

**REPORT OF MARKET CONDUCT EXAMINATION**

**UNITEDHEALTHCARE MIDWEST INC.**

**13655 RIVERPORT DRIVE**

**MARYLAND HEIGHTS, MO.63043**

**AS OF**

**NOVEMBER 30, 2000**

**BY**

**KANSAS INSURANCE DEPARTMENT**

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Honorable Kathleen Sebelius  
Insurance Commissioner  
Kansas Insurance Department  
420 SW Ninth Street  
Topeka, KS 66612

March 25, 2002

Dear Commissioner Sebelius:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

UnitedHealthcare Midwest, Inc.

13655 Riverport Dr.

Maryland Heights, Mo. 63043.

hereafter referred to as "UHC" or the "Company" and the following report as such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM  
Market Conduct Supervisor  
Examiner in Charge

## **SCOPE OF REVIEW**

A market conduct examination of UHC, Inc.'s operation was completed to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

The examination included, but was **not limited to the following:**

### **COMPANY OVERVIEW**

History and Profile  
Company Operations and Management  
Management Agreements  
Fines and/or Penalties  
Prior Examination Report  
Certificates of Authority  
Reinsurance  
Disaster Recovery Procedures  
Internal Audit Procedures  
Computer Security  
TPA  
Independent Quality Review  
Quality Assessment  
Utilization Review

### **COMPLAINT HANDLING**

Consumer complaints  
Appeal Process  
Grievance Process

### **UNDERWRITING**

Use of Appropriate Forms  
Promptness of Policy Issuance  
Proper Maintenance of Underwriting Files

### **POLICY HOLDER SERVICE**

Member information  
Provider information  
Credentialing  
Network Adequacy

### **LICENSING**

Appointment And Termination of Agents  
Agency Management

## **CLAIMS**

Claim Processing  
Use of Outside Pricing Entities  
Timeliness and Accuracy of Claim Payment  
Proper Maintenance of Claim Files

## **MARKETING**

Certificate Of Compliance – Advertising  
Buyer Guides  
Sales And Advertising  
Internet

## **SUMMARY OF REVIEW**

The market conduct examination focused on UHC. The review of their documents was conducted in their corporate office in St. Louis

The claim processing for UHC is handled primarily out of their claims office in Springfield Mo. The claim portion consisted of reviewing their claims on line and meeting with the director of their claims processing center and several claim's processors.

The examination included a review of the Company's Processed claims from January 1, 1998 thru November 30, 2000.

General topics were covered in Interrogatories submitted to UHC for their written response. Subjects covered were Company Operation, Policyholder Service, Agency y Licensing, Complaints, Sales and Marketing, Underwriting and Claims. The response received adequately addressed the issues presented.

This report is primarily written as a report by exception. The tests listed in this report primarily address those areas where the examiner felt the company was out of compliance.

## **DESK EXAMINATION/ON-SITE EXAMINATION**

### **COMPANY OVERVIEW**

#### **History**

United Healthcare of the Midwest, Inc was formed by the merger of GenCare Health Systems, Inc ("GenCare") and Physicians Health Plan of Greater St. Louis, Inc ("PHP"). UnitedHealthcare has owned PHP since 1986 and purchased GenCare in 1995. These two entities merged in October 1996. MetraHealth Care Plan of Kansas City, Inc., ("MetraHealth"), was acquired

in 1995 as a wholly owned subsidiary of UnitedHealthcare of the Midwest, Inc., until merging with UnitedHealthcare of the Midwest in April 1997.

GenCare Health System, Inc. ("GenCare") was established in 1985 as a joint venture between McDonnell Douglas Corporation, a major St Louis employer, and Sanus Corp. Health Systems. In 1989, General American purchased 70 percent of the company's stock, and in 1991, acquired 100 percent of the Sanus operation in St. Louis. Later that year, General American issued an initial public offering of stock in GenCare Health Systems, Inc., which was traded on the NASDAQ. On January 3, 1995, GenCare was purchased by UnitedHealthcare Corporation. This transaction was structured as a merger of GenCare into a subsidiary of UnitedHealthcare.

Physicians Health Plan of Greater St. Louis, Inc. ("PCP") was issued a license by the state of Missouri to operate as an HMO in March 1986. The company began as a joint venture between a group of local physicians (Physicians Health Association) and UnitedHealthcare.

The MetraHealth Companies, Inc. ("MetraHealth") was established when Metropolitan Life Insurance Company ("MetLife") and The Travelers Insurance Company merged group health operations in 1995. Missouri operations, which were established originally in St., Louis in 1969 as the Medical Care Group, included MetraHealth Care Plan of St. Louis, Inc. and MetraHealth Care Plan of Kansas City, Inc. UnitedHealthcare purchased The MetraHealth Companies, Inc. in October 1995, sold MetraHealth Care Plan of St. Louis to Principal Health Care and retained ownership of MetraHealth Care Plan of Kansas City.

#### Company Operations and Management

##### Board Structure

##### Management of the Corporation

Article III of the Bylaws of UnitedHealthcare of the Midwest was amended on September 27, 1997 and calls for 3 Board of Directors. Currently the 3 positions are filled by:

Robert J. Sheehy  
Stephen C. Spurgeon, M.D.  
Victor E. Turvey

Article V of the bylaws provides for the officers of the corporation.

Section 1 - The officers of the Corporation shall be a Chairman of the Board, a President, one or more Vice-Presidents (the number thereof to be determined by the Board of Directors), a Secretary and a Treasurer, each of whom shall be elected by the Board of Directors. Such other officers and

such assistant officers as may be deemed necessary may be elected or appointed by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary. No officer need be a shareholder

Section 2 - Election and term of office. The officers of the Corporation to be elected by the Board of Directors shall be elected annually by the Board of Directors at the first meeting of the Board of Directors held after each annual meeting of the shareholders. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as conveniently may be.

Each officer shall hold office until his successor shall have been duly elected and shall have qualified or until his death or until he shall resign or shall have been removed in the manner hereinafter provided.

The current officers of UnitedHealthcare of the Midwest are:

<u>Name</u>	<u>Office</u>
Victor E. Turvey	Chairman, President and Chief Executive Officer
William A. Munsell	Vice President and Assistant Treasurer
Jeannine M. Rivet	Executive Vice President
Robert J. Sheehy	Executive Vice President
Allan J. Weiss	Treasurer
Brian K. Beutner	Secretary
Diane L. Flottemesch	Vice President – Taxes
David J. Lubben	Assistant Secretary
Richard G. Kleiner	Chief Financial Officer
Daniel J. McAthie	Vice President – Finance and Assistant Treasurer
Stephen C. Spurgeon, M.D.	Medical Director

#### Territory And Plan of Operation

Combined, UnitedHealthcare's Missouri-based companies offer a wide variety of products to more than 600,000 members in 84 counties in the state of Missouri, 12 counties in west central Illinois and 12 counties in Kansas. Products offered include both an open-access and care coordinator HMO as well as POS, PPO, EPO, Medicare risk and managed indemnity plans.

Physician and ancillary services are provided through individual contracts as well as various group contracts. Services are provided in the full spectrum available from home health care agencies. United Behavioral Health, a UnitedHealthcare specialty company, delivers services related to mental health/chemical dependency outpatient facilities and services, hospitals and physician providers.

#### Reinsurance

##### Reinsurance Program

The current reinsurance program in effect is with United Reinsurance Co:

-Products: Choice, Choice Plus, Choice Individual Choice Plus Individual, Select Plus Medicare and Medicare Complete.

-Coverage:

- 1) Transplant services are at 100 percent of URN approved facilities. Services occurring in other than an URN facility are subject to the same eligibility requirements as any other inpatient stay.
- 2) Other Eligible Hospital services including extended care facility services used in lieu of and less costly than hospital confinement are at 90% coinsurance.

-Deductible: For commercial customers, the deductible is \$350,000; and for Medicare members, it is \$200,000.

-Limit of liability in excess of deductible: \$2,000,000 per member/per year

-Other Endorsements:

- 1) Continuation of coverage in the event of Plan insolvency for unlimited maximum liability.
- 2) 2) Out-of-area conversion (See Endorsement1 and 2)

-Claims eligible for recovery: Claims reported for eligible expenses for dates of service during the policy year must be submitted in writing to the reinsurer within 180 days of the contract year.

-Per Diem restrictions: None

-Reinsurance Payable: Reinsurance recovery is due to the Plan within 30 days of the reinsurer's receipt of written proof of loss.

-Reporting Requirements: Eligible expenses that meet 50% of the plan deductible must be reported monthly.

#### Fines and/or Penalties

The Kansas Insurance Department issued a cease and desist order against UnitedHealthcare of the Midwest on 8/16/99. The order was for failing to certify an agent as the agent of the company within 30 days of appointment of the agent by the company.

Regulatory Information Retrieval System indicated that there were 3 regulatory actions taken against UHC by other states during the exam period. These activities were reviewed by the examiners.

#### Audits

The examination team reviewed an audit preformed by Arthur Anderson on the key processes of their health plans. There were no criticisms found in the reviews.

The company provided an internal audit preformed on PDI Quality process. This report measures both timeliness and accuracy of data entered. There was also an ambulatory report that summarizes audits on PCP's for completeness and documentation to see that they are participating in their wellness program

#### Prior Market Conduct Examination Report(s)

The Missouri Insurance Department (MDI) conducted a financial examination that was finalized 3/26/98. All issues brought up in that review were resolved between MDI and the company. The Missouri Department of Insurance had just recently completed a market conduct exam of UHC, but the report had not been finalized when KID was on-site.

#### Disaster Recovery Program/Business Interruption Plan

The disaster recovery plan was review by the exam team. UHC has developed a Site Disaster Recovery Plan to help prevent a disruption to their daily business activity and minimize the impact of any disruption by containing it within predictable and predetermined period of time. To do this UHC has preventative controls, contingency resources and procedures administered by a formal internal management organization. The Crisis Assistance Team (CAT) develops the document and an assigned Business Continuation Plan Coordinator at the business unit level provides administration of the plan. The coordinator is under the direction of the respective site CEO or local senior management. To insure that the plan is continually updated and maintenance responsibilities are assigned and a test and maintenance checklist is developed for each team to update as needed. Updates are documented by the team members under the direction of team management and are submitted to the UHC Crisis Assistance team for review and revisions. Actual plan updates are required at least once every six months to facilitate and support the successful resolution of any event that results in the immediate or eventual loss of the ability to perform normal business operations There were no areas of recommendation.

#### Computer Security

The company has developed a "Company Information Security Policy". UHC has developed a 20-point plan that includes such areas as ISS function and responsibilities, new employee security, employment termination, information classification, password controls, virus detection Security etc.

#### Anti-Fraud Plan

UHC has an anti fraud plan in place. The utilize Ingenix. The health care information and research segment of an affiliate of United HealthCare Services, the parent corporation, offers reports

and services ideally suited to companies seeking to maximize their anti-fraud/abuse program capabilities. Ingenix products include compliance research and monitoring detection technology, investigation and recovery services, training, consulting and subrogation.

#### Certificate of Authority

The certificate of authority was reviewed to insure that UHC was complying within the scope of authority granted to them by the Kansas Insurance Department.

#### Independent Quality Review

On file with the Kansas Insurance Department is the most recent report by a quality of care review organization giving a written opinion concerning compliance with the quality care guidelines per KSDA 40-3211 (b). The letter was submitted by The Joint Commission on Accreditation of Healthcare Organization and dated 1/24/01. The review took place between 9/13/99 to 9/17/99.

### **COMPLAINT HANDLING**

#### UHC Grievance

UHC defines grievance as - a written complaint submitted by or on behalf of a Covered Person regarding: (1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a Covered Person and the PLAN. To comply with KSA 40-3228:

A health maintenance organization shall provide in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

- (a) The definition of a grievance;
- (b) how, where and to whom the enrollee should file such enrollee's grievance;  
and
- (c) that upon receiving notification of a grievance related for payment of a bill for medical services, the health maintenance organization shall:
  - (1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;
  - (2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. If the investigation cannot be completed within 20 working days after receipt of a grievance, the enrollee shall be notified in writing within 30 working days

time, and every 30 working days after that, until the investigation is completed. The notice shall state the reasons for which additional time is needed for the investigation;

(3) have within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision of the health maintenance organization regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

(4) notify, if the health maintenance organization has established a grievance advisory panel, the enrollee of the enrollee's right to request the grievance advisory panel to review the decision of the health maintenance organization. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make such enrollee's request for this review.

UHC has implemented a 4-phase process for resolving member complaints/grievances.

**Level 1 - Inquiry or Informal Complaint Process.** If you have a concern or question regarding the provision of Health Services or benefits under this Policy, you should contact the PLAN's Customer Service Department at the telephone number or address shown on your identification card.

You also have the right to contact a Customer Service Representative to lodge an informal complaint over the telephone or in person. When an informal complaint is made, the PLAN's authorized representative will attempt to resolve the complaint within 30 working days.

**Level 2 - Formal Complaint Process.** You have the right to submit a complaint or suggestion in writing. You may obtain a Complaint Form by calling or writing to the PLAN. The PLAN's designated representative will contact you to acknowledge receipt of the complaint within 10 working days (unless the complaint has been resolved within that time period,) and to advise you when to expect a written response.

The PLAN will perform an investigation of the complaint within 20 working days after receipt of the complaint. If the investigation cannot be completed within 20 working days, you will be notified in writing within 30 working days that a decision will be reached within an additional 30 working days. You will receive a written notice of the resolution.

**Level 3 - Formal Grievance Process.** A formal grievance is a second complaint filed by Covered Person, appealing the PLAN's response to the initial complaint. You have the right to submit a formal grievance in writing once a complaint has been denied. The PLAN will contact you in writing to acknowledge receipt of the grievance letter and to advise you when to expect a written response. A written response to the grievance will be provided within 30 days of receipt.

If the PLAN upholds the denial of the grievance, you will be advised in writing of your right to request a hearing. You may contact the PLAN's Quality Control Manager by telephone if you wish to exercise this option. It is not necessary to send a written request.

**Level 4 - Grievance Hearing.** If you request a hearing, the PLAN's authorized representative shall appoint a committee. The committee is empowered to resolve or recommend the resolution of the grievance.

The committee shall advise you of the date and place of the hearing within 30 days of your request. The hearing shall include testimony, explanation or other information received from Enrollees, Enrolled Dependents, PLAN staff, administrators, providers or other persons deemed by the committee to be necessary no a Air Review of the grievance.

The committee shall advise you of its findings at the conclusion of the hearing.

UHC also will offer an expedited Grievance in which the grievance will be investigated within 72 hours and the decision communicated to the member.

There were 14 files examined from 1999 and 19 in 2000 that were registered directly with UHC. The following tests were applied to that group.

-KSA 40-3228 (1) Acknowledge. Receipt within 10 working days. While UHC has it's own internal standard of 2 days. The exam team used the 10 days standard set by statute.

1999 - 14 reviewed. 0 errors. The company was 100% in compliance.

2000 - 19 reviewed. 1 error. The company was 95% in compliance.

-KSA 40-3228 (2) Complete the investigation within 20 working days.

1999 - 14 reviewed. 1 error. The company was 93% in compliance.

2000 - 19 reviewed. 2 errors. The company was 89% in compliance.

-KSA 40-3228 (3) Notify the member within 5 working days after a decision has been reached.

1999 - 14 reviewed. 0 errors. The company was 100% in compliance.

2000 - 19 reviewed. 0 errors. The company was 100% in compliance

-KSA 40-3228 (4) Notify the member of right to grievance advisory panel.

1999 - 19 reviewed. 2 errors. The company was 86% in compliance

2000 - 19 reviewed. 3 errors. The company was 84% in compliance

#### Recommendations

1. When handling a formal complaint, UHC must complete the investigation within 20 working days or notify the member in writing of the reason for delay. Per KSA 40-3228 (2).

2. When denying a formal grievance, UNC must advise the member of their right to request a formal hearing before the grievance committee. Per KSA 40-3228 (4).

#### KID Complaints

UHC maintains a complaint log in accordance with K.S.A. 40-2404 (10). Out of 84 complaint files requested, 12 were for UnitedHealthcare Insurance Company and not pertinent to this review.. Seventy-two complaint files were reviewed to verify that the Company was in compliance with Kansas statutes and regulations. This record listed all complaints that were filed with the company and KID.

Three files (the company was 94% compliant) lacked sufficient documentation per KAR 40-1-34 - Section 4. File and Record Documentation: "The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed."

One file (the company was 99% compliant) was not acknowledged by UHC to KID with in 15 days per KAR 40-1-34 - Section 6. Failure to Acknowledge Pertinent Communications" (b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry."

Two files (the company was 97% compliant) were not handled with 30 days per KAR 40-1-34 - Section 7. Standards for Prompt Investigation of Claims "Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time."

Two files (the company was 97% compliant) lacked documentation that the member was advised of a delay in the claims handling per KAR 40-1-34 - Section 8

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation."

#### **UNDERWRITING**

## POLICY FORMS

In the state of Kansas UHC offers both an HMO type program for individuals and for groups. This plan is referred to as their choice policy. They also provide a POS type plan for both individual and group customers. This plan is called Choice Plus.

Under their group program the department reviewed the forms for the period under review.

The following discrepancies were noted:

### A. Choice Plus

#### 1. Section 1 - Definitions

- Dependent - It should read " Section 13, Schedule of Benefits".

- The definition of dependent should also include:

1) The child was born out of wedlock or;

2) The child is not claimed as a dependent on the parent's federal income tax return

or;

3) The child does not reside with the parent or in the plan's service area.

Per KSA 40-2256 (c)

- Routine and Necessary Immunizations - reads: "consist of at least three doeses [*doses*] of vaccine against diphtheria, pertussis, tetanus, polio, Haemophilus B (Hib) and Hapatitis [*Hepatitis*] B: one does [*dose*] of vaccine against measles, mups [*mumps*] and rubella, and other vaccines and dosages as may be prescribed by the state."

It should read: "consist of at least five doses of vaccine against diphtheria, pertussis, tetanus, at least four doses of vaccine polio, Haemophilus B (Hib) and three doses of vaccine against Hepatitis B: two doses of vaccine against measles, mumps and rubella, one dose of vaccine against varicella and other vaccines and dosages as may be prescribed by the state" per KSA 40-2,102.

#### 2. Section 3 - Termination of Coverage

- Section 3.1 (b) - Reads " Coverage will terminate because the Covered Person failed to pay the required Copayment for Health Services rendered."

KSA 40-2209 (d1) requires that "an accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits must renew or continue in force such

coverage at the option of the policyholder or certificateholder except as provided in paragraph ( 2) below” . Nothing in KSA 40-2209 (d) (2) (A thru F) allows of non-payment of a co-pay as an acceptable reason for termination or denial of coverage.

Section 11 - Covered Health Services

- Section 11.1 Under Insurance Benefits”... Routine and Necessary Immunizations for children less than 36 months of age.”

It should read 72 months per KSA 40-2,102.

- Section 11.22 - Reads ”Coverage for the purchase of disposable medical supplies limited to catheter bags and colostomy bags.”

It should include as disposable medical supplies hypodermic needles used exclusively with diabetes management per KSA 40-2,163.

3. Section 12 - General Exclusions

- Section 12.1 (e) - Excludes “...Non-Medically Necessary Reconstructive Surgery”.

Breast reconstruction following mastectomy is considered reconstructive surgery and is covered under any individual or group health policy or health maintenance organization that provide coverage for accident and health services per KSA 40-2,166.

B. Choice

1. Section 3 - Termination of Coverage

- Section 3.1 (b) - Reads “ Coverage will terminate because the Covered Person failed to pay the required Copayment for Health Services rendered.”

KSA 40-2209 (d1) requires that “an accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits must renew or continue in force such coverage at the option of the policyholder or certificateholder except as provided in paragraph ( 2) below” . Nothing in KSA 40-2209 (d) (2) (A thru F) allows of non-payment of a co-pay as an acceptable reason for termination or denial of coverage.

2. Section 10 - Covered Health Services

- Section 11.22 - Reads ”Coverage for the purchase of disposable medical supplies limited to catheter bags and colostomy bags.”

It should include as disposable medical supplies hypodermic needles used exclusively with diabetes management per KSA 40-2,163.

3. Section 12 - General Exclusions

- Section 12.1 (e) - Excludes "...Non-Medically Necessary Reconstructive Surgery".

Breast reconstruction following mastectomy is considered reconstructive surgery and is covered under any individual or group health policy or health maintenance organization that provide coverage for accident and health services per KSA 40-2,166.

Under their individual program, the department reviewed the forms used during the period under review, the following discrepancies were noted:

A. Choice

1. Schedule of Benefits

Reads "immunizations for children from birth to age five". It should read "age six". Per KSA 40-2,102.

UHC also offers a conversion policy for those individuals that are no longer eligible for their group coverage. The items were noted in that form.

A, Choice

1. Section 10 – Covered Health Services

- Section 10.1 reads "coverage is provided for the following immunizations for children from birth to age five." It should read, "age 6 per KSA 40-2,102".

2. Section 12 – Schedule of Benefits

- Section – Copayment and Limitations 10.1 reads "... No Copayment applies when no Physician charge is assessed or to immunizations for children from birth to age five." It should read "age six per KSA 40-2,102".

- Section – Copayment and Limitations 10.12 "[0-20% of eligible Expenses] {\$100 - \$1000 per confinement} [Limited to [10] [30] days per calendar year.]. It should read same as any other health service [Limited to 30 days per year per KSA 40-2,105].

- The Copayment on a number of benefits including inpatient hospital and professional fees for surgical and medical services goes up to 30%. KSA 40-2209 (j)(11) (B) reads "Payment of

benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches \$1,000.” The 30% copayment exceeds the cap of 20% stated in the statute.

UHC’s Select and Select Plus forms were not reviewed since there is only 1 policy in force and it is being terminated per the insured’s request the end of this year.

UHC indicated that they were following the mandated coverages in Kansas. There were no formal recommendations regarding forms since UHC is using new forms that were approved by KID on 1/31/01. The policy language is now in compliance with the mandated coverages in Kansas.

#### UNDERWRITING INDIVIDUAL BUSINESS

The underwriting team had requested 50 new business declinations/cancellations from UHC’s plan submissions. 18 were Missouri risks. 16 Kansas individual account submissions and 16 group submissions were reviewed.

Two individual accounts did not reference the Kansas Uninsurable Health Insurance Plan Act or how to contact them in the declination letter. Per KSA 40-2122 (f): “All plan members, insurers and insurance arrangements shall notify in writing persons denied health insurance coverage, for any reasons, of the availability of coverage through the Kansas health insurance association.”

#### Recommendation:

All declinations for individual policies must mention to the customer the availability of the Kansas Uninsurable Health Insurance Act. Per 40-2122 (f).

#### **AGENT LICENSING**

##### Agent/Agency Licensing

Due to the prior cease and desist order issued by KID for not certifying an agent to the Department, a comparison of the KID agent’s database was run against the agent listing that UHC provided to the exam team. 41 agents that were on the UHCMW list and were not on the KID list were reviewed. 23 were in violation of KSA 40-241i:

(a) Any company authorized to transact business in this state may...appoint such agent as the agent of the company under the license in effect for the agent. The appointment shall be made to the commissioner

annually on a form prescribed by the commissioner at the same time the company files its returns under K.S.A. 40-252, and amendments thereto. A nonrefundable appointment or certification fee set forth in K.S.A. 40-252...and failure of the company to certify an agent shall subject the company to a penalty of not more than \$25 per calendar day from the date the appropriate return was required to the date proper certification is recorded by the insurance department.

Of these 41 agents, 10 of them wrote business prior to their being appointed by UHC with KID. This is a violation of KSA 40-241 which states that no agent shall have "authority to transact business in this state until the agent has been certified by a company pursuant to KSA 40-241i".

Out of these 10 agents that were not appointed by UHC with KID, 4 wrote business after the cease and desist order was issued in 1999.

The exam team reviewed 52 agents where there was a discrepancy between UHC and KID on either their appointment or termination date. 13 agents were in violation of KSA 40-241i. Eight of these agents wrote business prior to being appointed by UHC with KID. This is a violation of KSA 40-241. These 8 producers were the agent of record on 11 accounts after the 1999 KID cease and desist order.

KSA 40-239 defines "insurance agent to also include agencies.

Definition; insurance agent. An insurance agent is hereby defined to be an individual, corporation, association, partnership or other legal entity authorized in writing, by any insurance company or health maintenance organization lawfully qualified to transact the business of insurance, suretyship or indemnity in this state or authorized to operate as a health maintenance organization in this state, to negotiate or effect contracts of insurance, suretyship or indemnity on behalf of any such insurance company or health maintenance organization; or any member of a partnership or association, or any stockholder, officer or agent of a corporation, permitted by law to negotiate or effect such contracts, where such partnership, association or corporation holds a direct agency appointment from any insurance company or health maintenance organization. All such agents shall thereby become liable to all the duties, requirements, liabilities and penalties as provided in this code.

A company can certify the agency and all agents affiliated with the agency will automatically be certified. KSA 40-241i (b) specifies that the companies have to do this annually when they file their tax form.

(b) Certification of other than an individual agent will automatically include each licensed insurance agent who is an officer, director, partner, employee or otherwise legally associated with the corporation, association, partnership or other legal entity appointed by the company. The required annual certification fee shall be paid for each licensed agent certified by the

company and the prescribed reporting form shall be returned at the same time the company files its tax returns as required by K.S.A. 40-252, and amendments thereto.

A comparison of the agencies listed on the KID database as being appointed by UHC was run against the listing that the company provided to the exam team. 12 agencies were reviewed and 10 were not on the KID database as being appointed by UHC and were not certified by UHCMW as being appointed. This is in violation of KSA 40-241i (a & b).

Of these 10 agencies, one of them wrote business prior to their being appointed by UHC with KID. This is a violation of KSA 40-241 which states that no agent shall have "authority to transact business in this state until the agent has been certified by a company pursuant to KSA 40-241i".

#### Agent/Agency Terminations

The exam team reviewed the list of agents/agencies terminated by the company. 7 files were reviewed; there was no documentation in the files to indicate the reason for the cancellation of the contract.

These terminations appear to be in violation of KSA 40-2,107 "such contracts that have been in effect for more than one year shall not be terminated or amended by the company except by mutual agreement or 180 days prior notice has not been tendered to the agent."

#### Recommendations:

1. All agents/brokers must have a company appointment per K.S.A. 40-241i to received commissions. If an agency, they need to be licensed for Life and Health and also must have an appointment.
2. When processing an agent/agency termination the company file should contain adequate documentation for the reason of cancellation. Per KSA 40-2,107.

### **CLAIMS**

#### Claim Processing

The claims are processed on 2 computer platforms. These systems contain current and historical information about members, providers, claims and payments. With COSMOS and UNET systems, UHC can gather and maintain member and provider data, process physician, ancillary and

hospital claims, record and track authorization of services and maintain historical data. This system can also produce integrated reports. The COSMOS system is used primarily for UHC's individual and small group accounts with members and offices in one state.

UHC had an outside auditor review their operation in late 2000. The following is their summary of the regional mail centers in San Antonio and Georgia and their processing centers in Salt Lake and Puerto Rico.

Claims are delivered in mail flats by the post office to the inventory control area of the processing sites or regional Mail Operations (RMO) twice a day. Inventory control uses Intranet Document Retrieval System (IDRS) to track batches of claims through the claim receipt process. Claims are cut opened and sorted according to health plan, product and form type. All claims received are scanned and retained on the company Intranet using IDRS, microfilm is now used only for the enrollment process. The scanner divides the claims into batches of 50 and prints a batch header sheet. The batch header sheet includes the div, product type process date, audit number range, number of claims, and the location where the claim will be keyed. Audit numbers are assigned by the system and stamped on every page scanned. Employee group batches of claims to be sent to the processing center according to health plan. Claims received typically move through the inventory control process on the same day.

At the processing centers... employees pull batches of claims received from inventory control and key the information into COSMOS or TOPS [the UNET system]. The audit number assigned during the scanning process identifies the claim in the system. Once the information is keyed the system begins to adjudicate the claim. The system will review the claims and identify those that will require manual review by a processor to complete the adjudication process; other claims can be completely auto-adjudicated by the system. Adjudicated claims are then paid according to predetermined check-run schedules. A percentage of processed claims are subject to a quality review by a quality management team at each processing site.

The claims that do not clear the UHC' claim checks are adjudicated manually in their Uniprise office in Springfield, Mo. Uniprise is a subsidiary of UnitedHealthcare Corp. that handles the claim processing for the corporation.

#### Claim review

From the data runs received from the company, there were 1,614,220 claim lines from their COSMOS system and 6,307 claim lines from their UNET system. The exam team limited the samplings to their COSMOS System since the percent of business on the UNET system was only 4/10<sup>th</sup> of a percent.

The purpose was to see that regulation 40-1-34, Unfair Claims Settlement Practices, and other laws on claim handling practices were adhered to. The tests included:

-File and Record Documentation, Sec. 4:

- Misrepresentation of Policy Provisions, Sec. 5 a
- Failure to Acknowledge to Pertinent communication, Sec. 6
- Standards for Prompt Investigation of Claims, Sec. 7
- Standards for Prompt, Fair and Equitable Settlements Applicable to all Insurers, Sec. 8 a & c

1. K.A.R. 40-1-34 Sec. 4 - File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his/her duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

2. K.A.R. 40-1-34 Sec. 5a. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

3. K.A.R. 40-1-34 Sec. 6 - Failure to Acknowledge Pertinent Communications:

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant that reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

4. K.A.R. 40-1-34 Sec. 7 - Failure to Acknowledge Pertinent Communications

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

5. K.A.R. 40-1-34 Sec. 8 - Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within 15 working days after receipt by the insurer...of properly executed proofs of loss the first party claimant shall be advised of the acceptance or denial of the claim by the insurer... The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(c) If an insurer needs more time to determine whether a first party claim should be accepted or denied,...notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed...

The exam team reviewed ER claims to see if the company was applying the “prudent lay person” rule regarding how an ER claim was covered. The exam team reviewed 100 paid claims and 100 denied claims.

The exam team reviewed 50 paid and 50 denied other hospital claims.

The exam team reviewed 100 paid and 50 denied doctor and other provider claims.

-ER

Out of a sample of 100 ER denied claims, UHC had two claims fail 40-1-34 (5)(a). The company was 98% in compliance. Two claims failed KAR 40-1-34 (7). The company was 98% in compliance.

Out of a sample of 100 ER paid claims, UHC had three claims fail KAR 40-1-34 (7). The company was 97% in compliance. One claim failed 40-1-34 (8)(a). The company was 98% in compliance.

-OTHER HOSPITAL CLAIMS

Out of a sample of 50 denied claims, UHC had two claims fail 40-1-34 (5)(a). The company was 96% in compliance. Four claims failed KAR 40-1-34 (7). The company was 92% in compliance. Four claims failed 40-1-34 (8)(a). The company was 92% in compliance.

Out of a sample of 50 paid claims, UHC meet all tests and was 100% in compliance.

-DOCTOR AND OTHER PROVIDER CLAIMS

Out of a sample of 50 denied claims, UHC had three claims fail 40-1-34 (4). The company was 94% in compliance. Three claims failed 40-1-34 (5)(a). The company was 94% in compliance. Two claims failed KAR 40-1-34 (7). The company was 96% in compliance. Four claims failed 40-1-34 (8)(a). The company was 92% in compliance.

Out of a sample of 100 paid claims, UHC had two claims fail 40-1-34 (4). The company was 98% in compliance. Two claims failed 40-1-34 (5)(a). The company was 98% in compliance. Two claims failed KAR 40-1-34 (7). The company was 98% in compliance. One claim failed 40-1-34 (8)(a). The company was 99% in compliance.

-OVER 30 DAY To PAY

The exam team chose a sample of 50 paid claims that took over 30 days from receipt to payment and 50 denied claims that were over 30 days from receipt till notification was sent. The purpose of this test was to determine if there were any noticeable trends in the processing of these late claims.

– Out of a sample of 50 Dr And Other Provider Claims denied over 30 days, UHC had six claims fail 40-1-34 (4). The company was 88% in compliance. 22 claims failed KAR 40-1-34 (7). The company was 56% in compliance. Eleven claims failed 40-1-34 (8)(a). The company was 78% in compliance.

- Out of a sample of 50 Dr And Other Provider Claims paid over 30 days, UHC had five claims fail 40-1-34 (4). The company was 90% in compliance. Three claims failed 40-1-34 (5)(a). The company was 94% in compliance. 29 claims failed KAR 40-1-34 (7). The company was 42% in compliance. 28 claims failed 40-1-34 (8)(a). The company was 44% in compliance.

#### -Benefit Schedule (BPL)

The exam team reviewed 23 claims to insure that the schedule of benefits paid was the same as indicated in the member's certificate. We compared the hard copy of what was provided to the member verses what was on their Cosmos system for that group number and used to adjudicate the claim.

Out of the 23 requested. UHC's was not able to provide the exam team with a hard copy of the benefits schedule that was provided to the member for 9 examples. Out of the population of 14, the benefits listed in the group notes on their COSMOS system were different than the "Summary of Benefits" or "Contract Installation Form" in 4 cases. UHC was in compliance 71%.

This is a violation of KAR 40-1-34:

(5) (a) (a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

And KSA 40-2404:

Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations. The following are

hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which: Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

-Provider Contracts

The exam team reviewed the following:

- 1) Three Hospital Participation Agreements. One was not signed by an officer of the medical center.
- 2) One Network agreement
- 3) One Medical Group participation Agreement
- 2) Three 2 PHO agreements were reviewed
- 3) Ten Physician Participation Agreements were reviewed
- 4) Two Participating Agreements were reviewed for laboratory facilities.

A sample of 48 claims were reviewed to verify if UHC was paying their providers per the their contractual agreement.

-UTILIZATION REVIEW

UHC Introduced a program called "Care Coordination" in 1999 as an alternate solution to their Utilization review program. The program called for offering education, accelerating access to care and provides for surveillance and monitoring of chronic conditions. Care Coordination covers many elements: Health Education, Admission Counseling, Patient Care Advocacy, Complex Illness Support, Readmission Prevention, Pharmacy Management and Disease Management. The program allows the primary physician to decide if a referral is needed within certain parameters without prior approval from the company. Currently there are 6 areas where prior notification is required,

The care coordination staff uses: 1) Milliman & Robertson for all lines of business as the primary clinical review guideline for authorization review by diagnosis, and concurrent review of both medical and surgical diagnosis, 2) Interqual Indications for Surgery and Procedures (ISP) is used as the primary clinical review criteria utilized for appropriateness of surgical procedures and 3) The Medical Necessity Guidelines Manual (TMNGM) Preference contains medical necessity guidelines applicable to all lines of business.

Recommendations:

1. UHC shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 Section (8)(a).

2. If UHC needs more time to investigate the claim to determine if the claim should be accepted or denied, UHC shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, UHC shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per KAR 40-1-34 (8)(c).

3. UHC should insure that the schedule of benefits for their individual group accounts should be current and reflect the same list of benefits /copays/deductibles that are given to their members. Per KAR 40-1-34 (5)(a) and KSA 2404 (1).

### **MARKETING AND SALES**

UHC addressed their procedures for advertising and agency advertising in the interrogatories. The producers are provided material that has been approved by UHC's advertising department. If an agent has any custom material, it has to be cleared by UHC before it can be used.

### **GENERAL COMMENTS**

The following summarizes those areas that the examiners feel that UHC needs to improve on:

#### **1. COMPLAINT HANDLING**

a. When handling a formal complaint, UHC must complete the investigation within 20 working days or notify the member in writing of the reason for delay. Per KSA 40-3228 (2).

b. When denying a formal grievance, UNC must advise the member of their right to request a formal hearing before the grievance committee. Per KSA 40-3228 (4).

#### **2. UNDERWRITING**

All declinations for individual policies must mention to the customer the availability of the Kansas Uninsurable Health Insurance Act. Per 40-2122 (f).

### 3. AGENT/BROKER LICENSING

a. All agents/brokers must have a company appointment per K.S.A. 40-241i to received commissions. If an agency, they need to be licensed for Life and Health and also must have an appointment.

b. When processing an agent/agency termination the company file should contain adequate documentation for the reason of cancellation. Per KSA 40-2,107.

### 4. CLAIMS PROCESSING

a. UHC shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 Section 8(a).

b. If UHC needs more time to investigate the claim to determine if the claim should be accepted or denied, UHC shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, UHC shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per KAR 40-1-34 (8)(c).

c. UHC should insure that the schedule of benefits for their individual group accounts should be current and reflect the same list of benefits /copays/deductibles that are given to their members. Per KAR 40-1-34 (5)(a) and KSA 2404 (1).

### **CONCLUSION**

I would like to acknowledge the cooperation and courtesy extended to the examination team by the UHC Legal Regulatory and Compliance Unit and employees of the Company.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

**Market Conduct Division**

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Supervisor

Mary Lou Maritt  
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Respectfully submitted,

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