

**FOLLOW-UP REVIEW
OF THE
REPORT OF EXAMINATION
OF THE
MARKET CONDUCT AFFAIRS
OF
UNITED HEALTHCARE OF LOUISIANA
METAIRIE, LOUISIANA**

AS OF

DECEMBER 31, 1998

FOLLOW-UP REVIEW

AS OF

NOVEMBER 30, 1999

RECEIVED

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**COMMISSIONER OF INSURANCE
FINANCIAL SOLVENCY**

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December 19, 1999

Honorable James H. Brown
Commissioner of Insurance
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Sir:

Pursuant to your instructions and authorization, and in compliance with **LSA-R.S. 22:2012**, the undersigned has made a follow-up review of the December 31, 1998 "as of" examination of the market conduct activities of the

UNITED HEALTHCARE OF LOUISIANA

hereinafter referred to as UHCLA, or as Plan, at its home office located at 3838 North Causeway Boulevard, Suite 2100, Metairie, Louisiana 70002. The initial Report of the Examination of UHCLA was submitted on September 22, 1999 with an as of date of December 31, 1998. This follow-up report is dated as of November 30, 1999 and covers pertinent reviews and recommendations made in the Report.

FOREWORD

The follow-up market conduct examination was performed on the activities of United HealthCare of Louisiana as of November 30, 1999. The initial examination covered the period from December 31, 1996 through December 31, 1998; both examinations were authorized by the Louisiana Department of Insurance, hereinafter referred to as the Department.

The market conduct examination is, in general, a report by exception. This means that references in the examination report to procedures and/or files subject to review may be omitted if no improprieties or errors were noted.

Otherwise stated, the NAIC Market Conduct Examiners' Handbook, Volume II was used as a measure of compliance.

SCOPE OF FOLLOW-UP MARKET CONDUCT EXAMINATION

The scope of the follow-up examination covered the period from January 1, 1999 through November 30, 1999. The examination included, but was not limited to, the following areas of the Plan's operation:

- Complaint and Grievance Review;
- Producer Licensing;
- Network Adequacy;
- Underwriting and Rating;
- Utilization Review;
- Quality Assessment Review; and
- Claims Review.

The purpose of this examination was to review compliance by UHCLA with Louisiana Insurance Laws and Regulations and the National Association of Insurance Commissioners (NAIC) Guidelines. The NAIC Guidelines set the standards of conduct for a health care provider and promote a program of fair treatment of policyholders.

PLAN OVERVIEW

HMO STRUCTURE

United HealthCare of Louisiana was certified as an HMO on November 10, 1986 and commenced business on November 20, 1986. It is a licensed for profit IPA/Group model health maintenance organization.

The Plan is authorized only in Louisiana to provide comprehensive medical services to members, primarily through contractual arrangements with a network of hospitals and health care providers located in 58 of the 64 parishes in Louisiana.

United HealthCare Corporation (d/b/a United Health Group), a Minnesota Corporation, is the ultimate parent company of the Plan and all of the other United HealthCare entities. The parent company is only a holding company with no insurance functions.

COMPLAINT AND GRIEVANCE REVIEW

The NAIC's definition of a grievance is a written complaint submitted by or on behalf of a covered person regarding the

- 1) availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review;
- 2) claim payment, handling or reimbursement for health care services; or
- 3) matters pertaining to the contractual relationship between a covered person and a health carrier.

Complaints that do not meet any of the above definitions of a grievance should be addressed by use of appropriate complaint procedures utilized by the Company. LSA-R.S. 22:1214(17) states "complaint" shall mean *any written communication* received by the insurer from the Department of Insurance.

The complaints filed with the Department generally consist of complaints due to the member's misunderstanding of the policy provisions, delays in handling member's requests, delays in claim payments or dissatisfaction with the insurer's claims practices.

The follow-up review indicated that the Plan has reduced its number of open complaints. According to the Plan approximately 276 complaints have been closed since April 1999. As of December 18, 1999, the Plan had approximately eight open complaint files.

PRODUCER REVIEW

In the initial report a comparison review of the Plan's 1998 listing of producers receiving 1998 commissions against the Department's listing of agent appointments revealed that two hundred and sixty-eight (268) active agents were not appointed by the Plan. During the follow-up review the Plan responded that eighty-five (85) of the two hundred and sixty-eight (268) producers had been appointed.

NETWORK ADEQUACY

During the follow-up review the Plan provided documentation showing that in 1999 a data analysis was conducted on the Plan's Network. The results of the Plan's efforts were as follows:

- Geographic distribution of members and providers by specialty were plotted on a map of Louisiana for use by the Plan in strategic planning.
- The analysis identified a high ratio of providers in geographic areas such as New Orleans, Baton Rouge and Shreveport and a gap in coverage in the Monroe Area.
- The formation of a Network Analysis Committee that will routinely assess the adequacy of the provider network.

Currently, the Plan is determining if any inactive providers can be terminated from the high ratio areas and a plan of action for coverage gaps in the Monroe Area.

UTILIZATION REVIEW

An effective utilization review program should monitor the timely delivery of medically necessary services based on the member's coverage without diminishing the member's quality of care. While the utilization function will promote cost containment, which is important to the Plan's financial stability, it should work to insure and promote quality of care and services by not denying medically necessary and appropriate care, and by not approving unnecessary or inappropriate services.

During the initial review the Plan did not provide any reports relating to the timeliness of utilization review decisions. During the follow-up review the Plan provided documentation previously communicated to its providers stating that the Plan, effective October 1, 1999, had redesigned the traditional authorization process to a simplified prior

notification requirement list. The notification requirement list consists of only eleven services or procedures that require the physician to notify the plan. By simplifying these requirements the Plan feels that the members will have easier access to procedures and services covered in the member's certificate.

The Plan also provided a draft form to be used for ensuring that utilization review decisions are acted upon within 24 to 48 hours. According to the Plan, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will require utilization review monitoring for accreditation. The Plan previously indicated it would seek JCAHO accreditation in 2000.

QUALITY ASSESSMENT REVIEW

Quality Assessment should strive to provide health care that meets the needs of its

Members:

- by being available, and accessible when necessary;
- by providing appropriate and acceptable medical treatment;
- by satisfying the reasonable expectations of members under treatment;
- by providing prompt and effective treatment;
- by adhering to the state-of-the-art for health care management, education, prevention, diagnosis, and treatment; and
- by offering medical treatment in a physically safe environment.

During this follow-up review, the Plan provided a listing of audits of medical records and assessments of providers' facilities for 1998. According to the Plan these audits were not provided during the initial examination due to a misunderstanding by the Plan.

A statistical sampling of 30 medical records audits, representing approximately 10% of the Plan's 1998 audits, was selected from a listing provided by the Plan. These

audits are conducted on a sampling of five or ten medical records of Plan's members. The sample records are checked for patient identification, medical record structure, and preventive medical services offered to member. The schedule below and the following comments address the findings of this review.

SAMPLE #	MEDICAL RECORDS REVIEW RESULTS - 1998
1	FIVE CHARTS REVIEWED- 95% OVERALL COMPLIANCE
2	FIVE CHARTS REVIEWED- 89% OVERALL COMPLIANCE
3	FIVE CHARTS REVIEWED- 90% OVERALL COMPLIANCE
4	FIVE CHARTS REVIEWED- 88% OVERALL COMPLIANCE
5*	FIVE CHARTS REVIEWED- 70% FAILED REVIEW
6	FIVE CHARTS REVIEWED- 85% OVERALL COMPLIANCE
7	FIVE CHARTS REVIEWED- 86% OVERALL COMPLIANCE
8*	FIVE CHARTS REVIEWED- 93% OVERALL COMPLIANCE
9	FIVE CHARTS REVIEWED- 88% OVERALL COMPLIANCE
10*	FIVE CHARTS REVIEWED- 70% FAILED REVIEW
11*	FIVE CHARTS REVIEWED- 74% FAILED REVIEW
12	FIVE CHARTS REVIEWED- 83% OVERALL COMPLIANCE
13	FIVE CHARTS REVIEWED- 91% OVERALL COMPLIANCE
14	FIVE CHARTS REVIEWED- 89% OVERALL COMPLIANCE
15	FIVE CHARTS REVIEWED- 85% OVERALL COMPLIANCE
16	FIVE CHARTS REVIEWED- 91% OVERALL COMPLIANCE
17	FIVE CHARTS REVIEWED- 88% OVERALL COMPLIANCE
18	FIVE CHARTS REVIEWED- 90% OVERALL COMPLIANCE
19	FIVE CHARTS REVIEWED- 87% OVERALL COMPLIANCE
20	FIVE CHARTS REVIEWED- 87% OVERALL COMPLIANCE
21	FIVE CHARTS REVIEWED- 85% OVERALL COMPLIANCE
22	FIVE CHARTS REVIEWED- 87% OVERALL COMPLIANCE
23	FIVE CHARTS REVIEWED- 85% OVERALL COMPLIANCE
24	FIVE CHARTS REVIEWED- 89% OVERALL COMPLIANCE
25	FIVE CHARTS REVIEWED- 92% OVERALL COMPLIANCE
26	FIVE CHARTS REVIEWED- 94% OVERALL COMPLIANCE
27*	FIVE CHARTS REVIEWED- 79% FAILED REVIEW
28*	FIVE CHARTS REVIEWED- 73% FAILED REVIEW
29*	FIVE CHARTS REVIEWED- 76% FAILED REVIEW
30	FIVE CHARTS REVIEWED- 90% OVERALL COMPLIANCE

* AUDIT RESULTS THAT WERE BELOW THE REQUIRED 80% THRESHOLD

The Plan was asked to respond as to what corrective action was taken on the above providers who failed their reviews. The Plan's response was as follows:

Sample 5 - Procedurally the Plan would have entered this provider on its database for a follow-up audit. In this case, a data entry error was made in the year that resulted in this provider being omitted from a follow-up review.

Sample 10 - By letter dated October 5, 1999 the provider was asked to contact the Medical Director. It appears the Plan will terminate the provider.

Sample 11 - Medical Director communicated with provider in December 1998. Provider was successful in passing January 1999 audit.

Sample 27 - No follow-up was conducted because the provider's panel of members was only 21.

Sample 28 - No follow-up was conducted because the provider's panel of members was 0, meaning he or she had no UHC members assigned to him as a PCP.

Sample 29 - No follow-up was conducted because the provider's panel of members was 0.

According to the Plan's current procedures no audits are scheduled on providers with less than 50 members in their panel size.

A statistical sampling of 45 office assessment audits, representing approximately 10% of the Plan's 1998 audits, was selected from a listing provided by the Plan. These audits cover office accessibility, office safety, maintenance of medical records, office medications, form supply and handicapped accessibility. The schedule below and the following comments address the findings of this review.

REVIEW OF PLAN'S ASSESSMENT AUDITS-1998

Sample	Results	Sample	Results
1	Report 02/05/98-passed guidelines	25	Report 02/25/98-passed guidelines
2	Report 09/19/98-passed guidelines	26	Report 01/28/98-passed guidelines
3	Report 03/03/98-passed guidelines	27	Report 10/06/98-passed guidelines
4	Report -adverse findings	28	Report 01/28/98-passed guidelines
5	Report 09/01/98-passed guidelines	29	Report 01/21/98-passed guidelines
6	Report 10/15/98-passed guidelines	30	Report 10/19/98-passed guidelines
7	Report 09/10/98-passed guidelines	31	Report 10/06/98-passed guidelines
8	Report 10/22/98-passed guidelines	32	Report 10/06/98-passed guidelines
9	Report 09/23/98-passed guidelines	33	Report 10/14/98-passed guidelines
10	Report 01/28/98-passed guidelines	34	Report 03/03/98-passed guidelines
11	Report 09/01/98-passed guidelines	35	No report in file (assumed miss filed)
12	Report 02/25/98-passed guidelines	36	Report 10/15/98-passed guidelines
13	Report 10/23/98-passed guidelines	37	Report 10/06/98-passed guidelines
14	Report 10/06/98-passed guidelines	38	Report 10/06/98-passed guidelines
15	Report 02/11/98-passed guidelines	39	Report 06/11/98-passed guidelines
16	Report 10/06/98-passed guidelines	40	Report 10/06/98-passed guidelines
17	Report 10/15/98-passed guidelines	41	Report 10/13/98-passed guidelines
18	Report 11/11/98-passed guidelines	42	Report 10/06/98-passed guidelines
19	Report 02/25/98-passed guidelines	43	Report 06/22/98-passed guidelines
20	Report 02/25/98-passed guidelines	44	Report 08/11/98-passed guidelines
21	Report 09/21/98-passed guidelines	45	Report 07/02/98-passed guidelines
22	Report 01/15/98-passed guidelines		
23	Report 10/06/98-passed guidelines		
24	No report in file (assumed miss filed)		

The Plan responded that the above assessment audits were not part of the quality assessment function and consequently no tracking, trending, or analysis of the assessment audits was performed.

Beginning January 1999 the Quality Improvement Department (QID) assumed responsibility for these assessments. The QID now monitors not only the overall compliance rating, but also specific criteria relating to emergencies in order for a provider's office to meet the Plan's quality standards.

The QID provided a listing of twenty-six providers who were required to submit a corrective action plan because of a failed assessment audit in 1999 and a listing of thirty-five providers who scored below 80 on the medical records audit. These providers will

During the follow-up examination the Plan provided documentation showing that the remaining outstanding inventory of claims affected thirteen providers with unpaid claims totaling \$473,767. By letter dated December 13, 1999, the Plan contacted all thirteen providers with a settlement offer designed to resolve all claims with dates of services prior to June 1, 1998.

COMMENTS AND RECOMMENDATIONS

It is recommended that the Plan expedite its producer appointments in order to comply with LSA-R.S. 22:1114 B (2)(a) which states in part:

“Any insurer lawfully authorized to transact business in this state shall appoint as its agents any person or persons holding a license under the provisions of this part. No solicitation of insurance may be made by any agent prior to notification of the insurer that his appointment has been recorded by the commissioner of insurance...”

See PRODUCER REVIEW, page 5.

When the Quality Improvement Department (QID) conducts a medical record audit, the Plan's provider is advised approximately two weeks in advance of the audit and at that time is furnished a listing of the sampled medical records, usually consisting of five to ten records. In order to increase the effectiveness of these audits, it is recommended that the QID refrain from providing the list of sampled medical records to the providers until the QID auditor arrives at the provider's office. Preferably, the QID auditor should accompany the provider's representative when the sampled medical records are pulled from the provider's files. See QUALITY ASSESSMENT REVIEW, page 7.

CONCLUSION


I, Richard A. Spong, do solemnly swear and affirm that I am an examiner for the Commissioner of Insurance of the State of Louisiana and that as such I was assigned to conduct a follow-up examination of the market conduct activities of

UNITED HEALTHCARE OF LOUISIANA

METAIRIE, LOUISIANA

That I made such examination and the above and foregoing is a true and correct copy of my report of such company and the same is true and correct to the best of my knowledge, information and belief.

Respectfully submitted,



Richard A. Spong, CIE, CFE
Louisiana Department of Insurance