STATE OF MISSOURI

# DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

| | | |
|---|---|---|
| In re: | ) | |
| | ) | Examination No. 0612-62-TGT |
| Humana Health Plan, Inc. (NAIC #95885) | | |

## ORDER OF THE DIRECTOR

NOW, on this 25th day of ~~June~~ August, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of Humana Health Plan, Inc. (NAIC #95885), (hereafter referred to as "Humana") report numbered 0612-62-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2006), is in the public interest.

IT IS THEREFORE ORDERED that Humana and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

IT IS FURTHER ORDERED that Humana shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Humana in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that Humana shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $3,625.00, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 25th day of August, 2009.

John M. Huff
Director

STATE OF MISSOURI

# DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

TO: Office of the President
Humana Health Plan, Inc.
1100 Employers Blvd.
Green Bay, WI 54344

RE: Missouri Market Conduct Examination 0612-62-TGT
Humana Health Plan, Inc. (NAIC #95885)

## STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and Humana Health Plan, Inc., (hereafter referred to as "Humana"), as follows:

WHEREAS, John M. Huff is the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereafter referred to as "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, Humana has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of Humana and prepared report number 0612-62-TGT; and

WHEREAS, the report of the Market Conduct Examination has revealed that:

1. In some instances, Humana contracted with a third party administrator that was not licensed as a producer entity with the Department, in violation of §375.821(6), RSMo.

2. In some instances, Humana used a form for its chiropractic coverage that limited coverage to 26 office visits without a requirement for company approval and additional visits after receipt of company approval per calendar year, in violation of §376.1230, RSMo.

3. In some instances, Humana allowed some of its Small Employer Groups to designate a workweek of more than 30 hours per week before they are considered eligible for health plan coverage, thereby violating the requirements of §§379.930.2(15), 379.940.2, and 379.952.2(15), RSMo, and DIFP Bulletin, #07-07.

4. In some instances, Humana failed to maintain its books, records, documents, and other business records and to provide relevant materials, files, and documentation in such a way to allow the examiners to sufficiently ascertain the rating and underwriting and claims handling and payment, complaint handling, termination, and marketing practices of the Company, thereby violating §374.205.2(2), RSMo, and 20 CSR 100-8.040 (as amended).

5. In some instances, Humana failed to timely and completely respond to the examiners' requests for information and criticisms, thereby violating §374.205, RSMo.

WHEREAS, Humana hereby agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those corrective actions at all times, including, but not limited to, taking the following actions:

1. Humana agrees to take corrective action to reasonably assure that the errors noted in the above-referenced market conduct examination reports do not recur;

2. Humana agrees to reopen all denied ambulance and emergency room, childhood immunization, and cancer screening claims dated January 1, 2002, through the date that a final Order is entered closing this exam, to determine whether any claims were improperly denied, and, if so, to make all necessary readjudications and payments in full, including any applicable interest required under law within 90 days of the date that an Order is entered by the Director finalizing this exam; and

3. Humana agrees to file documentation of all remedial actions taken by it to implement compliance with the terms of this Stipulation and to assure that the errors noted in the examination report do not recur, including explaining the steps taken and the results of such actions, with the Director within 60 days of the entry of a final Order closing this examination; and

WHEREAS, Humana neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, Humana is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, Humana, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, which may have otherwise applied to the above referenced Market Conduct Examination; and

WHEREAS, Humana hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0612-62-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of $3,625.00

NOW, THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of Humana to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Humana does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of $3,625.00 such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: June 8, 2009

George Wheeler
President, Humana Kansas/Missouri Market

Carlene M.K. Marra, HIA
Director, Regulatory Compliance

Subscribed & sworn before me this 8th day of June, 2009.

Deanna L Thomas

DEANNA L. THOMAS
Notary Public-Notary Seal
State of Missouri, Jackson County
Commission # 08474202
My Commission Expires May 25, 2012

# STATE OF MISSOURI

## DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

## MARKET CONDUCT

## FINAL EXAMINATION REPORT

OF THE

LIFE, ACCIDENT AND HEALTH INSURANCE BUSINESS

OF

**Humana Health Plan, Inc**
NAIC NUMBER: 95885

**STATE OF DOMICILE: KY**

1100 Employers Boulevard

Green Bay, WI 54344

May 5, 2009

REPORT NUMBER: 0612-62-TGT

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## FOREWORD

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures, or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). In performing this examination, the DIFP selected a portion of the company's operations for its review. As such, this report does not reflect a review of all practices and all activities of the company. The examiners, in writing this report, cited errors made by the company. The final examination report consists of three parts: the examiners' report, the company's response and administrative actions based on the findings of the Director.

Wherever used in the report:

"Company", "Humana" or "HHP" refers to Humana Health Plan, Inc.;

"CSR" refers to Code of State Regulation;

"DIFP" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;

"NAIC" refers to the National Association of Insurance Commissioners;

"RSMo" refers to the Revised Statutes of Missouri.

## SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, Sections 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, Section 447.572, RSMo, grants authority to the DIFP to determine the company's compliance with the Uniform Disposition of Unclaimed Property Act.

The company reviewed was Humana Health Plan, Inc. (HHP).

The time period covered by this examination is primarily from January 1, 2002, through December 31, 2005, unless otherwise noted.

While the examiners reported on the errors found in individual files, the examination also focused upon the general business practices of the company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a 10 percent error tolerance ratio to all operations of the company with the exception of claims handling. The error tolerance ratio applied to claims matters was seven percent. Any operation with an error ratio exceeding these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business: Accident & Health insurance. The examination included, unless otherwise noted, a review of the following areas of the company's operations for the lines of business reviewed: underwriting, forms and filings, claims, and complaints.

## EXECUTIVE SUMMARY

This examination revealed the following principal areas of concern.

- The company maintained a contract with EyeMed Vision Care, LLC, to process claims for vision care. EyeMed did not maintain a TPA license which is required in Missouri.
- The law mandates companies to provide up to 26 chiropractic office visits during a policy year for treatment of a chiropractic condition. The company limits the visits to a calendar year, which can significantly reduce the coverage mandated.
- The company allows small employer applicants to specify that an employee must work more than 30 hours per week to qualify for group health insurance. Missouri's Small Employer Law was enacted to increase the number of employees who would be eligible for health insurance coverage. The law defines an eligible employee as one who works 30 or more hours per week. Since the law states that an employee who works 30 hours per week is an eligible employee, neither a company nor an employer can set limits to exclude those employees.
- The company failed to pay interest on delayed claims.
- The company denied payment for claims that were pre-cancer tests when an insured had a condition that is a symptom of cancer. Denials for this reason are not appropriate because many conditions that are symptoms of cancer can also be symptoms of non-cancerous illnesses.
- The company denied payment for claims to in-network providers for mandated childhood vaccinations when they were not pre-authorized. Mandated benefits should not require prior authorization when in-network.
- HHP failed to include two complaints in its complaint register.
- The company failed to respond to six (14.6%) criticisms within 10 days.
- The company failed to respond to 30 (46.88%) formal requests within 10 days.

# EXAMINATION FINDINGS

**For**

**Humana Health Plan, Inc.**
NAIC NUMBER: 95885

## I. SALES AND MARKETING

This section of the report details the examination findings regarding the company's compliance with the laws that monitor marketing practices. The items reviewed were the company's Certificate of Authority for Missouri, licensing records pertaining to the company's sales personnel, and product marketing/advertising materials.

### A. Company Authorization

Missouri law determines which company may sell insurance and the lines of insurance each may sell by requiring each company to obtain appropriate authority from the DIFP to transact the business of insurance. To protect the consumer, Missouri enacted laws and regulations to ensure that companies provide fair and equal treatment in its' business dealings with Missouri citizens. An insurance company receives a Certificate of Authority that allows it to operate within the state only after it has complied with certain application requirements regulated by the DIFP.

Humana Health Plan, Inc., a Kentucky corporation, was found to have current authority to transact business in the following lines of insurance:

Health Maintenance Organization

Regarding the company's operation in Missouri, the examiners found HHP within the scope of its Certificate of Authority.

## B. Licensing of Third Party Administrators

The State of Missouri requires entities, who are not an insurance company but perform insurance related operations for insurance companies, to obtain and maintain a Third Party Administrator (TPA) license. The examiner's review aimed to verify that these entities are licensed.

### 1. License Verification

The company contracted with EyeMed Vision Care, LLC, to process and pay vision care claims for Humana's members. An entity that pays claims for an insurance company must be licensed as a TPA. EyeMed Vision Care, LLC, is licensed as a Producer Entity with the State of Missouri but has not been licensed as a TPA. Humana failed to contract with a legally licensed entity to process its vision care claims. The officers and operating personnel of an insurance company must be competent and trustworthy to transact the business of insurance in Missouri. The state requires this to assure that the transaction of business in this state would not be hazardous to the general public. When an insurance company contracts with entities who are not licensed and who do not abide by the laws and regulations of the DIFP, it creates a potentially hazardous situation for Missouri residents.

Reference: Section 375.821(6), RSMo

## II. UNDERWRITING AND RATING PRACTICES

In this section of the report, the examiners reviewed the company's underwriting and rating practices. These practices included use of policy forms, adherence to underwriting guidelines, assessment of premiums and procedures to decline or terminate coverage. Because there were a large number of policy files, examining each and every policy file was not appropriate. To reduce the duration of the examination, while still achieving an accurate evaluation of the company's practices, the examiners employed a statistical sampling of the company's policy files. A policy file as a sampling unit is one complete premium unit representing the coverage provided or restricted by the riders attached to the policy. The most appropriate statistic to measure the company's compliance with the law is the percent of files in error. An error can include, but is not limited to, any miscalculation of the premium based on the information in the file or any improper acceptance or rejection of applications, misapplication of the company's underwriting guidelines, and any other activity violating Missouri laws.

### A. Forms and Filings

The examiners reviewed the company's policy forms to determine its compliance with filing, approval and content requirements to ensure that the contract language is not ambiguous and is adequate to protect those insured. The examiners conducted a review of forms used by the company.

The examiners noted the following errors in this review.

**FORMS**

The company provided forms that included coverage for treatment by a Chiropractor. The form indicates that coverage is limited to 26 office visits without a requirement for company approval and additional visits after receipt of company approval per calendar year. The law specifies that the benefits are to be considered on a policy year basis rather than on a calendar year basis.

Reference: Section 376.1230, RSMo

## B. Small Employer Group Underwriting

The examiners reviewed policies already issued by the company to determine the accuracy of rating and adherence to prescribed and acceptable underwriting criteria.

The following are the results of the reviews.

### New Business

Companies who underwrite small employer group insurance in Missouri must comply with the State's Small Employer Group Insurance law. Missouri enacted the law to set standards for insurance companies when soliciting and underwriting Small Employer Groups. The law was intended to improve availability and portability of group health insurance for employees of small employers. The law defines an eligible employee as one who works on a full-time basis and has a normal work week of 30 hours or more.

Humana's underwriting process for Small Employer Groups allows employers to select the number of hours per week required for an employee to qualify for group health insurance. In the following instances, the company allowed the employer to select an eligibility limit of more than 30 hours, thereby, diminishing the effect of the law aimed to increase the number of insured persons in Missouri. The company provided a current list containing 486 small group employer groups that stipulate 31 or more hours per week as the minimum limit for health insurance coverage eligibility.

References: Sections 379.930 and 379.952.2(15), RSMo

| Group Number | Policy Number | Number of Hours |
|---|---|---|
| 224338 | 002374 | 40 |
| 224466 | 075002 | 35 |

| Group Number | Policy Number | Number of Hours |
|---|---|---|
| 234130 | 026370 | 40 |
| 222237 | 075006 | 35 |
| 207023 | 075002 | 40 |
| 207282 | 002374 | 40 |
| 224293 | 002370 | 32 |
| 205870 | 075002 | 40 |
| 230788 | 002374 | 36 |
| 208523 | 002370 | 40 |
| 226757 | 002363 | 35 |
| 237035 | 002374 | 40 |
| 234145 | 002374 | 40 |
| NA | 5183031 | 40 |

## III. CLAIM PRACTICES

In this section, the examiners reviewed the claim practices of the company to determine its accuracy of payment, efficiency in handling, adherence to contract provisions and compliance with Missouri law. Because there were a large number of claim files, examining each and every file was inappropriate. The examiners conducted a statistical sampling of the company's claim files. A claim file as a sampling unit is an individual demand/request for payment under an insurance contract for benefits that may or may not be payable. The most appropriate statistic to measure the companies' compliance with the law is the percent of files in error. An error can include but is not limited to any unreasonable delay in the acknowledgment, investigation or payment/denial of a claim, the failure to calculate the claim benefits correctly or the failure to comply with Missouri law in claim settlement practices.

### A. Unfair Settlement and General Handling Practices

The examiners reviewed denied claims for adherence to Missouri mandated benefits.

For the following reviews the examiners eliminated claims that were subsequently paid and those that did not involve the parameters specified. They reviewed records to determine that company's claim process is fair, reasonable, prompt and equitable according to the laws and regulations of Missouri.

The examiners asked for the computer processing specifications that control the timeliness, requirements and payment levels for handling claims. The company provided manuals and access to computerized claim processing requirements and procedures.

The following are the results of the reviews conducted by the company at the direction of the examiners and the reviews performed directly by the examiners.

## 1. Denied Ambulance and Emergency Room Claims

Examiners used computerized procedures to isolate denied Ambulance and Emergency Room claims from those processed during the survey period. The review of computer-generated documentation for the selected claims indicated several issues that required further examination.

| | |
|---|---|
| Field Size: | 1311 |
| Type of Sample: | Census |
| Number of Errors: | 8 |
| Percent of Errors: | 0.6% |
| Within Dept. Guidelines: | Yes |

a. The company denied benefits for the following claims for the reason that the coverage had ended. The insured was covered when the treatment occurred.

References: Sections 375.1007(1), (3), (4) & (5), 376.1367, and 478.020, RSMo

| Member Number | Claim Number |
|---|---|
| 538428359 | 165053398 |
| H09442566 | 188376081 |
| 494565875 | 185517176 |

b. The company did not pay all benefits for the following claim, when first presented.
References: Sections 375.1007(1), (3), (4) & (5), 376.1367, and 478.020, RSMo

| Member Number | Claim Number |
|---|---|
| H03890305 | 172295175 |
| H03890305 | 172295176 |
| H07377332 | 177565318 |

c. The company did not pay all benefits for the following claim when it paid other benefits for this treatment. HHP did not pay this portion until the provider resubmitted it.

References: Sections 375.1007(1), (3), (4) & (5), 376.1367, and 478.020, RSMo

| Member Number | Claim Number |
|---|---|
| 508136598 | 183481108 |

d. When the insured first submitted the following claim, the company failed to pay all the benefits due.

References: Sections 375.1007(1), (3), (4) & (5), 376.1367, and 478.020, RSMo

| Member Number | Claim Number |
|---|---|
| H56011990 | 192110223 |

## 2. Denied Childhood Immunization Claims

Examiners used computerized procedures to isolate denied Childhood Immunization claims from those processed during the survey period. The review of the computer-generated documentation for the selected claims indicated several issues that required further examination.

| | |
|---|---|
| Field Size: | 424 |
| Type of Sample: | Census |
| Number of Errors: | 11 |
| Percent of Errors: | 2.6% |
| Within Dept. Guidelines: | Yes |

a. The company failed to provide the documentation for one claim that was to be placed at the Tab 55 position of the binder provided by the company. The claim was not identified.

Reference: 20 CSR 300-2.200(3)(B) (as amended 20 CSR 100-8.040)

b. The company failed to use the correct denial code for the following claims. The denial code used was for claims that the insured incurred after the termination date of the policy. The provider submitted the claims under a policy that was replaced.

References: Section 376.1210, RSMo, and Company Procedure

| Member Number | Claim Number |
|---|---|
| 541849293 | 189484235<br>189484710 |

c. The company denied benefits for the following claim because the treatment was not compatible for the diagnosis stated. The treatment was a mandated childhood immunization and should not be denied when the provider is in network.

References: Sections 375.1007, 376.1210 & 376.1218, RSMo

| Member Number | Claim Number |
|---|---|
| HO6470893 | 194987468 |

d. The company denied benefits for the following claims because the insured incurred the treatment after the termination date of the policy. The treatment was a mandated childhood immunization and was actually incurred during the period covered. HHP subsequently paid the claims but failed to pay interest for the period delayed

References: Sections 375.1007, 376.1210 & 376.1218, RSMo

| Member Number | Claim Number |
|---|---|
| 496961634 | 190252190<br>190252079 |

e. The company failed to pay all of the benefits for the following claim.

References: Sections 375.1007, 376.1210 & 376.1218, RSMo

| Member Number | Claim Number |
|---|---|
| H10125739 | 163643372 |

f. The company failed to pay benefits for the following claim. It discovered its error during the exam but failed to pay interest for the period delayed.

References: Sections 375.1007, 376.1210 & 376.1218, RSMo

| Member Number | Claim Number |
|---|---|
| H08102523 | 195271036 |

g. The company failed to pay all of the benefits for the following claim.

References: Sections 375.1007, 376.1210 & 376.1218, RSMo

| Member Number | Claim Number |
|---|---|
| H08413824 | 163112124 |
| 496761366 | 195394711 |
| | 195395463 |

3. **Denied Cancer Screening Claims**

Examiners used computerized procedures to isolate denied Cancer Screening claims from those processed during the survey period. The review of the computer-generated documentation for the selected claims indicated several issues that required further examination.

| | |
|---|---|
| Field Size: | 79 |
| Type of Sample: | Census |
| Number of Errors: | 4 |
| Percent of Errors: | 5% |
| Within Dept. Guidelines: | Yes |

a. The company denied the following two claims for cancer screening tests because the insured was symptomatic. Missouri requires companies to pay for cancer screening tests when the insured is non-symptomatic. The company denies benefits for those who have symptoms that may result in a diagnosis of cancer although the symptoms may also be for a non-cancerous condition.

Reference: Section 376.1250, RSMo

| Member Number | Claim Number |
|---|---|
| 290425789 | 198987081 |
| 486501945 | 165813800 |

b. The company failed to provide the complete claim documentation for the following two claims. On the last day of the on-site reviews, the company provided information that was found, but it was not adequate to allow the examiners to determine the inception, handling and disposition of the claim.

References: Section 376.1250, RSMo, and 20 CSR 300-2.200(3)(B) (as amended 20 CSR 100-8.040)

| Member Number | Claim Number |
|---|---|
| 493665415 | 169439277 |
| 491786932 | 165647055 |

## 4. Denied Mammography Claims

Examiners used computerized procedures to isolate denied Mammography claims from those processed during the survey period. The review of the computer-generated documentation for the selected claims indicated several issues that required further examination.

| | |
|---|---|
| Field Size: | 124 |
| Type of Sample: | Census |
| Number of Errors: | 0 |
| Within Dept. Guidelines: | Yes |

The company data included 162 claims for denied mammograms. The examiners reviewed all of the data for these claims.

The examiners found no errors in this review.

## 5. Denied PSA Test Claims

Examiners used computerized procedures to isolate Denied PSA Test claims from those processed during the survey period. The review of the computer-generated documentation for the selected claims indicated several issues that required further examination.

The company data included 26 claims for denied PSA Tests. The examiners reviewed all of these claims.

| | |
|---|---|
| Field Size: | 26 |
| Type of Sample: | Census |
| Number of Errors: | 0 |
| Within Dept. Guidelines: | Yes |

The examiners found no errors in this review.

## 6. Denied PAP Smear Claims

Examiners used computerized procedures to isolate Denied PAP Smear claims from

those processed during the survey period. The review of the computer-generated documentation for the selected claims indicated several issues that required further examination.

The company data included 39 claims for denied PAP Smears. The examiners reviewed all of the data for these claims.

| | |
|---|---|
| Field Size: | 39 |
| Type of Sample: | Census |
| Number of Errors: | 0 |
| Within Dept. Guidelines: | Yes |

The examiners found no errors in this review.

## IV. COMPLAINTS

### A. Missouri Department of Insurance, Financial Institutions and Professional Registration Complaints

The examiners reviewed the company's handling of 21 DIFP complaints dated January 1, 2002, through December 31, 2004.

The examiners noted no exceptions in this review.

### B. Consumer Complaints

The examiners requested a list of consumer complaints. The company provided a list of complaints dated January 1, 2004, through December 31, 2006.

The examiners noted no exceptions in this review.

### C. Appeals

The examiners requested a list of all appeals handled during the period under review. The company provided a list of 206 appeals. The examiners reviewed all of the appeals provided by the company.

The examiners noted the following exceptions in this review.

1. The company failed to provide the documentation for the following seven appeals that the examiners requested for review.

| Appeal Number | Member Number |
|---|---|
| 302202546002A | 515623283 |
| 301402546009A | 512722885 |
| 426808060001A | 495666516 |
| 301002546001A | 221362299 |
| 403611325001A | 494904935 |
| 331141736002A | 491529414 |
| 301402546001A | 510680609 |

2. The company failed to provide all documentation needed to properly review the following two appeal files.

| Appeal Number |
| --- |
| 418512281001A |
| 501403325009A |

References: Section 374.205, RSMo, and 20 CSR 300-2.200(3)(B) (as amended 20 CSR 100-8.040)

## V. CRITICISM AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the company to provide the examiners with the requested material or to respond to criticisms. Missouri requires a company to respond to criticisms and formal requests within 10 calendar days.

### A. Criticism Time Study

| Calendar Days | Number of Criticisms | Percentage |
|---|---|---|
| 0 to 10 | 35 | 85.4% |
| Over 10 | 6 | 14.6% |
| Total | 41 | 100.0% |

The company failed to return six criticisms (14.6%) within 10 calendar days.

Reference: Section 374.205.2, RSMo

Criticisms 4, 5, 6, 7, 8 and 40 were delayed.

### B. Formal Request Time Study

| Calendar Days | Number of Requests | Percentage |
|---|---|---|
| 0 – 10 | 34 | 53.12 |
| 11 – 20 | 17 | 26.56 |
| 21 - 30 | 6 | 9.38 |
| Over 30 | 7 | 10.94 |
| Total | 64 | 100.0% |

The company failed to return 30 formal requests (46.88%) within 10 calendar days.

Reference: Section 374.205.2, RSMo

Requests 9, 10, 16, 17, 18, 20, 21, 23, 24, 27, 28, 29, 30, 31, 32, 33, 35, 36, 37, 38, 39, 40, 41, 42, 44, 47, 48, 49, 51 and 52 were delayed.

## EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Humana Health Plan, Inc. (NAIC #95885), Examination Number 0612-0462-TGT. This examination was conducted by Michael D. Gibbons, Walter Guller, and Randy Kemp. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated February 25, 2009. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Michael W. Woolbright 6-17-09

Michael W. Woolbright Date
Chief Market Conduct Examiner