

REPORT OF EXAMINATION

OF THE

MARKET CONDUCT AFFAIRS

OF

HEALTH PLUS OF LOUISIANA, INC.

SHREVEPORT, LOUISIANA

AS OF

December 31, 2004

NAIC CODE 95009

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November 16, 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

HEALTH PLUS OF LOUISIANA, INC.
2219 LINE AVENUE
SHREVEPORT, LOUISIANA 71104

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 Health Plus of Louisiana, Inc. from January 1, 2002 through December 31, 2004. 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 Health Plus of Louisiana, Inc., hereinafter referred to as ("The Plan", "Company" or "Health Plus") was a limited routine market conduct examination authorized by the Louisiana Department of Insurance ("Department"). The examination was limited, in that not all examination procedures recommended by the National Association of Insurance Commissioners ("NAIC") were performed.

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

- Plan Overview;
- Complaints/Grievance;
- Producer Licensing and Appointments;
- Marketing and Sales;
- Underwriting and Rating;
- Network Adequacy;
- Provider Credentialing;
- Quality Assessment and Improvement;
- 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 Company'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 Company 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

Health Plus of Louisiana, Inc., a for-profit stock corporation, was incorporated in Louisiana on April 19, 1994 and was issued a Certificate of Authority to act as a health maintenance organization on September 28, 1994. On January 2, 1995, Health Plus

began providing health care services to subscribing employer groups through service contracts with physicians, physician groups and hospitals.

CERTIFICATE OF AUTHORITY

The Plan's original Certificate of Authority was issued on September 28, 1994 in the name of Health Plus of Louisiana, Inc. The Plan is authorized to act as a health maintenance organization in the State of Louisiana.

TERRITORY AND PLAN OF OPERATIONS

Although authorized to market in all parishes in Louisiana, the Plan offered medical coverage to large and small groups in the Northwest Louisiana Area, which consists of fourteen (14) parishes. See Network Adequacy for more details on the service area.

The Plan contracted with local physicians, hospitals, outpatient facilities, pharmacies and other health care services either on a fee-for-service or a capitated basis.

For the period under examination, the Plan's annual statements reflected the following Louisiana premium volume:

<u>YEAR</u>	<u>PREMIUM VOLUME*</u>
2002	\$ 62,594,420
2003	51,736,313
2004	53,495,722

*From Schedule T

RECOMMENDATIONS FROM PREVIOUS REPORT

The Plan addressed the recommendations from the previous Louisiana Market Conduct Examination dated November 26, 2002.

AFFILIATED COMPANIES

Health Plus is a member of an insurance holding company system. Willis-Knighton Medical Center (“WK”) owns and controls the subsidiary and acts as paymaster of employees to the Plan. Ownership of the companies in the holding company system is depicted by indenture in the following organizational chart:

<u>CORPORATE NAME</u>	<u>OWNERSHIP</u>
Willis-Knighton Medical Center (LA)	
Health Plus of Louisiana, Inc. (LA)	100%
Virginia Hall Nursing Home (LA)	100
South Shreveport Pharmacy, Inc. (LA)	100
Willis-Knighton Physician/Hospital Org, Inc. (LA)	50
Willis-Knighton Lab and X-Ray Services, Inc. (LA)	100
Claims & Benefits Administrators of Louisiana, Inc. (LA)	100
Marshall Clinic, Inc. (TX)	100

ANTIFRAUD POLICY

An employee (or Contract Employee, Advisor or Consultant) of Health Plus or its parent, Willis-Knighton, is provided ample documentation relating to the protection of corporate assets.

COMPLAINTS/GRIEVANCE REVIEW

This review was conducted in accordance with the provisions of **LSA-R.S. 22:1214 (17)**.

The Company provided its complaint register and copies of complaints and correspondence for those complaints received during the period under examination.

The complaint register was in compliance with **LSA-R. S. 22:1214(17)** by containing a total of complaints filed and the processing time for each complaint. The

examiner reviewed ten (10) of the eighteen (18) complaints filed during the period under examination. It should be noted that the Company had a small number of complaints during the period under examination.

A review was conducted of the Plan's grievance procedures for the period under examination. These procedures appeared in compliance with applicable statutes, rules and regulations.

The Plan defines an "appeal" as a communication, whether written or spoken, from a Health Plus member expressing dissatisfaction with an adverse benefit determination, and expressing a request for a review of such an adverse determination when there is a basis for such a request for further review and reconsideration of that benefit determination.

The review indicated that the member was notified of receipt of the appeal and a meeting was timely scheduled at the Plan's home office, or if the appealing parties could not attend, a conference call was arranged.

ACL was utilized to generate a sampling of twenty (20) appeals from the Plan's data base. These appeals were handled timely and it appeared appropriate reconsideration was given during the appeal process. No exceptions were noted.

PRODUCER LICENSING AND APPOINTMENTS

The Plan provided procedures which appeared appropriate for the proper processing of producer appointments.

The Plan provided a July 31, 2005 listing by CD of its active producers that was verified against the Department's website of producer appointments. Approximately fifteen (15) exceptions were detected. These exceptions were recorded as active

appointments by the Department's listing but did not appear on the Company's list of active producers provided to the examiner. The Plan explained the exceptions not reported on an active producer listing represented employees and inactive producers still holding active licenses and appointments. This review indicated that the Plan's producers were properly appointed during the period under examination in compliance with statutes, directives and regulations.

A sample of fifteen (15) newly contracted producers was selected at random for review. The Plan had little activity in newly contracted producers; however, the Plan's process of contracting of a new producer through the appointment process with the Department was handled timely in accordance with Louisiana Statutes.

A sample of fifteen (15) terminated producers was selected at random for review. These sampled terminations were for causes of non-production. The Company did not terminate any producers during the period under examination for fraudulent causes as addressed in **LSA-R.S. 22:1142**. Producer terminations were handled in accordance with Louisiana Statutes

The Company believes its procedures for hiring employees and contracting producers are in compliance with the Department's Bulletin #99-01 dated June 1, 1999 referencing "Consent for Prohibited Person to engage in Insurance Business".

MARKETING AND SALES REVIEW

The Company's sales material for the period under examination consisted of limited television advertising and hand outs. It appeared advertising was primarily for name recognition. The advertisements appeared to be in accordance with applicable statutes, rules and regulations.

UNDERWRITING AND RATING REVIEW

The Plan provided a Rating and Underwriting Manual that appeared adequate for the proper underwriting of its small group business. The Plan contracts with an outside individual, who previously held the position of Senior Underwriter with the Plan, to assist primarily with the underwriting of medical applications on small groups.

ACL was utilized to select a systematic sampling of sixty (60) new business files, small and large groups, issued during the examination period in order to determine how the Company treats its members and whether that treatment is in compliance with applicable statutes, rules and regulations. All of the underwriting files sampled were well documented and contained completed and signed applications.

The Plan provided a file containing copies of letters relating to non-renewed policies and a computer listing of all groups terminated during the period under examination. A review of this material indicated that groups terminated for non renewal due to failure to meet the Plan's underwriting requirements represented about five percent (5%) of all terminations during the period under examinations. Failure to meet the underwriting guidelines generally was a result of a reduction in the number of members participating in the group program. Certified letters were mailed timely advising the employer of the non renewal of the group due to insufficient participation.

A review of the Plan's Certificates of Coverage was performed in order to verify the inclusion of mandated benefits required by Louisiana Statutes. No exceptions were noted during this review.

The Plan's medical underwriting process for groups with two (2) to fifty (50) eligible employees is based on health history statements completed by each small group

employee. Debits are assigned for each illness or disease disclosed on these statements by utilizing the "Milliman Small Group Underwriting Manual". The Milliman debits are used in determining the rate.

The Company filed Small Group Rate Certifications of Actuarial Opinions for year-ended 2002, 2003 and 2004 as required by **LSA-R.S. 22:228.5 B.** in order to demonstrate compliance with the underwriting and rating requirements contained in Title 22 of the Louisiana Insurance Code and Regulation 52.

CLAIMS REVIEW

The Company entered into an administrative agreement on February 25, 2003 with Synertech Health Systems Solutions ("Synertech") to implement a claim system called "QMACS". Prior to the claim system implementation, Synertech was purchased by Amysis which later changed its name to Amysis Synertech, Inc ("ASI").

ASI provided claim procedures which appeared adequate for the processing of claims for Health Plus, which are now all processed in Harrisburg, Pennsylvania.

Health Plus provided a CD of the 2004 claim activity which was reconciled to the NAIC Annual Statement. ACL was utilized to select random samplings of paid, denied, pending and claim reversals from the CD. A Company monitor was used at the Company's location in Shreveport to review samplings of claims.

ACL was utilized to pull a sampling of sixty (60) paid claims. It appeared paid claims were paid in accordance with applicable statutes, rules and regulations.

Normally ACL is utilized to generate a time study of the paid claims. In this case the claim fields labeled "Date Adjudicated" and "Date Check" would be used in

producing the time study report for paid claim's activity for 2004. As a result of the claim conversion, the Company used claim records labeled Reversals which also included a Date Check Field. "Reversals" were used during the conversion to categorize and recover overpayments of fee schedules during the conversion period. A closer review of the Date Check Field included in the Reversal computer file revealed that this date did not represent the issuance of the date of a current check; consequently, the ACL Time Study Report of the results for paid claims in 2004 appeared skewed and was not used in this report.

It is recommended that the Plan have the QMACS Claim Program changed so that future claim reports will include only the issue date of a *paid* check in the Date Check Field.

ACL was utilized to select a sampling of sixty (60) denied claims. It appeared denied claims were handled in accordance with applicable statutes, rules and regulations.

ACL was utilized to select a sampling of sixty (60) pended claims. It appeared pended claims were handled in accordance with applicable statutes, rules and regulations.

During this review, it was noted that during the 2003 claim conversion a number of claims filed in 2003 and 2004 were pended and were not paid within the time frames specified in **Regulation 74- "PAYMENT OF HEALTH COVERAGE CLAIMS"**. Some of the late payments were the result of fee schedules not readily retrievable to process claims after the claim conversion.

In order to be in compliance with Louisiana Regulations, Health Plus hired Praeses Corporation, a local consulting firm, to implement a program which would calculate interest due on late claim payments in accordance with Regulation 74. This

program was completed in March 2004. During the examination, Health Plus provided the report representing interest payments paid to providers that were affected by late claim payments.

Two (2) random samples of five (5) payments each were selected to verify interest payments to providers. Health Plus was able to provide cancelled checks of interest payments only of amounts over twenty-five dollars (\$25) because the program's business logic only generated checks of twenty-five dollars (\$25) and greater.

With the discovery that interest payments of less than twenty-five dollars (\$25) had not been paid, the examiner contacted the Department for instruction. As a result, The Plan requested Praeses Corporation to assist in implementing a new program for automatically processing missing interest payments in accordance with the Department's consultation.

Toward the end of the examination, The Plan provided a revised report of interest payments payable to providers with the understanding that at a later date this report of interest payments could be tested for canceled checks by the Department.

The Plan has no formal documented program in place to detect fraud perpetrated by its providers. However, The Plan utilizes certain protocols that detect duplicate claims, invalid providers and providers with multiple billing addresses.

NETWORK ADEQUACY

The Plan markets the Northwest Louisiana Area that consists of fourteen (14) parishes: Bienville, Bossier, Caddo, Claiborne, DeSoto, Jackson, Lincoln, Natchitoches, Ouchita, Red River, Sabine, Union, Webster and Winn.

When asked to provide documentation supporting the Company's determination that its networks were sufficient to assure that all services are accessible without unreasonable delay, The Plan responded as follows:

“To the best of our knowledge, Health Plus has contracted with the majority of physicians and hospital providers in Northwest Louisiana. Health Plus has not conducted any formal studies to determine network sufficiency since the majority of physicians in the service area are contracted with Health Plus. Health Plus Provider Agreements set forth Standards of Care that require accessibility to care without unreasonable delay.”

During this review, The Plan provided an Access data base of all providers in the Plan's Network which contained all primary care providers (“PCP”) and specialty care providers (“SCP”) in the Plan's service area. According to the Plan's records this equates to approximately one (1) PCP per every eighty-five (85) members and one (1) SCP for every thirty-eight (38) members.

UTILIZATION REVIEW

The Plan's Utilization Policies and Procedures were reviewed and appeared adequate to monitor and evaluate the clinical necessity or efficiency of health care services and procedures.

QUALITY ASSURANCE REVIEW

The Plan's Quality Management Programs was reviewed and appear adequate to assure that The Plan's assessment programs evaluate and improve the quality of health care services provided to members.

PROVIDER CREDENTIALING REVIEW

The Plan acknowledged that WK provided The Plan's provider credentialing and re-credentialing function. On October 20, 2005, WK provided a written statement that the credentialing service was performed by WK and met Joint Commissions on Accreditation of Healthcare Organizations (JCAHO) standards. WK's current accreditation is valid until the next accreditation examination is scheduled. Future accreditation is based on unscheduled examinations without prior notice by JCAHO.

CONSUMER PRIVACY POLICY

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

Privacy Notices are mailed annually to The Plan's clients. Group enrollees receive a printed notice which is included with the Certificate of Coverage. When coverage is renewed, the Plan Member is again provided an annual privacy notice as part of the re-enrollment process. In addition, Privacy Notices are mailed to all members with recent terminated coverage.

COMMENTS AND RECOMMENDATIONS

It is recommended that The Plan have the QMACS Claim Program changed so that future claim reports will include only the issue date of a *paid* check in the Date Check Field. With the completion of the claim system conversion, it is possible that the computer file labeled "Reversals" will not be used, thereby eliminating the issue date problem.

During the examination, The Plan provided a revised report to the examiner of interest payments due to providers on late claim payments. This listing represented interest payments of less than twenty-five dollars (\$25) that were erroneously not paid because of the program's business logic. At a later date, the Department may verify interest payments to providers from this revised report.

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

HEALTH PLUS OF LOUISIANA, INC
SHREVEPORT, 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