become effective until the entry of an

Order by the Director approving this Stipulation.

L. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: November 21, 2025

Teresa Kroll
Chief Market Conduct Examiner
Division of Insurance Market Regulation

DATED: 10/13/25

Heather Lang
Assistant Secretary
UnitedHealthcare Insurance Company

MARKET CONDUCT EXAMINATION REPORT
Life and Health Business of

UnitedHealthcare Insurance Company
NAIC # 0707-79413

MISSOURI EXAMINATION # 386423

Covering The Time Period of
January 1, 2018, Through December 31, 2020

Home Office
185 Asylum Street
Hartford, CT 06103

STATE OF MISSOURI
DEPARTMENT OF COMMERCE & INSURANCE

JEFFERSON CITY, MISSOURI

Governor Mike Kehoe
State of Missouri

Missouri Department of
Commerce & Insurance
Angela L. Nelson, Director

Division of Insurance Market Regulation

November 21, 2025

Honorable Angela L. Nelson, Director
Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101

Director Nelson:

In accordance with the market conduct examination warrant and in compliance with the statutory requirements of the State of Missouri, a targeted market conduct examination has been conducted of the business practices of:

UnitedHealthcare Insurance Company (NAIC #79413)

This examination was conducted as a desk examination at the offices of the Missouri Department of Commerce and Insurance (DCI) in Jefferson City, MO by the following DCI staff market conduct team members:

Julie Hesser, Market Conduct Examination Manager
John Korte, Market Conduct Examiner-in-Charge
Aubrey Snyder, Market Conduct Examiner

The examination results are contained in the attached report for your consideration. The report provides the scope of the examination, summarizes the applicable NAIC *Market Regulation Handbook* standards and testing performed, and lists the findings identified in reviews.

The Market Conduct team thanks you for the opportunity to serve the Missouri Department of Commerce and Insurance and the citizens of the great State of Missouri in conducting this examination.

Respectfully,

Teresa Kroll
Chief Examiner, Market Conduct
Missouri Department of Commerce and Insurance

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FOREWORD

The following is a Market Conduct Examination Report performed by DCI market conduct examiners. The Division of Insurance Market Regulation is an area of the Department of Commerce and Insurance that is statutorily required to perform the functions of rate and form regulation and monitor marketplace activity of insurance companies in addition to other functions assigned by the Director. The Market Conduct Section is tasked with the responsibility of ensuring equitable treatment of Missouri policyholders. One mechanism for performing this duty is to conduct a market conduct examination to review insurers documents for compliance with Missouri statutes and regulations. Based on information obtained through market analysis, the Director of the Missouri Department of Commerce and Insurance determined the market activities of UnitedHealthcare Insurance Company warranted additional scrutiny and an examination warrant was issued on October 19, 2021.

The following is a "report by exception." The report does not present a comprehensive overview of the insurer's practices. Rather, it contains a summary of the non-compliant activities discovered during the course of the examination regarding the Company's accident and health insurance. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon, or criticize non-compliant practices, procedures, products or files in this state or other jurisdictions does not constitute acceptance or approval of such practices.

Pursuant to § 374.205.4 RSMo, all working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the director or any person in the course of the examination are provided confidential treatment.

Statutory citations that were in effect during the time of the examination period were applied.

When used in this report:

- "Company" or "UHIC" refers to the UnitedHealthcare Insurance Company
- "CSR" refers to the Missouri Code of State Regulations
- "DCI" refers to the Missouri Department of Commerce and Insurance
- "Director" refers to the Director of the Missouri Department of Commerce and Insurance
- "NAIC" refers to the National Association of Insurance Commissioners
- "RSMo" refers to the 2016 Revised Statutes of Missouri, unless otherwise noted.
- "UR" refers to Utilization Review, as defined in § 376.1350(34), RSMo.
- "URA" refers to Utilization Review Agent, as defined in § 374.500(6), RSMo.

SCOPE OF EXAMINATION

The DCI has authority to conduct this examination pursuant to, but not limited to, §§ 374.110, 374.190, 374.205, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if UHIC complied with Missouri statutes and regulations. The primary period covered by this review is January 1, 2018, through December 31,

2020, unless otherwise noted. Errors found outside of this time period may also be included in the report.

The examination was a targeted examination involving the following lines of business and business functions: Accident and Health Insurance in the areas of Operations/Management, Complaint Handling, Claims, Grievance Procedures, Utilization Review, and External Review.

The examination was conducted in accordance with the standards in the NAIC's *2021 Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the NAIC *2021 Market Regulation Handbook* when conducting reviews that are subject to a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices it is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized for reviews not applying the general business practice standard.

In performing this examination, the examiners reviewed only a sample of the Company's practices, procedures, products, and files. Therefore, some noncompliant practices, procedures, products, and files may not have been found. As such, this report may not fully reflect all the practices and procedures of the Company.

COMPANY PROFILE

UnitedHealthcare Insurance Company, part of the UnitedHealth Group, (NAIC Group # 0707), is a foreign insurer domiciled in the State of Connecticut. UHIC was incorporated on March 24, 1972, and obtained their Certificate of Authority in the State of Missouri on July 11, 1975. The Company is licensed in Missouri under Chapter 376, RSMo. UHIC is a wholly owned subsidiary of UHIC Holdings, Inc., whose parent is UnitedHealthcare Services, Inc. UnitedHealthcare Services, Inc is a wholly owned subsidiary of UnitedHealthcare Group Inc., that provides services to UHIC under the terms of a management agreement.

The Company is licensed in all states in the United States except New York and primarily issues group accident and health insurance contracts to employers, governmental agencies, and associations. At the end of the examination scope, the Company was the top carrier for Group Comprehensive Medical Expense – Large Employer. The table below represents UHIC's total number of insureds and direct written premium (DWP) as reported in the Missouri Supplement to the Financial Annual Statement in 2018, 2019, and 2020 for the lines of business recommended for examination.

UnitedHealthcare Insurance Company				
	Group Comprehensive Medical Expense - Large Employer		**Group Comprehensive Medical Expense - Small Employer**	
	Insureds	**DWP**	**Insureds**	**DWP**
2018	109,508	$613,966,948.00	107,231	$454,567,127.00
2019	152,034	$689,823,300.00	75,656	$450,985,869.00

UnitedHealthcare Insurance Company				
	Group Comprehensive Medical Expense - Large Employer		Group Comprehensive Medical Expense - Small Employer	
	Insureds	DWP	Insureds	DWP
2020	137,606	$687,218,129.00	71,971	$441,877,005.00

EXECUTIVE SUMMARY

The DCI conducted a targeted market conduct examination of the Company. The examiners found the following areas of concern:

OPERATIONS/MANAGEMENT

- The Company did not adequately monitor the utilization review activities of its URAs.
- The Company contracted with one URA, which did not have a Missouri Utilization Review Certificate.
- The Company did not provide information responsive to requests submitted by examiners.
- The Company filed inaccurate annual utilization review activities reports.
- The Company's Annual Utilization Review Activities Reports omitted URAs for reviews conducted in 2018 and 2019.

GRIEVANCE PROCEDURES

- Two versions of "Missouri Final Member Grievance Rights" templates contained inaccurate time periods to file grievances.
- Six "Missouri Resolution 1st Level" grievance outcome templates did not contain the toll-free telephone number for the DCI.
- Seven "Initial Member Grievance Rights" templates state grievances will be resolved within 30 calendar days.
- The Company's URA produced six "Initial Member Grievance Rights" templates which informed recipients that an external review could be requested if the member does "not receive a timely decision" of an appeal.
- Four grievance files did not contain an acknowledgment letter.
- Three grievance files did not contain correspondence to the enrollee on or before the twentieth working day stating additional time is needed to complete the investigation.
- Eight first level grievance resolution letters referenced another insurance company.
- One second level grievance resolution letter referenced another insurance company.
- One second level grievance panel did not indicate a preliminary panel meeting was held and a decision rendered.
- One second level grievance file involving an adverse determination did not indicate a peer review was conducted.
- The Company did not correctly conduct two second level grievance panels.

- The Company did not correctly process one second level grievance file. The two physician peer reviewers noted in the file were a part of the panel hearing.
- Two files did not contain second level grievance reviews that included clinical peers with the same or similar specialty as the medical condition or treatment under review.

UTILIZATION REVIEW

- The Company denied two claims where a prior authorization approval was on file.
- In two files, the Company issued inaccurate explanation of benefits and provider remittance advices to insureds and claimants.
- Two prior authorization reviews were performed by clinical peers who were not of the same or similar specialty as the medical condition or treatment under review.
- The Company did not send UR determination notices to members of 10 concurrent reviews.
- Two concurrent reviews were reviewed by clinical peers who did not hold the same or similar specialty as typically manages the medical condition.
- Thirteen retrospective review files contain adverse determinations where clinical rationale was not provided in writing to the provider and member.
- One retrospective review was reviewed by a clinical peer who did not hold the same or similar specialty as the medical condition or treatment under review.
- The Company did not follow its clinical criteria in one file.

EXAMINATION FINDINGS

I. OPERATIONS/MANAGEMENT

The operations/management portion of the examination provides a review of what the Company is and how it operates.

A. NAIC Market Regulation Handbook Chapter 20 - Operations/Management Standard 1: The regulated entity has an up-to-date, valid internal or external audit program.

To test for this standard, the examiners reviewed the sufficiency of the Company's audit plans, audit reports, findings, and procedural manuals.

Finding 1: The Company did not adequately monitor the utilization review activities of its URAs. During the three-year exam period, the Company performed six file reviews of its delegated URA's for Missouri. Company URAs performed UR services for 170,979 Missouri files per the data provided.

Reference: §§ 376.1353, 376.1356, RSMo.

B. NAIC Market Regulation Handbook Chapter 20 - Operations/Management Standard 5: Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and

management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

To test for this standard the examiners reviewed the contracts and agreements between the Company and its contracted UR agents or entities performing UR services to determine accurate reporting to the DCI. The examiners also validated the licenses of URAs contracted with the Company.

Finding 2: The Company contracted with one URA, which did not have a Missouri Utilization Review Certificate to perform UR services in Missouri throughout the examination period.

Reference: § 374.503.1, RSMo.

C. NAIC Market Regulation Handbook Chapter 20 - Operations/Management Standard 7: Records are adequate, accessible, consistent and orderly, and comply with state record retention requirements.

To test for this standard, the examiners evaluated the Company's cooperation on a timely basis with the examiners conducting the reviews.

Finding 3: The Company did not provide information responsive to requests submitted by examiners. The Company's response to initial formal requests included records outside of the examination scope of January 1, 2018, to December 31, 2020. This required the examiners to create additional requests for applicable records, causing a delay in the review of those documents.

Reference: § 374.205.2(2), RSMo, and 20 CSR 100-8.040(2)

D. NAIC Market Regulation Handbook Chapter 20 - Operations/Management Standard 18: All data required to be reported to departments of insurance is complete and accurate.

To test for this standard, the examiners validated Company responses to the initial data requests. The examiners also monitored the accuracy and completeness of all other information provided during the examination.

Finding 4: The Company filed inaccurate annual utilization review activities reports. The total number of grievances in the reports were not consistent with total number of grievances contained in the Company data provided for this examination.

Reference: § 376.1375.1, RSMo.

Finding 5: The Company's Annual Utilization Review Activities Reports omitted eight URAs that conducted reviews in 2018 and 2019. The Company omitted two of those eight URAs on its 2020 Annual Utilization Review Activities Report. The Company also stated that those two

URAs did not conduct reviews; however, it was found that the two URAs had conducted reviews in 11 files.

Reference: § 374.210.1(2), RSMo.

II. GRIEVANCE PROCEDURES

The grievance procedures portion of the examination is designed to evaluate how well the Company handles grievances. The Missouri definition of a "grievance" is set forth in § 376.1350(17), RSMo.

A. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedure Standard 3: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

To test for this standard, the examiners requested the Company provide its grievance log. The examiners reviewed the grievance log to assess whether it meets the standards in §§ 376.1375, 376.1378, RSMo, and 20 CSR 400-7.110. Examiners also reviewed a census of 68 Grievance rights notices sent to consumers.

Finding 6: Two versions of "Missouri Final Member Grievance Rights" templates did not contain the same time periods to file grievances as those listed in regulation. The templates stated members have 120 days or 4 months to file a grievance. Members have 180 days to file a grievance.

Reference: § 376.1387, RSMo, and 20 CSR 400-10.100(2).

Finding 7: Two versions of "Missouri Final Member Grievance Rights" templates misrepresented the number of days members have to file a grievance with the Department for Independent Review Organization considerations. The templates stated members have 120 days or 4 months to file a grievance. Members have 180 days to file a grievance.

Reference: § 375.936(6)(a), RSMo.

Finding 8: Six "Missouri Resolution 1st Level" grievance outcome templates did not contain the toll-free telephone number for the DCI.

Reference: § 376.1378.3, RSMo.

Finding 9: Seven "Initial Member Grievance Rights" templates state grievances will be resolved within 30 calendar days. Section 376.1382.2(2), RSMo, references 20 working days.

Reference: § 376.1382.2(2), RSMo.

Finding 10: The Company's URA produced six "Initial Member Grievance Rights" templates which informed recipients that an external review could be requested if the member does "not receive a timely decision" of an appeal. An adverse determination is required to request an external review by the Director.

Reference: § 376.1387, RSMo, and 20 CSR 100-5.020(3).

B. NAIC Market Regulation Handbook Chapter 24 – Grievance Procedure Standard 4: The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners requested and reviewed 92 first level grievance files to assess whether the Company correctly processed grievances pursuant to § 376.1382, RSMo. This assessment considered the timeliness, accuracy, adequacy of the grievance reviews, and that the notices advising resolution are clear and specific.

Examiners requested a stratified random sample from Company provided data. Examiners sampled grievance data applicable to "Utilization Review Determination" for Missouri residents with Missouri issued policies.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
§ 375.1007(1), RSMo.	92	Stratified Random	8	8.69%
§ 376.1382.2(1), RSMo.	92	Stratified Random	4	N/A
§ 376.1382.2(2), RSMo.	92	Stratified Random	3	N/A

Finding 11: Four first level grievance files did not contain an acknowledgment letter acknowledging receipt of the grievance within 10 working days.

Reference: § 376.1382.2(1), RSMo

Finding 12: Three first level grievance files did not contain correspondence to the enrollee on or before the twentieth working day stating additional time is needed to complete the investigation with the reasons why the additional time is needed.

Reference: § 376.1382.2(2), RSMo.

Finding 13: Eight first level grievance files referenced another insurance company on its resolution letter.

Reference: § 375.1007(1), RSMo.

C. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 6: The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

The examiners tested this standard through file review. The examiners utilized a stratified random sample to select second level grievances files. Reviews were conducted to determine if second level grievance reviews involving adverse determinations were being handled in accordance Missouri statutes and regulations and the Company's written procedures. This assessment considered the timeliness, accuracy, and adequacy of the grievance reviews, and that the notices advising resolution of the grievances are clear and specific.

The examiners also requested and reviewed the Company's procedures specific to second level grievances.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
§ 375.1007(1), RSMo.	15	Stratified Random	1	6.6%
§ 376.1385.1(3), RSMo.	15	Stratified Random	2	N/A
§ 376.1385.2, RSMo.	15	Stratified Random	5	N/A

Finding 14: Correspondence for one second level grievance resolution letter referenced another insurance company.

Reference: § 375.1007(1), RSMo.

Finding 15: In one second level grievance file, a preliminary panel meeting was not held and a decision was not rendered prior to submitting the grievance to clinical peers for review.

Reference: § 376.1385.2, RSMo.

Finding 16: One second level grievance file involving an adverse determination did not indicate a peer review was conducted. Reviews involving an adverse determination require the carrier submit the grievance for review to two independent clinical peers.

Reference: § 376.1385.2, RSMo.

Finding 17: In two second level grievance files, the grievance was submitted to only one peer reviewer. Reviews involving an adverse determination require the Company submit the grievance for review to two independent clinical peers.

Reference: § 376.1385.2, RSMo.

Finding 18: In one second level grievance file, the two clinical peer reviewers noted in the file were a part of the panel hearing. Reviews involving an adverse determination require the Company submit the grievance for review to two independent clinical peers.

Reference: § 376.1385.2, RSMo.

Finding 19: In two files, second level grievance reviews were not performed by clinical peers with the same or similar specialty as the medical condition or treatment under review.

Reference: § 376.1385.1(3), RSMo.

III. UTILIZATION REVIEW

The Utilization Review portion of the examination provides a review of the Company's compliance with Missouri statutes and regulations regarding utilization review practices such as agent and administrator licensing, oversite, adherence to contract provisions, and compliance with Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 24 – Utilization Review Standard 2: The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

The examiners reviewed sampled files to determine UHIC's compliance with Missouri's utilization review requirements. This assessment considered the timeliness, accuracy, adequacy of the utilization reviews, appropriate application of clinical coverage guidelines, and that the benefit determination notices contained the required information.

1. Prior Authorization Reviews

A prior authorization review is a utilization review conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pre-treatment review, and case management.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
§ 376.1361.13, RSMo.	37	Stratified Random	2	N/A
§ 375.1007(1), RSMo.	37	Stratified Random	2	5.4%
§ 376.1361.2, RSMo.	37	Stratified Random	2	N/A

Finding 20: Two claims were denied by the Company even though a prior authorization approval was on file.

Reference: § 376.1361.13, RSMo, and 20 CSR 400-10.200(1)

Finding 21: In two files, the Company issued explanation of benefits and provider remittance advices to insureds and claimants which misrepresented that prior approval was not obtained.

Reference: § 375.1007(1), RSMo.

Finding 22: Two prior authorization reviews resulting in adverse determinations were reviewed by a clinical peer who did not hold the same or similar specialty as the medical condition or treatment under review.

Reference: § 376.1361.2, RSMo.

2. Concurrent Reviews

A concurrent review is a utilization review conducted during a patient's hospital stay or course of treatment.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
§ 376.1363.3(1), RSMo.	37	Stratified Random	10	N/A
§ 376.1361.2, RSMo.	37	Stratified Random	2	N/A

Finding 23: In 10 concurrent review files, the Company did not send UR determination notices to members.

Reference: § 376.1363.3(1), RSMo.

Finding 24: Two concurrent reviews resulting in adverse determinations were reviewed by a clinical peer who did not hold the same or similar specialty as the medical condition or treatment under review.

Reference: § 376.1361.2, RSMo.

3. Retrospective Reviews

A retrospective review is a review of medical necessity conducted after services have been provided but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
§ 376.1363.5, RSMo.	37	Stratified Random	13	N/A
§ 376.1361.2, RSMo.	37	Stratified Random	1	N/A

Finding 25: Thirteen retrospective review files contain adverse determinations where clinical rationale was not provided in writing to the provider and member.

Reference: § 376.1363.5, RSMo.

Finding 26: One retrospective review resulting in an adverse determination was reviewed by a clinical peer who did not hold the same or similar specialty as the medical condition or treatment under review.

Reference: § 376.1361.2, RSMo.

B. NAIC Market Regulation Handbook Chapter 24 – Utilization Review Standard 7: The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable statutes, rules and regulations.

To test for this standard, the examiners reviewed files sampled in UR Standard 2, above, for consistent use of clinical criteria for review of adverse determinations.

Finding 27: In one file, the Company's URA did not follow its clinical criteria.

The member was five days into a combined detoxification/rehabilitation treatment program when the provider requested more inpatient stays and was denied. The case notes describe major substance abuse and high anxiety. The Company's clinical criteria guidelines support additional inpatient treatment days for co-occurring mental health conditions and risk of relapse. Although the Company eventually provided benefits for additional inpatient days, the examiners observed case notes which show the requested benefits met clinical criteria for additional days of inpatient stay in the initial review.

Reference: § 376.1361.3, RSMo.

IV. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri statutes and regulations require companies to respond to criticisms and formal requests within 10 calendar days. In the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the subsequent time frame. If the response was not received within the allotted time, the response was not considered timely.

A. Criticism Time Study

Number of Calendar Days to Respond	Number of Criticisms	Percentage of Total
0 to 10 days	21	43.75%
Over 10 days with extension	27	56.25%
Over 10 days without extension or after extension due date	0	0%
Totals	48	100.00%

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	28	37.83%
Over 10 days with extension	46	62.16%
Over 10 days without extension or after extension due date	0	0%
Totals	74	100.00%

FINAL EXAMINATION REPORT SUBMISSION AND ACKNOWLEDGEMENT

Attached hereto is the Division of Insurance Market Regulation's final report of the examination of UnitedHealthcare Insurance Company (NAIC #0707-79413), Missouri examination number 386423. The findings in the final report were extracted from the Draft Market Conduct Examination Report, dated June 27, 2024. Any changes from the text of the Draft Market Conduct Examination Report reflected in this final report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This final report has been reviewed and approved by the undersigned.

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

November 21, 2025
Date

Teresa Kroll
Chief Examiner, Market Conduct

This examination was conducted by and the draft report was produced by the following team members:

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