

EXECUTIVE SUMMARY

The Kansas Department of Insurance performed a market conduct examination of UnitedHealthcare of the Midwest (UHC). The examination was conducted by reviewing company manuals, provider contracts, claims from the Springfield office, underwriting files of large groups and small groups, emergency room claims, grievance procedures, and holding a series of meetings with UHC staff that focused on current operations. To supplement and verify the understanding of the examiner, a series of samples were selected for review.

UHC passed most tests and, in terms of delivering good service to its subscribers, the examiner was impressed with the overall positive service provided to the members by UHC staff and management. The examiner has made recommendations on several issues. Where deficiencies have been identified, corrective action should remedy the problems identified.

The examiner reviewed the UHC Provider Contracts. The HMO Physician Agreement provides the definition of several key words such as Emergency, Medically Necessary or Medical Necessity in defining policy language. The agreement provides Physician Agreements and Obligations, Plan Agreements and Obligations, Plan's Payment for Physician Services, Utilization Review and Quality Assurance Program, Records, Mutual Obligations, and Term and Termination.

The examiner reviewed a sample of Emergency Room (ER) claims from the Springfield office. The ER claims were reviewed for timeliness of processing and whether the definition of Emergency treatment was consistent in determining whether an ER claim should be paid or denied. A sampling of the medical claims were also reviewed from the Springfield office to determine if the claims were reviewed in a timely manner for processing, number of suspended claims, and accuracy of the claims processed according to policy language utilized by the different member groups. The examiner determined that UHC appears to handle claims consistently in terms of the content, the organization, and the decisions made, whether the claim was submitted on paper or electronically.

UHC has a formal procedure for auditing participating providers and participating hospitals to assure that providers and hospitals do not seek or secure payments from the members in violation of statutory and contractual requirements.

UHC has language in all the Provider Contracts, in the Hospital, and Ancillary Agreements addressing the grievance and appeal process.

UHC has a Network Security Policy to assure protection of UHC information handled by computer networks. It is the policy of UHC to prohibit unauthorized access, disclosure, duplication, modification, diversion, destruction, loss, misuse, or theft of this information. UHC is constantly reviewing the status of UHC computers and network security systems.

UHC has a disaster Recovery Plan that is periodically reviewed, updated and tested.

LIST OF RECOMMENDATIONS

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 403228(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. 40-241 i 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).