

REPORT OF EXAMINATION
OF THE
MARKET CONDUCT AFFAIRS
OF
LOUISIANA MEDICAL MUTUAL
INSURANCE COMPANY

METAIRIE, LOUISIANA

AS OF

December 31, 2004

NAIC CODE 43656

NAIC ETS EXAM # MCD-04-034

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LOUISIANA DEPARTMENT OF INSURANCE

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March 5, 2005

Honorable Robert Wooley
Commissioner of Insurance
P O Box 94214
Baton Rouge, Louisiana 70804-9214

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

LOUISIANA MEDICAL MUTUAL INSURANCE COMPANY

1 GALLERIA BOULEVARD, SUITE 700

METAIRIE, LOUISIANA 70001-9915

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

COMPANY OVERVIEW

COMPANY HISTORY

On March 20, 1981, the Louisiana State Medical Society (LSMS) appointed an AD Hoc Committee to study the formation of a captive insurance company to underwrite professional liability coverage for Louisiana physicians. Upon the recommendation of the AD Hoc Committee, the LSMS resolved to form the Company.

Although the impetus to form the Company originated with the LSMS, which also sponsored the formation of the Company, the Company is a separate corporate entity operating independently of LSMS.

TERRITORY AND PLAN OF OPERATIONS

LAMMICO is organized as a mutual insurance company under the Louisiana Insurance Code and underwrites medical professional liability insurance coverage for physicians, physician partnerships, professional medical corporations and other health care practitioners in Louisiana.

Medical professional liability insurance may be purchased in two (2) forms: occurrence or claims-made. The difference in these two (2) policies lies in how each policy responds to a loss. An occurrence policy responds to a loss if a policy is in effect at the time of the occurrence of the medical incident precipitating subsequent malpractice claims. A claims-made policy responds to a loss if a policy is in force at the time a claim is reported. In addition, the Company offers a reporting endorsement (“tail coverage”) for claims-made policies, which covers all future claims based on acts done during a previous policy year. The net impact of the reporting endorsement is to make a claims-made policy respond on an occurrence basis.

ACT 817-Louisiana Medical Malpractice Act covers private health care providers, licensed in Louisiana, who are qualified with the Patient's Compensation Fund (PCF). To be qualified, a health care provider must maintain primary coverage of \$100,000 through an insurance company such as LAMMICO, or self insure by posting a \$125,000 security fund with the PCF, and paying a surcharge (premium) to the PCF. The Act was passed in 1975 and covers alleged acts of malpractice occurring after September 1, 1975.

Although there have been many amendments to the statute since that time, the basic constitutionality of the limitation of liability has been upheld on numerous occasions by the Supreme Court. Limitation of liability is addressed in the statute as follows:

- 1) Total amount recoverable - \$500,000 plus interest, costs and related medicals from the date of malpractice
- 2) Physicians responsible for first \$100,000 plus interest on that amount after April 1, 1991
- 3) PCF is responsible for \$400,000 plus interest on that amount, cost, medicals related to malpractice, both past and future, and interest on past medicals.

LAMMICO is responsible for collecting PCF surcharges (premiums) from its policyholders and remitting same to the PCF on a timely basis. Surcharges are stated separately and collected in full with the LAMMICO policy premium.

Forms and records as prescribed by the Executive Director of PCF shall accompany the remittances of surcharges (premiums) in order to identify and classify the healthcare provider.

During the period under examination the Company wrote the following Louisiana premiums:

YEAR LA PREMIUMS WRITTEN

2002	\$ 42,862,180
2003	55,668,588
2004	61,506,650

REINSURANCE

During the period under examination, the Company had a ceded reinsurance agreement with General Reinsurance Corporation (Gen Re) until January 1, 2004. That agreement covered the Company's business known as "Health Care Provider Professional Liability." Under this agreement, the Company would retain the first \$100,000 of loss for each insured/medical incident. The next \$400,000 is covered by the Patients Compensation Fund and, in most instances, covered by the Company, too. This double coverage gives protection for an insured whose claim may be denied by the PCF. The Company was then responsible for the amount of loss from \$500,000 to \$1,000,000. Gen Re assumed losses from \$1,000,000 up to \$2,000,000. On January 1, 2003, the contract with Gen Re was amended to limit Gen Re's losses to \$20,000,000 in the aggregate.

Effective January 1, 2004, the Company changed its reinsurance and placed all of its professional liability reinsurance through a broker, John B. Collins Associates. In the treaty in effect in 2004, the coverage is the same as previously described. However, the attachment point was lowered to \$500,000 with the reinsurers being responsible for losses from \$500,000 up to \$2,000,000.

In addition, the Company entered into another ceded reinsurance with Gen Re, effective October 1, 1997. That agreement covered the business known as "Employment Practice Liability" (EPL). Under that agreement, the Company retained fifty percent

(50%) of the first \$250,000 of net loss, each claim and twenty percent (20%) of the next \$750,000 of net loss, each claim with Gen Re assuming the remaining loss of each layer. The limit of liability for Gen Re was \$1,000,000 each claim/policy aggregate. Due to the small number of policies written during the time the Company wrote those policies, the Company discontinued EPL coverage in 2003.

Effective April 15, 1999, the Company entered into a quota share treaty with various syndicates at Lloyd's of London (Lloyds). Under that agreement, one hundred percent (100%) of the business known as "MEDEFENSE" was ceded to Lloyds. The contract was later amended and the Company retained twenty percent (20%) of the loss and ceded eighty percent (80%). MEDEFENSE is the physician's legal expense reimbursement coverage for allegations of Medicare/Medicaid fraud and abuse. The limit of liability for this agreement was \$25,000 per disciplinary proceeding. The insured was subject to a deductible of \$1,000 per disciplinary proceeding. This contract was not renewed by the Company.

PARENT, SUBSIDIARIES AND AFFILIATED COMPANIES

LAMMICO Insurance Agency, Inc. (Agency) is a wholly owned subsidiary of the Company. The Agency was incorporated on September 11, 1985. The Agency has an affiliation with several agencies that solicit life, health and disability income coverage to the Company's policyholders.

The Agency has one (1) employee with the title of Agency Supervisor and Assistant Vice President. A portion of the employee's salary is charged to the Company for managing the Company's insurance program.

ANTIFRAUD POLICY

Currently, LAMMICO has in place Standards of Conduct which require all employees to accurately and truthfully complete all personnel information forms, time sheets, expense statements and other related documents. Any employee who engages in acts of dishonesty, fraud, theft or sabotage is subject to immediate termination of employment. In addition, the Company's Grievance Procedure provides an avenue for an employee to report fraud or theft of Company assets.

In conjunction with the implementation of the NAIC Model Audit Rule, LAMMICO plans to enhance its corporate governance by evolving its Standards of Conduct and Grievance Procedures into a Code of Ethics and Compliance Plan. These enhancements will include annual employee education on the Company's position on integrity and honesty.

The implementation of a corporate compliance plan has been part of the Company's strategic goals but was delayed pending the final adoption of the NAIC Model Audit Rule.

RECOMMENDATIONS FROM PRIOR EXAMINATION REPORTS

There was a recommendation in the Louisiana Financial Examination Report as of December 31, 2000 that requested the Company to have three (3) policy forms approved because the original policy approval with the Department could not be located. During the course of this examination the Company provided copies showing that two (2) of the forms had been approved by the Department on December 31, 2002. The third policy form in question was discontinued by the Company.

COMPLAINT REVIEW

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

The Company had a small number of complaints during the period under examination. The Company's responses to the Department on these complaints were timely and appeared adequate.

The Company provided complaint procedures, which appeared appropriate for the timely processing of complaints. During the examination the Company provided a complaint register for the three (3) year period, which was in compliance with the above Louisiana Statute.

PRODUCER REVIEW

The Company does not have any formal written procedures for contracting or investigating an agent. An application designed since the last examination, requires disclosure of any prohibited person who is employed with the applicant/agency. A copy of **Louisiana Bulletin #99-01** is provided to the applicant/agency which defines a prohibited person.

The Company has a small agency force and experiences limited activity in hiring and terminating agencies. The Company contracted one agency in 2004 in which an application and contract were completed in detail. The agency was promptly appointed with the Department. Also, there was one (1) name change and no terminations noted during the period under examination.

The Company provided a listing of active agencies which was checked against the Department's listing of appointments without exception.

MARKETING AND SALES REVIEW

The Company's advertising and its website were reviewed. The Company does little advertising; six (6) advertisements were run over the period under examination primarily in Louisiana medical journals. The advertisements provided information about various Company programs which were available on the Company's website.

The Company's website, www.lammico.com presents information about Company history, products and an application which can be downloaded. Also, the website provides risk management techniques with the opportunity to earn continuing education credits and premium discounts. No exceptions were noted during this review.

UNDERWRITING AND RATING REVIEW

The Company provided underwriting guidelines that appeared adequate for the underwriting of the Company's new business, renewals and endorsement processes in accordance with policy provision, statutes and regulations. The underwriting process includes a review of a completed application, verification of current Louisiana licensing as a physician, location of the school of graduation, Board Certification, Medical Specialties and previous and pending claims activity.

The Underwriting Department consisted of the following positions: Vice President, Underwriting Manager, Underwriting Supervisor, four (4) Underwriting Specialists, one (1) Underwriter, three (3) Assistant Underwriters, one (1) System Analyst, two (2) Service Support Technicians, one (1) File Clerk and one (1) Administrative Assistant.

The Company provided a CD containing all Louisiana business policies issued in 2002, 2003 and 2004. ACL was utilized to select a random sampling of sixty (60) new business policies from the three (3) years under examination.

A review of this sampling indicated that applications were complete and signed by the applicant. Underwriting requested that the applicant submit his or her application at least sixty (60) days prior to the effective date of the policy; the sixty (60) days allowed the underwriter to complete the various underwriting processes. Once the underwriting processes were completed, the policy was issued timely.

Various discussions were held with the Company's system analyst involved in the rating process. A sampling of five (5) applications was selected at random from the initial sampling of sixty (60) new business policies in order to verify premium charges. These sampled ratings were verified with rates filed with the Department without exception.

The Company provided a listing of approximately thirty (30) non-renewed policies for the three (3) year period under examination. Underwriting stated that it had started the non-renewal process in 2003; consequently few non-renewal transactions occurred during the period under examination.

A judgmental sampling of ten (10) non-renewed policies was selected for review. The review indicated that the Company non-renewed policies due to claims experience. No exceptions were noted during this review and the reasons for non-renewal were in accordance with policy and statutory provisions.

The Company had received Departmental approvals in 2002 for its revised contracts for Physicians & Surgeons Professional Liability, Medical Group Practice

Professional Liability and Miscellaneous Healthcare Provider Professional Liability. During the underwriting review, it was noted that the Company was utilizing approved policy forms. No exceptions were noted during the review of policy forms.

CLAIMS REVIEW

LAMMICO provided claim guidelines that appeared adequate for the proper processing of claims in accordance with policy provision, statutes and regulations. Claims and related documentation are received primarily by mail or by facsimile. Claims are received in the Company's mailroom and are stamped with a Rapid Print Stamper which reflects the current time and date. Claims are then routed to the proper claims representative.

The Claims Department consisted of the following positions: one (1) Vice President of Claims, three (3) Claims Unit Managers, sixteen (16) Senior Field Representatives, one (1) Regional Senior Field Representative, one (1) Inside Claims Representative, three (3) Claims Administrative Assistants and eight (8) Claims Support Associates.

When a *medical event* is reported by the insured, the Claims Department promptly documents the events. All events or issues reported by an insured that do not require any investigation and/or which are reported only to comply with policy reporting requirements are considered *incident files*. An incident file occurs from doubtful events or no apparent liability, slight or no injury or no payment liability.

Pursuant to **R. S. 40:1299.47 (A) (1)(c), (d) and (e)**, once receipt of the formal Request for Medical Review Panel is confirmed, the claimant has forty-five (45) days to

pay a \$100 filing fee for each named defendant health care provider. Failure to pay the filing fee renders the panel request *invalid and without effect*.

Generally a *PCF/Incident* occurs where there is a medical event involving an insured healthcare provider with a formal claim against the provider's policy but the filing fee was not paid or waived. This event is not considered a potential claim.

Upon receipt of a Request for Medical Review Panel with confirmation of payment of the required filing fees from the PCF, the Claims Department will begin the process of establishing the appropriate file to maintain and organize all claim information throughout the life of the potential claim.

The PCF's Medical Review Panel is composed of three (3) practicing physicians licensed in the State of Louisiana presided over by an attorney chairman. The first nomination is granted to the plaintiff party. Within fifteen (15) days thereafter, the defendant party is allowed to select a second physician to serve on the panel. The third physician panel member is selected by joint agreement of the two (2) sitting panelists. Selection of the defense nominee to the panel should be approved by LAMMICO.

The Company's Claims Committee consists of a panel of physicians accompanied by the Company President acting as an ex-officio non-voting member. The Senior Vice President of Claims presides as the Committee Chairman. The Claims Committee serves to advise the Claims Department regarding medical issues encountered in the handling of claims against LAMMICO's insured healthcare providers. The Claims Committee remains active in reviewing medical issues during the progression of a claim.

A systematic sample of twenty (20) paid claims was selected from the Company's list of 2004 paid claims. The sampling represented about twenty-three percent (23%) of

the total number of paid claims from the listing. These claims were closed with payment in an average of three (3) years. The Company responded timely during the progression of the claim.

ACL was utilized to select a random sampling of sixty (60) claims closed without payment. The following is a breakdown of the review of the sample of claims closed without payment:

- 6 trial judgment in favor of defendant
- 1 was an incident-complaint but filing fees were paid
- 2 dismissed prescription defense
- 51 complaints or suits dismissed by complainant or plaintiff

The claim files were well documented and the Company responded timely during the development of the claim. The Company has satellite claim offices in Baton Rouge and Shreveport, Louisiana. The Company maintains paper files for claims which are periodically stored off site at all claim offices.

CONSUMER PRIVACY POLICY REVIEW

The Company has a privacy and confidentiality policy and procedures in place to secure information regarding policyholders and claimants, which are in compliance with the Louisiana Department of Insurance **Regulation 76 / PRIVACY OF CONSUMER FINANCIAL INFORMATION.**

It should be noted that **Section 9905** in **Regulation 76** exempts the Company from providing privacy notices to its policyholders. However, the Company does annually provide a privacy notice in its July/August LAMMICO Newsletter on behalf of LAMMICO Insurance Agency to its policyholders.

COMMENTS AND RECOMMENDATIONS

The Company provided timely responses to the examination requests submitted during this examination.

CONCLUSION

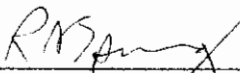
I, Richard A. Spong, do solemnly swear and affirm that I am an examiner for the Commissioner of Insurance of the State of Louisiana and that as such, I was assigned to conduct an examination of the market conduct activities of

LOUISIANA MEDICAL MUTUAL INSURANCE COMPANY

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