

**REPORT OF EXAMINATION
OF THE
MARKET CONDUCT AFFAIRS
OF
HMO LOUISIANA, INC.
BATON ROUGE, LOUISIANA
AS OF
DECEMBER 31, 2004**

COMPANY CODE 95643

COMPANY ETS EXAM # LA071-M40

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August 22, 2005

Honorable J. Robert Wooley
Commissioner of Insurance
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Sir:

Pursuant to your instructions and authorization, and in compliance with statutory provisions, a limited market conduct examination has been made of the affairs of the

HMO LOUISIANA, INC
5525 REITZ AVENUE
BATON ROUGE, LOUISIANA 70809

as of December 31, 2004 and the report of examination is herewith submitted.

FOREWORD

In accordance with **LSA-R.S. 22:1301 D.**, a market conduct examination was conducted on the activities of HMO Louisiana, Inc., hereinafter referred to as (“HMO LA”) or (“Plan”), from January 1, 2002 through December 31, 2004. Since the Plan could only provide a “snap shot” of its active producers, the Producer Review was extended to July 11, 2005. The examination was performed by test and all tests applied are included in this report.

PURPOSE AND SCOPE OF MARKET CONDUCT EXAMINATION

The market conduct examination of HMO Louisiana, Inc. was a limited, routine market conduct examination authorized by the Louisiana Department of Insurance, hereinafter referred to as (“Department”). The examination was limited, in that not all examination procedures recommended by the National Association of Insurance Commissioners, hereinafter referred to as (“NAIC”), were performed.

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

- Company Overview;
- Complaints/Grievance;
- Producer Licensing and Appointments;
- Marketing and Sales;
- Underwriting and Rating;
- Network Adequacy;
- Provider Credentialing;
- Quality Assessment;
- Utilization Review;
- Claims and
- Consumer Privacy Policy.

The purpose of this examination was to review compliance by the Plan with Louisiana Insurance Laws, Regulations, Directives and the NAIC Guidelines. The NAIC Guidelines set the standard of conduct for a health insurance company and promote a program of fair treatment of policyholders. Portions of the **NAIC'S Market Conduct Examiner's Handbook, Volume II** were used as a measure of compliance.

The ACL Program, a data manipulation program, provided by the Department was utilized in this examination. Samplings were utilized to test the Plan's records and procedures for statutory compliance. The ACL Program was used, when possible, to automatically generate a random sampling of data records. "Random" is a theoretical concept meaning that all items in a population or file, before selection, have an equal chance of appearing in the sampling. In instances in which ACL was not used, a systematic (sequential) sampling of certain Plan record listings or a manual random sampling was performed.

Generally a random or systematic sampling size of sixty (60) records will be selected for review. A minimum confidence level of ninety-five percent (95%) with a maximum error rate of five percent (5%) will be used for most samples. Based on a review of the sampling's error rate, additional samplings may be required.

COMPANY OVERVIEW

COMPANY HISTORY

HMO LA was incorporated December 19, 1985, as a for-profit health maintenance organization domiciled in Louisiana. HMO LA received a certificate of authority and commenced business on July 15, 1986. The Plan was organized as a

wholly owned corporate subsidiary of Louisiana Health Service & Indemnity Company, d.b.a. Blue Cross and Blue Shield of Louisiana ("LHSIC").

The Plan ceased operations in 1988 due to the cost of operations, but on February 17, 1997, began operations again due to the market demand for HMO Products.

TERRITORY AND PLAN OF OPERATIONS

The Plan has a certificate of authority to operate as a health maintenance organization in Louisiana.

On March 1, 1999, approval was received from HCFA to market the Medicare+Choice product and the Plan began selling the product in April 1999. In July 2000 the Plan formally notified HCFA of its intent to withdraw from this market.

The Plan has approximately two thousand (2,000) appointed producers located throughout the state of Louisiana. Independent producers have no authority to bind. HMO products are marketed in the New Orleans, Baton Rouge and Shreveport service areas covering twenty-eight (28) parishes.

Effective January 1, 2004, the Plan discontinued its HMO product to the individual market. Existing members were moved to a comparable individual HMO POS plan upon renewals in 2004.

The following schedule depicts premiums written during the examination period:

<u>YEAR</u>	<u>LA PREMIUMS WRITTEN*</u>
2002	\$ 213,570,044
2003	250,932,231
2004	276,677,646

*Schedule T of the Annual Statements

AFFILIATED COMPANIES

HMO Louisiana, Inc. is wholly owned by its parent, Louisiana Health Service & Indemnity Company, ("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 group life and disability products to insureds of LHSIC and HMO LA. It is ninety-nine and nine tenths percent (99.9%) owned by LHSIC.

SNLIC owns one hundred percent (100%) of Southern National Marketing Company, Inc. ("SNMC") d.b.a. Fidelity Management Services, a Louisiana corporation. SNMC's purpose is to act as agent or broker to sell contracts of insurance.

RELATED PARTY TRANSACTIONS

The Plan entered into an agreement with LHSIC, effective December 31, 2001, which replaced agreements dated August 6, 1998 and September 26, 1996, whereby LHSIC guaranteed the financial responsibility for all outstanding eligible claims for covered service rendered to the Plan's enrollees in the event the Plan becomes insolvent and unable to pay its debts. This agreement cannot be cancelled until a one hundred eighty (180) day notice is given to the Department.

HMO LA entered into an Administrative Services and Operations Agreement with LHSIC, effective July 30, 1998, and amended January 1, 2000, whereby LHSIC provides physical facilities and performs the administrative functions for the Plan.

HMO LA entered into a Mental and Nervous and Alcohol and Substance Abuse Services Management Agreement on May 1, 2002, with Magellan Behavioral Health Inc., ("MHB") and Human Affairs International, Inc., both Delaware corporations ("HAI").

MHB is to provide utilization management and review, and customer service including addressing appeals, complaints and grievances. HAI, an affiliate of MBH and a licensed third party administrator in the State of Louisiana, has established systems and procedures and will provide claim processing services to the Plan as set forth in the agreement.

By amendment, effective January 1, 2004, HAI changed its name to Magellan Behavioral Health Systems, LLC.

On November 1, 2000, the Plan entered into a Integrated Prescription Drug Program Master Agreement along with its parent, LHSIC dba Blue Cross Blue Shield of Louisiana with Merck-Medco Managed Care, L.L.C., ("Merck-Medco") Paid Prescriptions, L.L.C., ("PAID") (both located in New Jersey), Merck-Medco Rx Services of Texas and Merck-Medco Rx Services of Massachusetts, L.L.C. (collectively "Rx Services"). According to this agreement Merck-Medco, PAID and its affiliates will provide prescription drug benefits programs to members of LHSIC and HMO LA.

Effective April 1, 2004, the above agreement with Merck-Medco and affiliates was replaced with a prescription drug benefit management services agreement between Express Scripts, Inc., a Delaware corporation, and its affiliates and LHSIC and HMO LA.

URAC ACCREDITATION

The Plan received URAC accreditation effective June 28, 2001 in accordance with **LSA-R.S. 22:2017 C**. Currently, the Plan has full accreditation thorough April 1,

2007. URAC, founded in 1991, was initially named Utilization Review Accreditation Committee and is the largest accrediting body for health care nationally.

RECOMMENDATIONS FROM PRIOR EXAMINATION REPORTS

The Plan addressed the recommendations from the previous Department Market Conduct Report as of December 31, 1999.

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:

- Availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review;
- claim payment, handling or reimbursement for health care services; or
- 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 Plan. **LSA-R.S. 22:1214 (17)** states *““complaint” shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance”*.

A systematic sample of thirty (30) complaints was selected for review from complaints filed against the Plan during the period under examination. A review of these complaints indicated the Plan responded to the Department on a timely basis with adequate documentation.

The Plan maintains a complaint register as required by statute and all complaints were maintained in the Plan's register.

A systematic sampling of fifteen (15) grievances of dissatisfaction of quality of care was selected for review. A review of these grievances indicated the Plan responded timely and when required took corrective action to the benefit of the Plan member.

The Plan maintained procedures that appear adequate for responding to inquiries and resolving member's complaints, grievances, and appeals.

PRODUCER REVIEW

The Plan provided a CD of its active producers as of July 11, 2005. ACL was utilized to match the Plan's approximately two thousand (2,000) active producers against the Department's electronic listing of active appointments. ACL generated twenty-two (22) exceptions caused primarily by producers terminated by the Plan but still shown as active producers by the Plan. After a review of these exceptions, no violations of Louisiana Statute had occurred. The Plan took immediate corrective action on these producer exceptions. This ACL review revealed that all of the Plan's producers held current appointments.

A judgmental sampling of ten (10) producers was selected for review. This review indicated that once the producer signed a contract, an appointment was timely submitted to the Department in accordance with **LSA-22:1144 B (1)**.

A judgmental sampling of fifty (50) terminated producers was selected for review. These appointments were canceled timely in accordance with **LSA-22:1145 B**. No producers were terminated during the period under examination for causes addressed in **LSA-22:1142**. No exceptions were noted during this review.

The Plan provided detailed appointment procedures for hiring and terminating producers which appeared to be in accordance with Louisiana Statutes.

The Plan provided a revised application for the contracting of new producers which required the applicant to disclose if he or she had ever been convicted of insurance fraud or a felony involving dishonesty or a breach of trust. Beginning in 2000, the plan utilized a stand alone attestation document for this purpose. The Plan implemented this 2004 revised application in order to comply with **Louisiana Bulletin #99-01**, dated June 1, 1999, titled "Consent for Prohibited Person to engage in Insurance Business, 18 United States Code, Sections 1033 and 1034.

MARKETING AND SALES REVIEW

The Plan did not engage in any radio or television advertising during the period under examination. Newspaper and magazine advertisements, along with sales brochures and producer communications, were reviewed which appeared in compliance with statutes and regulations.

The overall website was redesigned and was launched in June 2002. Additions made to the website, www.bcbsla.com, included prescription drug information for members, preventive medicine guidelines and HIPAA and privacy information. The Plan shares LHSIC's website.

The first phase of member self-service was launched in March 2004 in conjunction with the total redesign of the company's website in late August 2004. **AccessBlue** was introduced along with online claims review capability for all members. More than nine thousand (9,000) member registrations/account activation code mailers for **AccessBlue** have been processed from August 27, 2004 through May 6, 2005.

UNDERWRITING AND RATING REVIEW

The Plan provided underwriting guidelines that appeared in accordance with policy provisions, statutes and regulations.

The Plan provided a CD containing all new business (group and individual coverage) for policies issued in 2002, 2003 and 2004 to Louisiana residents. ACL was utilized to select a random sampling of thirty (30) group policies and thirty (30) individual policies for review.

A review of the group sampling revealed that the applications were complete and well documented and were issued on an average of twenty-five (25) days after receipt of the application. A review of the individual sampling revealed that the applications were complete and well documented and were issued on an average of nine (9) days after receipt of the application. No exceptions were detected during these reviews.

ACL was used to select a random sampling of sixty (60) declined small group applications for the period under examination. The sampling revealed that the applications were declined either by the group or the Plan. The group applicant declined coverage due to the rate offered by the Plan usually by not responding to the Plan's offer. The Plan declined coverage due to the group applicant's failure to provide requested data for underwriting purposes. It was noted that the Plan, when asked, did provide time extensions to the group applicant in order to provide requested data. The underwriting files were processed timely and were well documented. No exceptions were noted during this review.

ACL was used to select a random sampling of sixty (60) declined individual applications for the period under examination. These applications were declined for

medical reasons and the applicant was advised by letter of the reason for declining the applications. The Plan's reasons for declination of the applications were in accordance with Louisiana Statutes and regulations. No exceptions were noted during this review.

CLAIMS REVIEW

The Plan provided underwriting guidelines that appeared in accordance with policy provisions, Louisiana Statutes and Regulations. Approximately seventy-five percent (75%) of the claims are received electronically from the hospitals and approximately eighty-two percent (82%) of the claims are received from physicians. The claim system documented the date the claim was received.

The Plan provided a CD of paid claims for 2004 per the examiner's request. After the total of the paid claims from the CD were reconciled with the Plan's 2004 Annual Statement, ACL was utilized to select a random sampling of sixty (60) paid claims for review. The sampling indicated paid claims were paid in an average of twenty-four (24) days in accordance with policy provisions, Louisiana statutes and regulations.

ACL was utilized to generate a time-study from the CD for all 2004 paid claims. The following schedule depicts the time study:

RANGE	COUNT	← %	% →	DOLLAR AMOUNT
0 TO 30 DAYS	2,075,092	94.06%	92.56%	\$ 156,193,354
31 TO 60 DAYS	59,620	2.7	4.33	7,306,756
61 TO 91 DAYS	20,895	0.95	1.56	2,640,577
>91	50,532	2.29	1.55	2,608,688
TOTALS	2,206,139	100.00%	100.00%	\$ 168,749,376

The ACL time study indicated that approximately ninety-four percent (94%) of the number of claims and ninety-three percent (93%) of the dollar amount of claims for 2004 were paid within thirty (30) days from the date the Plan received notification of the claim.

ACL was utilized to select a random sampling of sixty (60) denied claims from the 2004 claim activity. Claims were denied timely and in accordance with policy provisions, Louisiana Statutes and Regulations. No exceptions were noted during this review.

The Plan was unable to provide a listing of pending claims for 2004. Only a current snapshot of pending claims was available. A "snapshot" of pending claims was pulled by the Plan as of June 21, 2005. ACL was used to extract all pended claims with a date earlier than January 1, 2005. Nine (9) claims were extracted. These extracted pended claims had already been cleared earlier in 2005.

Due to such a small number of pended claims prior to 2004, another ACL sample of thirty (30) pended claims was selected from 2005 activity. A review of this sampling indicated these pended claims contained current received dates. No exceptions were noted and no additional review of these pended claims was deemed necessary.

ANTIFRAUD POLICY

HMO LA and LHSIC 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. During the period under examination, HMO LA recovered eight hundred seventy-seven thousand six hundred fourteen dollars (\$ 877,614) from false or abusive claim submissions.

NETWORK ADEQUACY

As a result of the Plan's URAC Accreditation, a limited review was conducted and no exceptions were noted.

PROVIDER CREDENTIALING

As a result of the Plan's URAC Accreditation, a limited review was conducted and no exceptions were noted.

QUALITY ASSESSMENT REVIEW

As a result of the Plan's URAC Accreditation, a limited review was conducted and no exceptions were noted.

UTILIZATION REVIEW

As a result of the Plan's URAC Accreditation, a limited review was conducted and no exceptions were noted.

CONSUMER PRIVACY POLICY REVIEW

The Plan's privacy and confidentiality policy and procedures in place to secure information regarding policyholders and claimants were in compliance with the Louisiana Department of Insurance **Regulation 76 / PRIVACY OF CONSUMER FINANCIAL INFORMATION.**

Privacy Notices are mailed annually to the Plan's clients. Group enrollees receive a printed notice in the Group Enrollment Kit provided to the new subscriber. Individual enrollees receive the privacy notice with their initial enrollment packet. This privacy notice is also available electronically if a subscriber enrolls through the Plan's eBlue

system. In addition, the privacy notice is displayed on the Plan's website which is shared with its parent, LHSIC.