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CERTIFIED MAIL
RETURN RECEIPT REQUESTED

October 10, 2000

Mr. Darrell S. Langlois, CIA, CFE
Senior Director/Deputy Compliance Officer
HMO of Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

Re: Market Conduct Examination Report

Dear Mr. Langlois:

Enclosed is a copy of the adopted Examination Report of your Company. This report is now a public document.

Should you have any questions, please feel free to contact me at (504) 342-9173.

Sincerely,

A handwritten signature in cursive script that reads "Larry Hawkins".

Larry Hawkins
Assistant Director
Market Conduct Division
Office of Financial Solvency

LDH: me

Enclosure



JAMES H. "JIM" BROWN
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June 1, 2000

Honorable James H. Brown
Commissioner of Insurance
P O Box 94214
Baton Rouge, Louisiana 70804-9214

Sir:

Pursuant to your instructions and authorization, and in compliance with LSA-R.S.

22:2012, a market conduct examination has been made of the affairs of

HMO LOUISIANA, INC.

BATON ROUGE, LOUISIANA

as of December 31, 1999 and the report of examination is herewith submitted.

FOREWORD

A market conduct examination was performed of the activities of HMO LOUISIANA, Inc. for the period from January 1, 1997 through December 31, 1999.

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. Unless otherwise stated, the NAIC Market Conduct Examiners' Handbook, Volume II was used as a measure of compliance. Also, in conducting some of the reviews, the Audit Command Program ("ACL") that was provided by the Louisiana Department of Insurance ("Department") or ("DOI") was utilized.

PURPOSE AND SCOPE OF MARKET CONDUCT EXAMINATION

The market conduct examination of HMO Louisiana, Inc., hereinafter referred to as ("HMOLA") or ("Plan"), was a routine market conduct examination conducted in conjunction with the financial examination with both being authorized by the Louisiana Department of Insurance.

The examination included, but was not limited to, the following areas of the Plan's operation:

- Company Overview;
- Complaint and Grievance Review;
- Producer Review;
- Marketing and Sales Review;
- Network Adequacy;
- Provider Credentialing;
- Utilization Review;
- Quality Assessment Review;
- Underwriting and Rating Review, and
- Claims Review.

The purpose of this examination was to review compliance by HMOLA 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

Plan History

HMOLA was incorporated December 19, 1985, as a for-profit health maintenance organization (HMO) domiciled in Louisiana. HMOLA received a certificate of authority and commenced business on July 15, 1986. HMOLA was organized as a wholly owned corporate subsidiary of Louisiana Health Service & Indemnity Company, d.b.a. Blue Cross Blue Shield of Louisiana (LHSIC).

HMOLA ceased operations at the end of 1988. On August 20, 1996, LHSIC contributed funds to HMOLA in order for the HMO to reenter the Louisiana Market.

Affiliated Companies

HMOLA is wholly owned by its parent, Louisiana Health Service & Indemnity Company, Inc. ("LHSIC"). LHSIC's business is transacted under the trade name of Blue Cross and Blue Shield of Louisiana. The Blue Cross and Blue Shield Association, a national organization incorporated in Illinois, contracts annually with LHSIC for the use of the trade name.

Southern National Life Insurance Company ("SNLIC") has a certificate of authority to write life and health and accident insurance in Louisiana. LHSIC owns 99.9% of the stock of SNLIC. Its group life and disability products are offered to insureds of LHSIC and HMOLA. It also contracts with self-funded groups as a third party administrator.

SNLIC owns 100% of the stock of Southern Marketing Company, Inc. ("SNMC"), d.b.a. Fidelity Management Services, formerly Bluebonnet Marketing Company, Inc., a Louisiana corporation. SNMC acts as agent or broker to sell contracts of insurance.

HMOLA owns 75.5% of the stock of Northwest Louisiana Integrated Delivery System ("Northwest"). Northwest is a Louisiana limited liability company formed for the purpose of marketing and administering managed-care business in Northwest Louisiana. PrimeMed, a network of primary care physicians, holds the remaining 24.5% of the shares.

National Committee of Quality Assurance Accreditation

The National Committee Quality Assurance ("NCQA") awarded to the Plan the New Health Plan Accreditation on June 22, 1999. This accreditation is a nationally recognized evaluation that purchasers, regulators, and consumers may use to access managed care plans. NCQA reviews are on-site and off-site evaluations by a team of physicians and managed care experts. A national oversight committee analyzes the findings and assigns an accreditation level.

Antifraud Policy

HMOLA and LHSIC, its parent, share an antifraud policy for the review, investigation and documentation of fraudulent or abusive acts with respect to claims, premium defalcations, provider billing misappropriations, or misuse of corporate assets. From false or abusive claim submissions for 1998 and 1999 both insurers shared in the recovery of claim payments in the amount of \$2,275,828 and prevented improper

payments of \$ 667,666. LHSIC was unable to provide allocation of these recovered and prevented claim payments between itself and HMOLA.

Certificate of Authority

On July 15, 1986 the Louisiana Department of Insurance granted the Plan a Certificate of Authority to operate as a Health Maintenance Organization in the State of Louisiana in accordance with LSA-R.S. 22:5. The Plan offers managed care products by delivering health care services through a network of providers who share financial risk or have incentives to deliver cost-effective medical services. The managed care products include HMO and Point of Service (POS) and are marketed to employer groups and individuals. On March 1, 1999, the Health Care Financial Administration permitted the Plan to market the Medicare+Choice product.

Accounts and Records

HMOLA and its parent, LHSIC, use the same mainframe and server based computer systems for processing policies, claims, premium billings, commissions and accounting records. HMOLA or LHSIC records can be identified and separated by usage of certain codes in order to provide separate reporting and accounting information. This sharing of electronic programs and files benefit both Companies by decreasing administrative expenses.

Comments and Recommendations from Previous Examinations

The Plan was inactive during the previous examination period and there were no comments and recommendations in the previous examination report.

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) circumstances 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.

A sampling of complaints filed in 1998 and 1999 were reviewed without exception. The Plan maintains a complaint register as required by statute; complaints were handled on a timely basis. Also, the Plan has adequate Grievance and Appeal Procedures.

PRODUCER REVIEW

As of December 31, 1999 the Plan had contracts with approximately 1,550 agents. Because of the large number of agent appointments the ACL Program was utilized to match the Plan's listing of agent appointments against the DOI's listing of agent appointments. This review indicated two distinct problems: the Company had some

incorrect license numbers in its database, and the Company had failed to remove some canceled agents from its active files. Both conditions resulted in mismatches against the Department's list of active agent appointments. However, in spite of these conditions, it appeared that the Company's active agents were properly appointed. Also, the Company provided timely notification to the Department of agent terminations.

During the course of the examination, the Plan responded that it was in the process of correcting any discrepancies in its database to ensure annual reconciliation with the Department's listing of agent appointments.

Once the Plan has updated its agent database, future annual reconciliation may be possible by securing a download of agent appointments from the Department. The Department's agent appointments could then be matched against the Plan's agent appointments by computer software in order to detect any discrepancies. Due to the Plan's large number of agent appointments the use of a software program to reconcile agent appointments should reduce the man-hours normally required for a review of the agent appointments.

The Company had no formal procedure for the investigation of its newly hired agents during the period under examination. During this review the Company was reminded of the Department's Bulletin #99-01 dated June 1, 1999 referencing "Consent for Prohibited Person to engage in Insurance Business". This Bulletin was a notification to all persons and entities engaged in or contemplating engagement in the business of insurance in this state that the Louisiana Department of Insurance has enacted guidelines and requirements for granting written consent to engage in the business of insurance for

individuals who are considered "prohibited persons" under The Violent Crime Control and Law Enforcement Act of 1994, Title 18 U.S. Code, Sections 1033 and 1034.

A "prohibited person" is an individual who has been convicted of any felony involving dishonesty or a breach of trust, or who has been convicted of an offense under this section, and who willfully engages in the business of insurance whose activities affect interstate commerce or participates in such business.

Every prohibited person must be granted written consent to engage in the business of insurance by the Commissioner of Insurance and that consent must specify that it is granted for the purpose of Title 18 U. S. Code Section 1033, before engaging in the business of insurance. *The granting of a license does not constitute a written consent under 1033.*

The Company responded that plans were in place to require each agent to sign a statement attesting that he or she had never been convicted of a felony. In addition, a recommendation will be presented to Management that an investigative report conducted by the Louisiana State Police should be secured on all newly hired agents. It is recommended that Management consider some type of investigative report for agent applicants.

MARKETING AND SALES REVIEW

Advertising and sales material used by the Plan during the period under examination was reviewed. This material appeared to comply with applicable statutes, rules and regulations.

NETWORK ADEQUACY

A review of the Plan's provider contracts utilized during the period under examination revealed that these contracts were in compliance with LSA-R.S. 2018.

The Plan utilizes a program referred to as Geo-Access for determining its accessibility to members in geographical service areas in Louisiana. This program is capable of matching the number of the Plan's contracted providers by their locations to the number of member locations in the same zip code area. Geo-Access Reports are reviewed annually by the Plan. In addition, satisfaction surveys and complaint files are assessed.

It appears that the Plan maintains a network of providers that is sufficient in number and types of providers to assure that all services to members will be accessible without unreasonable delay.

As of December 31, 1999 the Plan operated in the following twenty-eight (28) parishes in Louisiana:

BATON ROUGE
REGIONAL OFFICE

Ascension
Assumption
East Baton Rouge
East Feliciana
Iberville
Livingston
Point Coupee
St. Helena
St. James
Tangipahoa
West Baton Rouge
West Feliciana

NEW ORLEANS
REGIONAL OFFICE

Jefferson
Lafourche
Orleans
Plaquemines
St. Bernard
St. Charles
St. John the Baptist
St. Tammany
Terrebonne
Washington

SHREVEPORT
REGIONAL OFFICE

Bossier
Caddo
Claiborne
De Soto
Red River
Webster

PROVIDER CREDENTIALING

The National Committee for Quality Assurance awarded the Plan the New Health Plan Accreditation effective June 22, 1999. In accordance with LSA-R.S. 22:2021 the Provider Credentialing Review was not performed by the market conduct examiners.

QUALITY ASSESSMENT REVIEW

The National Committee for Quality Assurance awarded the Plan the New Health Plan Accreditation effective June 22, 1999. In accordance with LSA-R.S. 22:2021 the Quality Assessment Review was not performed by the market conduct examiners.

UTILIZATION REVIEW

The National Committee for Quality Assurance awarded the Plan the New Health Plan Accreditation effective June 22, 1999. In accordance with LSA-R.S. 22:2021 the Utilization Review was not performed by the market conduct examiners.

UNDERWRITING AND RATING REVIEW

A review was performed of the Plan's currently used policy forms in order to determine that these forms were filed with and approved by the Department. This review was performed with exception.

A random sampling of 25 individual health applications was selected in order to determine if policy forms filed with the Department were used. In addition, writing agents on these applications were checked for proper appointments. These reviews were performed without exception.

A random sampling of approximately 20 policies was selected from a listing of active health policies with pre-existing condition exclusions. A review of this sampling indicated that the Company provided a Schedule of Benefits that properly disclosed to the new member the term of the standard twelve-month waiting period as well as any creditable coverage adjustments to the twelve-month waiting period. These adjustments represented credits for prior health coverage that was continuous to a date not more than sixty-three days prior to the effective date of the members' new coverage.

Creditable coverage was recorded on the sampled policies by adjusting the effective date of the new policy coverage. To expedite the enrollment process, the Company does not require the applicant to secure a Prior Carrier Health Coverage Form from the prior health carrier if the applicant will complete his or her prior coverage data on the Plan's Prior Carrier Health Coverage Form (01100 00040 0898R).

A random sampling of 12 small and large group cases issued in 1998 and 1999 was reviewed in order to determine if Underwriting applied rates in accordance with its group rating manuals. No discrepancies were noted.

The Company provided copies of its annual filing of its Actuarial Certification for the years 1997, 1998 and 1999. Every small group carrier is required to file this certification in order to show compliance with LSA-R.S. 22:228 and that its rating methods are actuarially sound.

A random sampling of approximately 20 individual health applications issued in 1998 and 1999 was reviewed in order to determine if the Company's rates were applied consistently and in accordance with the Company's own rating manuals. This review indicated field underwriters did consistently use the proper rating manuals.

However, a review of the rates indicated that the one-time enrollment fee was not always included in the calculation of the premium on some of the applications. From this sampling, twelve applications did not include the enrollment fee. The Plan responded that it estimates approximately 5% of its applications are received without the enrollment fee. In order to avoid delaying the underwriting process by returning the application for the collection of the fee, the application is processed without the enrollment fee.

The Plan's practice of not enforcing the collection of the enrollment fee (premium) may be violations of LSA-R.S. 22:652 and 22:1214 (7) (b) & (c) which state as follows:

LSA-R.S. 22:652

"No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal life expectancies."

LSA-R.S. 22:1214 (7) (b)

"Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any policy or contract of health or accident insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor."

LSA-R.S. 22:1214 (7) (c)

"Violating the provisions of R.S. 22:652."

The Plan stated it was in the process of preparing a bulletin to their field underwriters stating that applications received in the future without the enrollment fee will be returned in order to ensure that enrollment fees are collected on all applications.

Finally, the Plan's Individual Products Field Manual indicates that exclusionary riders can be placed on individual health policies that are not portable. The Company responded that portability laws addressed in LSA-R.S. 22:250.11 do not prohibit the application of riders to policies, as a pre-existing condition limitation works independently of an exclusionary rider. This issue was referred to the Department for review.

CLAIMS REVIEW

According to the Plan's procedures, claim forms received by the mailroom are sorted by claim type and assigned that day's Julian date. The claim forms are then batched and delivered to Claims Control where the claims are scanned. During scanning the Julian date is recorded at the top of each scanned page of the claim form. During this process, claim totals are maintained by Claims Control and verified against the number of images scanned in order to detect the loss of any claim forms. A batch control report is

generated to verify that all claims were processed. Approximately fifty-six percent (56%) of the Plan's 1999 claims were electronically submitted.

It is the Company's policy to pay all "clean" claims within thirty days or less. Clean claims are defined as completed claims that are ready for adjudication. If it is determined that a claim form is not complete, the claim is pended and a claim processor generates a letter within two business days to the member or provider advising the status of the claim.

The following ACL Report was generated for 1999 paid claims:

SUMMARY OF PAID CLAIMS FOR 1999

Percentage of claims paid in	0 to 30 days	95.06%
Percentage of claims paid in	31 to 60 days	2.85%
Percentage of claims paid in	61 to 90 days	0.71%
Percentage of claims paid in	91 to 120 days	0.38%
Percentage of claims paid in	121 to 365 days	<u>1.00%</u>
		100.00%*

- Percentages were based on the number of paid claims. Estimated paid claims for this report were 660,381.

A random sampling of twenty-five (25) pended claims as of December 31, 1999 was selected for review by utilization of the ACL Program. Claims were pended for a variety of reasons and no adverse patterns were detected during this review.

A random sampling of 60 claims paid in 1999 was selected for review by utilization of the ACL Program. In addition, a random ACL sampling of 60 paid claims in 1999 was selected with payment amounts greater than five hundred dollars (\$500).

The Plan provided claim documentation for a general review of these claim samplings and no discrepancies were detected. A smaller sampling was selected from the original paid samplings for a more detail review of the Plan's claims processing. It was noted during this review that the Explanation of Benefits furnished to the providers and

members explained in detail the reason for any amount not covered by contract. In addition, discounted amounts from participating network health care providers were disclosed on the Explanation of Benefits and deducted from the benefit cost before applying the member's deductible or determining the member's coinsurance payment.

LHSIC entered into an integrated prescription drug program agreement with Paid Prescriptions, L.L.C., a New Jersey corporation ("Paid"); Merck-Medco Rx Services or Texas, L.L.C. ("Rx SERVICES"); and Merck-Medco Managed Care, L.L.C., a New Jersey corporation ("MEDCO"). Paid has a network of retail pharmacies to provide prescription drugs to members and Rx SERVICES, a licensed pharmacy, provides prescription drugs through the mail.

An addendum to the 1995 agreement dated April 1, 1998 revealed that National Rx Services had changed its name to Merck-Medco and HMOLA's members were eligible participants under this contract. Another addendum, dated May 1998, added provisions required by HCFA to insure that Medicare enrollees were considered eligible participants and that Paid and Rx Services would allow utilization management and quality assurance reviews. In addition, the May 1998 addendum added a hold-harmless provision stating that in the event of non-payment by HMOLA, neither Paid nor Rx Services would bill or seek payment from affected members of HMOLA.

Pursuant to an addendum dated May 1, 1999, Medco Managed Care, L.L.C., the parent company of Paid and Rx Services, agreed to provide a service know as "Well Informed Services". This is a 24-hour service to HMOLA members that provides health care information, education and support services designed to help individuals make informed health care decisions.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. **Producer Review - Page 7** - It is recommended that Plan Management consider some form of investigative reports in their review of agent applicants.

Once the Plan has updated its agent database future annual reconciliations may be possible by securing a download of agent appointments from the Department.

2. **Underwriting and Rating Review - 12-** The Plan's practice of not enforcing the collection of the enrollment fee may be a violation of **LSA-R.S. 22:652** and **22:1214 (7) (b) & (c)**. During the course of the examination the Plan agreed to strictly enforce the collection of the enrollment fee.

A review of the Plan's Individual Products Field Manual indicated that exclusionary riders could be placed on individual health policies that are not subject to portability. It appears that this practice is in conflict with **LSA-R.S. 22:250.11**. The Company responded that portability laws addressed in **LSA-R.S. 22:250.11** do not prohibit the application of riders to policies not subject to portability, as a pre-existing condition limitation works independently of an exclusionary rider. This issue was referred to the Department for review.

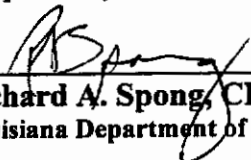
CONCLUSION

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 an examination of the market conduct activities of

**HMO LOUISIANA, INC
BATON ROUGE, 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