REPORT OF EXAMINATION

OF THE

MARKET CONDUCT AFFAIRS

OF

LOUISIANA HEALTH SERVICES & INDEMNITY, INC.

d.b.a. BLUE CROSS BLUE SHIELD OF LOUISIANA

BATON ROUGE, LOUISIANA

AS OF

December 31, 1999

NAIC CODE 81200

TABLE OF CONTENTS

SUBJECT PAGE

Salutation…1

Foreword…2

Purpose and Scope of Market Conduct Examination…3

Company Overview…4

- Company History…4
- Territory and Plan of Operations…4
- Affiliated Companies…5
- Antifraud Policy…5
- Accounts and Records...6
- Certificate of Authority…6
- Comments and Recommendations from Previous Reports…6

Complaints and Grievance Review… 7

Producer Review…7

Marketing and Sales Review…10

Policyholder Service Review...10

Underwriting and Rating Review…10

Claims Review…14

Summary of Comments and Recommendations…17

Conclusion…18

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June 6, 2000

Honorable James H. Brown
Commissioner of Insurance
P O Box 94214
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Sir:

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

Louisiana Health Service & Indemnity Company

d.b.a. Blue Cross Blue Shield of Louisiana

5525 Reitz Avenue

Baton Rouge, Louisiana 70809-3802

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

FOREWORD

A market conduct examination was performed of the activities of Louisiana Health Service & Indemnity Company from July 1, 1996 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 Louisiana Health Service & Indemnity Company, hereinafter referred to as ("LHSIC") or ("Company"), 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 Company's operation:

- Company Overview,
- Complaint and Grievance Review,
- Producer Review,
- Policyholders' Service Review,
- Marketing and Sales Review,
- Underwriting and Rating Review, and
- Claims Review.

The purpose of this examination was to review compliance by the Company 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 insurer and promote a program of fair treatment of policyholders.

COMPANY OVERVIEW

Company History

The Company was organized under an Agreement and Company of Consolidation dated August 15, 1974, between Louisiana Hospital Service, Inc., of Baton Rouge, Louisiana and Hospital Services Association of New Orleans, Louisiana. The two companies were consolidated/merged into a new company known as Louisiana Health Service & Indemnity Company. LHSIC was incorporated and commenced business on January 1, 1975 as a non-profit mutual insurer under the laws of the state of Louisiana.

LHSIC's business has been 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.

Territory and Plan of Operations

The Company has a certificate of authority to write health and accident insurance in the state of Louisiana. The Company's marketing system is comprised of five regional offices in New Orleans, Baton Rouge, Monroe, Lafayette and Shreveport. In addition, the Company has satellite offices in Lake Charles, Alexandria and Houma. The regional offices work with independent agents and brokers throughout the state. Only corporate officers have authority to bind the Company's business.

The Company writes a variety of individual, group and Medicare supplement polices with an emphasis on indemnity products. In addition to direct sales to groups and individuals, the Company has two service segments: the Federal Employee Program (FEP) and the National Accounts.

The National Accounts Program is a system of providing indemnity products to groups that have employees/retirees in more than one state. Under this system, multiple BCBS Companies coordinate activities in order to provide coverage to the multistate groups. In order to provide effective coverage, one BCBS Company assumes the role of "Control Plan" and coordinates the activity between the national account and participating plans. The underwriting risk is usually retained by the Control Plan. Other BCBS Plans service the claims for members in their respective states.

The FEP business segment services approximately 56% of federal employees in Louisiana. This business is administered pursuant to a participation agreement with the National Blue Cross and Blue Shield Association, which, in turn, contracts with the U. S. Office of Personnel Management. The Company also acts as a Third Party Administrator for self-funded groups and provides stop-loss protection for those groups.

Affiliated Companies

The Company has two wholly owned subsidiaries: Southern National Life Insurance Company, Inc. and HMO Louisiana, Inc. Southern National Life is domiciled and licensed in Louisiana to offer group life and accident insurance. HMO Louisiana, Inc. is domiciled and licensed in Louisiana to operate as a health maintenance organization.

Antifraud Policy

LHSIC and HMO Louisiana Inc., a subsidiary, share an antifraud program 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 its subsidiary.

Accounts and Records

The Company and its subsidiary, HMO Louisiana Inc., 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.

Certificate of Authority

The Company's Certificate of Authority was issued with an effective date of January 1, 1975 and authorized the Company to transact the business of health and accident insurance.

Comments and Recommendations from Previous Reports

In the previous examination report as of June 30, 1996, the Company was cited for possible violations of **LSA-R.S. 22:215.12** for attaching exclusionary riders on individual health policies subject to portability. Also, health conditions excluded by these riders appeared so general as to be considered vague and misleading pursuant to **LSA-R.S. 22:621(3).**

The current examination did not detect any exclusionary riders on individual

health policies subject to portability. The Company stated that the practice of attaching these riders on individual health policies subject to portability was discontinued on May 15, 1996.

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 Company. **LSA-R.S. 22:1214(17)** states "complaint" shall mean *any written communication* received by the insurer from the Department of Insurance.

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

A sampling of complaints filed with the Department 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.

PRODUCER REVIEW

As of December 31, 1999 the Company had contracts with more than 2,000 agents. Because of the large number of agent appointments the ACL Program provided by the Department was utilized in order to match the Company's listing of agent appointments against the DOI's listing of agent appointments. The result was approximately 200 mismatches (discrepancies).

A review of a substantial number of these discrepancies revealed 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 Company responded that it was in the process of correcting any discrepancies in its database to ensure annual reconciliation with the Departments listing of agent appointments.

Once the Company 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.

MARKETING AND SALES REVIEW

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

POLICYHOLDER SERVICE REVIEW

Individual and group billings being prepared by the mailroom were reviewed during the course of this examination. These billings were mailed in a timely manner usually two weeks before the due date of the premium.

Samplings of refunds made in 1999 were reviewed for timeliness. Refunds due to overpayments of premium, incorrect premium amounts and premiums paid on canceled applications were refunded on an average of fourteen days. Refunds of premium due to the death of an insured were processed on an average of thirty days.

UNDERWRITING AND RATING REVIEW

For individual policies, rates are charged based on age, area and class of coverage. Applications for individual coverage may be denied or limited based on the health status of the individual.

With the advent of the Health Insurance Portability and Accountability Act ("HIPAA") effective in 1997, small groups with 2-35 employees can no longer be medically underwritten. The rates for larger groups of 2-99 are based on manual rates that are adjusted for age, sex, geographic and benefits selected. Although rates for groups

of 100 or more are based on claims experience, some blending with manual rates may occur.

A sampling of 36 small group new business cases was reviewed. The sampling represented the first application processed on the first and fifteenth day of each month for the years 1997, 1998 and 1999. This review detected that 16 of these new business applications had been submitted on out-dated employer application forms instead of the Company's current application form 23XX9416 R8/97.

When the Company was notified of this finding, it responded that the field agents and internal personnel would be notified that only currently approved application forms for individual and group products should be used to enroll future members.

A random sampling of approximately 30 individual health policies was selected from a listing of active 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 his or her prior health carrier if the applicant will provide prior coverage data on the Company's Prior Carrier Health Coverage Form (23XX1938 R4/96).

Although no exclusionary riders were detected on individual health policies subject to portability in compliance with **LSA-R.S. 22:250.11**, two policies not subject to portability were detected that contained two and five-year exclusionary riders that were in addition to the standard twelve-month waiting period for pre-existing conditions. This practice of issuing exclusionary riders on individual health policies not subject to portability complies with the Company's Individual Products Field Manual which states 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.

A random sampling of approximately 20 individual health applications issued in 1997, 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 that 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 eleven 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 a 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.

A random sampling of twelve small and large group cases issued in 1997, 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.

CLAIMS REVIEW

According to the Company'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 prevent 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 Company'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, a claim processor generates a letter within two business days to the member or provider requesting the necessary documentation.

The ACL Program provided by the Department was utilized during this review. 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**	**93.99%**
Percentage of claims paid in	**31 to 60 days**	**3.44%**
Percentage of claims paid in	**61 to 90 days**	**0.83%**
Percentage of claims paid in	**91 to 120 days**	**0.43%**
Percentage of claims paid in	**121 to 365 days**	**1.04%**
Percentage of claims paid in	**366 days or greater**	**.27%**
		100.00%*

- **Percentages were based on the number of paid claims.**
  Estimated paid claims for this report were 7,746,531.

A random sampling of sixty (60) 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 sixty (60) claims paid in 1999 was selected for review by utilization of the ACL Program. Also, a random sampling of twenty-five (25) paid claims in 1999 with payment amounts greater than one thousand ($1,000) was selected by the ACL Program.

The Company provided adequate documentation for a review of these claim samplings and no discrepancies were detected. 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.

In October 1999 the Louisiana Supreme Court denied the Company's application for a rehearing and upheld the Department's position that insurers must comply with current law relating to pre-existing condition limitations on group policies issued *prior* to the effective date of the new law. At issue was whether or not **LSA-R.S 22:215:12,** that restricts a health insurer's ability to exclude coverage for losses due to pre-existing condition limitations in health insurance policies, applies to individuals who enroll in group health plans on or after January 1, 1993, when the group master policy was issued prior to January 1, 1993.

In December of 1999 the Company meet with the Department concerning the resolution of certain claims that were improperly denied based on the Company's interpretation of the statute relating to the pre-existing condition limitation. The Department requested that the Company provide procedures for re-adjudicating these denied claims.

On March 27, 2000, the Company responded to the examiners that its action plan for reprocessing these denied claims affected by the Louisiana Supreme Court Ruling was nearly completed. The Company also stated that the completed action plan would be submitted to the Department for approval. On May 19, 2000, the Company submitted its action plan to the Department.

LHSIC entered into an integrated prescription drug program agreement with Paid Prescriptions, L.L.C., a New Jersey corporation ("Paid"); Merck-Medco Rx Services of 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 known 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** - Page 10 - The Plan's practice of not enforcing the collection of the enrollment fee on applications 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.

   During a review of new business 16 applications had been submitted on out-dated employer application forms. Once the Company was informed of this finding it agreed to notify field agents and internal personnel that only currently approved applications for individual and group products should be used to enroll future members.

   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

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.

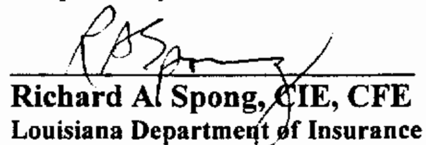
d.b.a.

BLUE CROSS BLUE SHIELD OF LOUISIANA

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