

**IN THE DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION
STATE OF MISSOURI**

In Re:)
)
HUMANA HEALTH PLAN INC.) **Market Conduct Exam No. 1003-08-TGT**
(NAIC # 95885))
)

ORDER OF THE DIRECTOR

NOW, on this 13th day of JANUARY, 2014, 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 number 1003-08-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3) (a)¹ 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 work papers, and any written submissions or rebuttals, the findings and conclusions of such report are deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4).

This order, issued pursuant to §374.205.3(4), §374.280, and §374.046.15. RSMo (Cum. Supp. 2012), is in the public interest.

IT IS THEREFORE ORDERED that Humana and the Division of Insurance Market Regulation having agreed to the Stipulation, 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

1 All references, unless otherwise noted, are to Missouri Revised Statutes 2000 as amended.

Voluntary Forfeiture of \$99,000 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 13th day of JANUARY, 2014.


John M. Huff
Director



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**STIPULATION OF SETTLEMENT
AND VOLUNTARY FORFEITURE**

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter "the Division") and Humana Health Plan Inc. (NAIC #95885) (hereinafter referred to as "Humana"), as follows:

WHEREAS, the Division is a unit of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereinafter, "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 Division conducted a Market Conduct Examination of Humana and prepared report number 1003-08-TGT; and

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

1. Humana's form number HSCH2MO 05/06 limits chiropractic service visits to 26 visits without allowing or considering prior authorization requests by members for additional services in violation of §376.1230 RSMo. Supp. 2012 and §354.430.3 (1)¹;
2. In one instance, information provided to a Department Life & Healthcare Analyst misrepresented Humana's intended claims adjudication process in violation of §374.210.1 (2);
3. In twenty instances, Humana committed errors in the processing of denied emergency

1 All references, unless otherwise noted, are to Missouri Revised Statutes 2000, as amended.

room and ambulance claims in violation of §375.1007 (3) and (4) and 20 CSR 100-1.050 (1) (A);

4. In six instances, Humana committed errors in the processing of denied childhood immunization claims in violation of §375.1007 (3) & (4), §376.1215, §376.383.5 RSMo. Supp. 2009, and 20 CSR 100-1.050 (1) (A);

5. In nine instances, Humana committed errors in the processing of denied diabetes benefit claims in violation of §375.1007 (3) and (4), §376.383.5 RSMo. Supp. 2009, and 20 CSR 100-1.050 (1) (A);

6. In two instances, Humana committed errors in the processing of denied chemotherapy claims in violation of §375.1007 (3) and (4), §376.383.5 RSMo. Supp. 2009, and 20 CSR 100-1.050 (1) (A);

7. In twelve instances, Humana committed errors in the processing of denied mental health and chemical dependency benefit claims in violation of §375.1007 (3) and (4), §376.383.5 RSMo. Supp. 2009, and 20 CSR 100-1.050 (1) (A);

8. In three instances, Humana committed errors in the processing of denied mammography claims in violation of §375.1007 (3) and (4) and 20 CSR 100-1.050 (1) (A);

9. In sixty-one instances, Humana committed errors in the processing of denied chiropractic claims in violation of §375.1007 (3) and (4), §373.383.5 RSMo. Supp. 2009, and 20 CSR 100-1.050 (1) (A);

10. Humana maintained policies and procedures to systematically deny all claims for chiropractic benefits after the 26th visit in violation of §375.1007 (3) and (4) and §376.1230 RSMo. Supp. 2012;

11. In two hundred fifty one instances, Humana failed to process claims for chiropractic services in compliance with the 50% copayment requirement in violation of §375.1007 (3) and (4) and §376.391 RSMo Supp. 2012;

12. In six hundred fifty one instances, Humana applied copayments to members that exceeded 50% of the total cost of providing any single service to its enrollees in violation of §375.1007 (3) and (4), §354.410.1 (2) and 20 CSR 400-7.100;

13. In one instance, Humana provided the Department with incorrect information in responding to a Complaint in violation of §374.210.1 (2) and 20 CSR 100-4.100 (2) (A).

WHEREAS, the Division and Humana have agreed to resolve the issues raised in the Market Conduct Examination Report as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent that no promise, inducement or agreement not herein expressed has been made, and acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** Humana agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those remedial actions at all times, to reasonably assure that the errors noted in the above-referenced market conduct examination report do not recur. Such remedial actions shall include, but not be limited to, the following:

1. Humana agrees to provide Explanations of Benefits (EOB's) to its members for adjusted claims even when the member's liability is \$0;

2. Humana agrees to comply with the provisions of §376.1230 in processing claims for chiropractic benefits;

3. Humana agrees to review all denied chiropractic claims from January 1, 2006 to December 31, 2007 to determine if any claims were improperly denied after the 26th visit. If a claim was improperly denied, Humana must pay restitution to the claimant, including the payment of interest at the rate of 1% per month as required by §376.383 RSMo Supp. 2009. A letter must be included with the payments, indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim;

4. Humana agrees not to impose copayments exceeding 50% on claims for chiropractic services;

5. Humana agrees not to impose copayments exceeding 50% of the total cost of providing any single basic health care service to its enrollees.

C. **Compliance.** Humana agrees to file documentation with the Division within 90 days of the entry of a final order of all remedial action taken to implement compliance with the terms of

this stipulation and to document the payment of restitution required by this Stipulation.

D. **Voluntary Forfeiture.** Humana agrees, voluntarily and knowingly, to surrender and forfeit the sum of \$99,000, such sum payable to the Missouri State School Fund, in accordance with §374.049 and §374.280 RSMo Supp. 2012.

E. **Other Penalties.** The Division agrees that it will not seek penalties against Humana, other than those agreed to in this Stipulation, for the conduct found in Market Conduct Examination 1003-08-TGT.

F. **Waivers.** 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, and review or appeal by any trial or appellate court, which may have otherwise applied to the above referenced Market Conduct Examination.

G. **Changes.** No changes to this stipulation shall be effective unless made in writing and agreed to by all signatories to the stipulation.

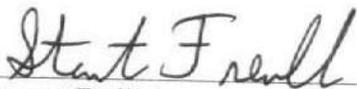
H. **Governing Law.** This Stipulation of Settlement and Voluntary Forfeiture shall be governed and construed in accordance with the laws of the State of Missouri.

I. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation of Settlement and Voluntary Forfeiture.

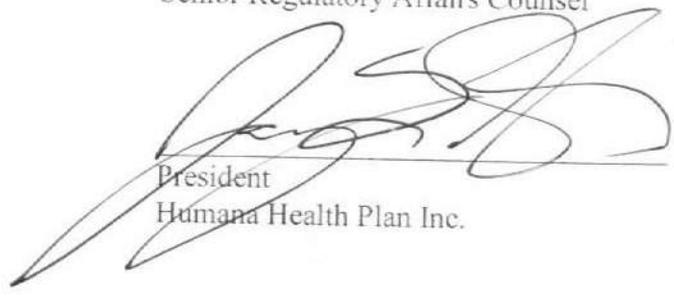
J. **Effect of Stipulation.** This Stipulation of Settlement and Voluntary Forfeiture shall not become effective until entry of a Final Order by the Director of the Department of Insurance, Financial Institutions and Professional Registration (hereinafter the "Director") approving this Stipulation.

K. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation of Settlement and Voluntary Forfeiture and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: 1/7/14


Stewart Freilich
Senior Regulatory Affairs Counsel

DATED: 12/18/13


President
Humana Health Plan Inc.

STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS
AND
PROFESSIONAL REGISTRATION



FINAL MARKET CONDUCT EXAMINATION REPORT
of the Life and Health Business of

Humana Health Plan Inc.

NAIC # 95885

MISSOURI EXAMINATION # 1003-08-TGT

NAIC EXAM TRACKING SYSTEM # MO341-M3

January 7, 2014

**Home Office
PO Box 740036
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FOREWORD

This is a targeted market conduct examination report of Humana Health Plan Inc., (NAIC Code # 95885). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- “ACL®” refers to Audit Command Language – proprietary software;
- “Company” or “Humana” refers to Humana Health Plan, Inc.;
- “CPT” refers to “Current Procedural Terminology.” CPT codes are used to identify medical procedures and are published by American Medical Association;
- “DIFP” or “Department” refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- “Director” refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- “EOB” refers to Explanation of Benefits. A document submitted to an insured, member, or subscriber to explain the amount of payment and/or how a claim is resolved;
- “HMO” refers to Health Maintenance Organization as defined and described in chapter 354;
- “NAIC” refers to the National Association of Insurance Commissioners;
- “RSMo” refers to the Revised Statutes of Missouri. All citations are to RSMo 2000, unless otherwise specified;
- “SERFF” refers to the NAIC’s System for Electronic Rate and Form Filing.

SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§354.465.1, 374.110, 374.190, 374.205, 375.445, 375.938, 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and regulations and to consider whether the Company's operations are consistent with the public interest. Unless otherwise noted, the primary period covered by this review is January 1, 2006, through December 31, 2009. Errors uncovered outside the examination time period, may also be included in the report. The examination was a targeted examination involving the following business functions:

- Underwriting
- Claims handling
- Complaints

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews applying a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, examiners only reviewed specific segments of the Company's practices, procedures, products, and files. Therefore, some noncompliant practices, procedures, products and files may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

This market conduct examination was performed as a desk audit at the following DIFP offices:

Harry S Truman State Office Building
301 W. High Street
Jefferson City, MO 65101

COMPANY PROFILE

The Company is licensed by the DIFP under Chapter 354, RSMo, to operate as a Health Maintenance Organization (HMO) as set forth in its Certificate of Authority.

The Company was incorporated as a for-profit corporation under the laws of the state of Kentucky on August 23, 1982, and it was first licensed to operate as a HMO in Missouri on March 30, 1987. A wholly owned subsidiary of Humana Inc., the Company is the surviving corporation of mergers with three affiliated HMOs – Humana Health Plan of Missouri, Inc. (1987), Humana Health Plan of Kansas, Inc. (1988) and Humana Kansas City, Inc. (2001). During the time period of the examination, the Company's service area encompassed the Missouri counties of Bates, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Henry, Jackson, Johnson, Lafayette, Platte, and Ray.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Humana. The examiners found the following principal areas of concern:

- The Company limited chiropractic benefits to 26 visits;
- The Company failed to adopt and implement reasonable standards for an investigation and settlement before denying chiropractic claims;
- The Company incorrectly calculated interest payments;
- The Company did not send EOBs to members for all claims;
- The Company inaccurately calculated copayment amounts; and
- The Company submitted incorrect information to the DIFP.

Examiners requested the Company make refunds concerning underwriting premium overcharges, claim underpayments and or interest uncovered during the examination, if any were found.

Various noncompliant practices were identified, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the Missouri insurance statutes and regulations. When applicable, corrective action for other jurisdictions should be addressed.

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report details the examiners' review of the Company's underwriting and rating practices. These practices include the use of policy forms, adherence to underwriting guidelines, assessment of premium, and procedures to decline or terminate coverage.

An error can include, but is not limited to, any miscalculation of the premium based on the information in the file, an improper acceptance or rejection of an application, misapplication of the Company's underwriting guidelines, incomplete file information preventing the examiners from readily ascertaining the Company's rating and underwriting practices, and any other activity indicating a failure to comply with Missouri statutes and regulations.

The examiners did not conduct specific reviews of the Company's underwriting and rating practices in this targeted examination. The examiners, however, reviewed the Company's filing and use of policy and certificate forms to determine their compliance with Missouri statutes and regulations.

Forms and Filings

In review of the 2006 through 2009 DIFP consumer complaint files, examiners observed a Certificate of Coverage to contain "Spinal manipulations, adjustments and modalities therapy" in the "Schedule of Benefits" section with the form number HSCH2MO 05/06. This benefit section states the benefits are "limited to 26 visits per year." The "Covered Expenses" section of the certificate of coverage clarifies "Spinal manipulations, adjustments and modalities" are to be "delivered by a licensed chiropractor."

In reviewing the 2006 through 2009 form filings, filed with the DIFP, for the Company's certificate form, the examiners noted the chiropractic services provision in the "Schedule of Benefits" (form number HSCH2MO 05/06) stated as follows:

**[Chiropractic services] [Spinal [manipulations, adjustments and modalities]
[therapy]]**
[Limited to [#] visits [per year]]

OPTION 3

Included with the certificate form filing was a document entitled "Variable Options" (form number CHMO-VOS SCH2 0506). This document appears to set forth what is to be inserted as "Option 3" in issued certificates as follows:

[Provider]	[[Your] [copayment] [and] [or] [coinsurance]]
[Level 1][non-]network provider [copayment] [coinsurance]	
[[Level 2] [non-]network provider] [copayment] [coinsurance]	
[Non-network provider] [copayment] [coinsurance]	

Subsequently appearing in the "Variable Options" document is a table that appears to set forth the range of coinsurance/copayments that may be inserted in the "Option 3" table above and the range in the number of visits that may be inserted in the preceding language in the "Schedule of Benefits" form HSCH2MO 05/06 as follows:

[Chiropractic services] [Spinal [manipulations, adjustments and modalities] [therapy]]	Coinsurance Percentage paid by you: 0% - 100%	Coinsurance Percentage paid by us: 0% - 100%	Copayment: [0% - 100%] [\$0-0\$200]
[Chiropractic services] [Spinal [manipulations, adjustments and modalities] [therapy]] maximum number of [days] [visits] per year:	26 - unlimited		

This contract language for the "Schedule of Benefits" form number HSCH2MO 05/06 appears to have been originally approved on August 25, 2006 in SERFF filing number 0601270001. While the Department was in the course of reviewing filing number 0601270001 to determine whether it should be approved, the Company also submitted another form filing, SERFF filing number 0606190009, that contained a duplicate filing for form number HSCH2MO 05/06. In reviewing filing number 0606190009, the limitations on spinal manipulations or chiropractic services were questioned by the DIFP Life & Healthcare Section analyst. The Company responded to the DIFP analyst with the following August 10, 2006 letter stating (in part) as follows:

Page two;

DIFP analyst: "Would the Chiropractic services only be limited to the Spinal treatments?"

Humana: "No. A member's office visit to a Chiropractor would be covered under Health Care Practitioner's Office Visit with unlimited visits."

Page three;

DIFP analyst: "Therefore, if this form only applies to the spine, you will need to revise for compliance."

Humana: "The only service we are limiting is spinal manipulations, adjustments and modalities. The visits would be limited to the 26 as allowed by RSMo 376.1230. At the point a member receives the limit of 26 we would require prior notice for additional services. In this way I believe we are less restrictive than insurance code RSMo 376.1230."

Humana submits form filings in a "matrix" format consisting of groups of paragraphs, each with their own form number, intended to be combined as needed in issued certificates in order to fit the Company's marketing needs. Because Humana submits form filings in a "matrix" format, it appears the DIFP analyst had difficulty in reviewing the forms, or paragraphs, and understanding how they would be implemented for delivery to the consumer. Based upon representations made about the administration of claims for chiropractic services in the August 10, 2006, correspondence from the Company, however, the DIFP analyst approved the "Schedule of Benefits" form number HSCH2MO 05/06 in filing number 0601270001.

Although the Department's Life & Healthcare Section approved form number "HSCH2MO 05/06" as indicated in SERFF filing number 0601270001 based upon a letter from the Company in SERFF filing number 0606190009, this approval appears to have been mistaken since the terms applicable to the "Chiropractic services" or "Spinal manipulations, adjustments and modalities therapy" do not appear to comply with the requirements of §§376.1230 and 354.430 because:

1. Limiting chiropractic service visits to 26 visits without allowing or considering prior authorization requests by the member for additional service visits is inconsistent with §376.1230, RSMo Supp. 2012
2. The terms and limitations applicable to "Spinal manipulations, adjustments and modalities therapy" appear to be contrary to the requirements of an evidence of coverage in §354.430.3(1) RSMo.

Reference: §376.1230, RSMo Supp. 2012, and §354.430.3(1), RSMo

In addition, it appears the information provided to the DIFP Life & Healthcare analyst in the August 10, 2006 correspondence misrepresented the Company's intended claims adjudication processes since the process actually implemented by the Company denied all chiropractic claims beyond 26 visits rather than merely requiring prior notice for "Spinal manipulations, adjustments and modalities therapy" beyond 26 visits as the Company said in its letter. Chiropractic claims processing is discussed in more detail later in the "Claims Practices" section of this report. Filing incorrect information with the DIFP appears to be the type of conduct prohibited in §§374.210.1(2) and 375.936(5) RSMo.

Reference: §§374.210.1(2) and 375.936(5), RSMo

II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed the Company's claims handling to determine the timeliness, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, examiners used ACL® to extract specific populations of claim lines from the claims data provided by the Company. Examiners then requested for review entire claim files for the claim lines extracted. The review consisted of claims submitted, reviewed or processed by the Company from January 1, 2009, through December 31, 2009.

A claim file, as a sampling unit, is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g., §§375.1000 – 375.1018 and 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%) for sampled populations. Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to the law. Errors indicating a failure to comply with statutes and regulations not applying to the general business practice standard are separately noted as errors and were not included in the error rates.

A claim error includes, but is not limited to, any of the following:

- An unreasonable delay in the acknowledgement of a claim;
- An unreasonable delay in the investigation of a claim;
- An unreasonable delay in the payment or denial of a claim;
- A failure to calculate claim benefits correctly; or
- A failure to comply with Missouri statutes and regulations regarding claim settlement practices.

Missouri statutes and regulations require the Company to disclose to first-party claimants all pertinent benefits, coverage or other provisions of an insurance policy under which a claim is presented. Claim denials explaining the reason for disallowing a payment request must be given to the claimant in writing, and the Company must maintain a copy of all pertinent documentation in its claim files.

A mandated health benefit, such as chiropractic visits, must be included in the certificate of coverage. A required policy provision, such as coordination of benefits, is a regulatory requirement similar to a mandate. The person or policyholder buying the insurance coverage cannot choose to leave either benefit out of a contract.

Examiners requested separate samples of denied or closed without payment claims related to health care benefits and policy provisions mandated by Missouri law. Populations of mandated health benefits were identified by using ACL® to identify

claims with specific claim characteristics, such as CPT codes, diagnostic codes or provider types. While examiners reviewed the separate claim samples for compliance with the benefits mandated by law, they also reviewed Humana's standard operating procedures and claim processing manuals.

A. Unfair Claims Practices – Denied Emergency Room and Ambulance Claims

Section 376.1367, RSMo, mandates benefits for emergency services by health carriers in their managed care plans. Examiners extracted 132 claim lines (representing 38 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to emergency room visits. Copies of the claim files for the 38 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	38
Type of Sample	Census
Number of Errors:	20
Error Ratio:	52.6%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The following 20 claims were initially denied and subsequently reprocessed and paid by the Company. When the claims were paid, however, the Company did not send the members EOBs describing the details of how the claims were paid. Regulation 20 CSR 100-1.050(1)(A) requires insurers to notify first-party claimants (which includes an HMO member) of the acceptance or denial of a claim. The Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

406867744	404229105	404731364	392425260	394554261
417447857	418581454	407807873	396403120	397387637
412053897	422917607	424204223	407149011	407807835
415551669	417471150	444828632	446174025	444412258

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

In response to Examiner Finding 6, the Company agreed with the examiners' assessment of its processes. The Company explained that it has two computer system platforms for processing claims. Each platform has different methods for providing its members with EOBs. The Claims Administration System (CAS) platform does not provide members with EOBs if the member has no liability, only owes the provider a copay or coinsurance amount, or the claim is a duplicate of a previously submitted claim. After August 14, 2009 the Metavance (MTV) system suppressed EOBs from being generated if a submitted claim was a duplicate of a prior submission in which

the member had no responsibility to the healthcare provider. The Company agreed to modify its systems to generate EOBs for all claims.

B. Unfair Claims Practices – Denied Childhood Immunization Claims

Section 376.1215, RSMo, mandates the payment of benefits for immunizations of a child from birth to five years of age. Examiners extracted 30 claim lines (representing 8 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to childhood immunizations. Copies of the claim files for the 8 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	8
Type of Sample	Census
Number of Errors:	6
Error Ratio:	75%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

In Examiner Finding 3, examiners noted expenses submitted for immunizations provided to twin children on the same day, by the same provider that were not correctly processed. The provider submitted a separate claim for each child, one was correctly processed and the second claim, 454549280, was denied as a duplicate submission. During the course of the examination the Company reprocessed and paid the claim with appropriate interest. The Company's action in denying this claim appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4), RSMo.

Reference: §§375.1007(3) and (4) and 376.1215, RSMo

The Company initially denied and subsequently paid the following three claims, but it failed to pay any interest on the claims even though they were paid more than 45 days after the date of first receipt. In response to Examiner Finding 1, the Company agreed that it had incorrectly failed to pay interest on these claims, and it reprocessed the claims and paid appropriate interest during the course of the examination. The Company's actions in initially failing to pay the interest required by §376.383.5, RSMo Supp. 2009, however, appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

403507561 438301546 460337993

Reference: §§375.1007(3) and (4), RSMo, and 376.383.5, RSMo Supp. 2009

The Company initially denied and subsequently reprocessed and paid the following two claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

415837005 474636951

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

C. Unfair Claims Practices – Denied Diabetes Benefit Claims

Section 376.385, RSMo, mandates benefits for equipment, supplies and self-management training used in the management and treatment of diabetes. Examiners extracted 44 claim lines (representing 11 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to diabetes benefits. Copies of the claim files for the 11 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	11
Type of Sample	Census
Number of Errors:	9
Error Ratio:	81%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The Company failed to pay the interest required by §376.383, RSMo Supp. 2009, when it reprocessed and paid the following three claims that it initially denied. As with similar claim errors noted above, the Company agreed interest was due and paid appropriate interest on the claims during the course of the examination.

Claim number

416929584 417815752 419023761

Reference: §§375.1007(3) and (4), RSMo, and 376.383.5, RSMo Supp. 2009

The Company initially denied and subsequently reprocessed and paid the following five claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

397879961 404979601 412052589 434123788 455208613
460375052

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

D. Unfair Claims Practices – Denied Chemotherapy Claims

Section 376.1200, RSMo, requires health carriers to provide benefits for the treatment of breast cancer. Examiners extracted 51 claim lines (representing 4 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where CPT codes or diagnostic codes were related to chemotherapy benefits for the treatment of breast cancer. Copies of the claim files for the 4 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	4
Type of Sample	Census
Number of Errors:	2
Error Ratio:	50%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The Company failed to pay the interest required by §376.383, RSMo Supp. 2009, when it reprocessed and paid the following claim that it initially denied. As with similar claim errors noted above, the Company agreed interest was due and paid appropriate interest on the claim during the course of the examination.

Claim number

460957005

Reference: §§375.1007(3) and (4), RSMo, and 376.383.5, RSMo Supp. 2009

The Company initially denied and subsequently reprocessed and paid the following two claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

460957005* 471562921

Claim numbers designated with an asterisk* are also noted within this finding and only counted once for the purpose of an error ratio.

Reference: §§375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

E. Unfair Claims Practices – Denied Mental Health and Chemical Dependency Benefit Claims

Section 376.1550, RSMo Supp. 2012, mandates benefits for mental health conditions. Examiners extracted 41 claim lines (representing 26 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to mental health benefits. Copies of the claim files for the 26 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	26
Type of Sample	Census
Number of Errors:	11
Error Ratio:	42%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The Company failed to pay the interest required by §376.383, RSMo Supp. 2009, when it reprocessed and paid the following five claims that it initially denied. As with similar claim errors noted above, the Company agreed interest was due and paid appropriate interest on the claims during the course of the examination.

Claim numbers

390495740 404971487 408432366 419596895 443962151

Reference: §§375.1007(3) and (4), RSMo, and 376.383.5, RSMo Supp. 2009

The Company initially denied and subsequently reprocessed and paid the following nine claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

390495740* 394515677 394828113 394946757 400223749
400965125 403997677 404006731 404971487*

Claim numbers designated with an asterisk* are also noted within this finding and only counted once for the purpose of an error ratio.

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

F. Unfair Claims Practices – Denied Mammography Claims

Section 376.782, RSMo, mandates benefits for mammography screenings. Examiners extracted 37 claim lines (representing 7 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to mammography benefits. Copies of the claim files for the 7 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	7
Type of Sample	Census
Number of Errors:	3
Error Ratio:	42.8%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The Company initially denied and subsequently reprocessed and paid the following three claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

419792130 423921295 454369663

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

G. Unfair Claims Practices – Denied Chiropractic Claims

Section 376.1230, RSMo Supp. 2012, mandates benefits for chiropractic services. Examiners extracted 164 claim lines (representing 73 claim numbers) from the data provided by the Company that were indicated in the data as either being denied or paid at \$0.00 and where the CPT code was related to chiropractic services. Copies of the claim files for the 73 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	73
Type of Sample	Census
Number of Errors:	61
Error Ratio:	83.5%
Within DIFP's Guidelines?	No

The examiners noted the following errors during their review:

The Company failed to pay the interest required by §376.383, RSMo Supp. 2009, when it reprocessed and paid the following 10 claims that it initially denied. As with similar claim errors noted above, the Company agreed interest was due and paid appropriate interest on the claims during the course of the examination.

Claim numbers

466512953	467754179	467754183	468013168	468813355
468813765	468813778	469302264	469302444	469302505

Reference: §§375.1007(3) and (4), RSMo, and 376.383.5, RSMo Supp. 2009

The Company initially denied and subsequently reprocessed and paid the following 51 claims, but it did not send the members EOBs explaining the processing of the claims. As noted above, the Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Claim numbers

443267979	443955345	445455615	446585005	459142196
462479611	404033409	398540229	452815258	456054849
462479782	467043770	397628126	471918782	460818034
434056788	437275394	440581539	468853663	405469276
405469456	404939610	406052886	408969472	394823610
395889549	405494994	465926941	452309811	459150541
460355442	466786989	407303924	407303955	407304479
408658529	410796770	413829623	414780241	418329794
419761237	419490394	419490396	420691151	420691152
425214289	444129999	457647190	460292007	465193080
462086755				

Reference: §375.1007(3) and (4), RSMo, and 20 CSR 100-1.050(1)(A)

H. Unfair Claims Practices – Limitations on Chiropractic Benefits

Section 376.1230, RSMo Supp. 2012, requires health carriers to provide their members with coverage for up to 26 chiropractic office visits per policy period without the need to obtain a prior authorization. For visits after the 26th, the statute allows a health carrier to require "prior authorization or notification" in order to make a determination as to medical necessity; however, the statute does not permit the limitation of benefits to 26 visits if proof of medical necessity is provided.

In the course of reviewing the sampled claims above, examiners also reviewed the Company's internal procedures for processing claims. The examiners found that the Company maintained policies and procedure manuals during the examination period to systematically deny all claims for chiropractic benefits after the 26th visit. Such a practice appears contrary to the benefit requirements of §376.1230, RSMo Supp.

2012, and appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

In response to the examiners' inquiry, the Company reviewed its records during the course of the examination and found 87 chiropractic service claim lines (representing 62 claim numbers) for dates of service between 1/1/08 and 12/31/09 that were previously denied in error due to the 26 visit limitation. During the examination, the Company made adjusted payments to the providers, including interest, for the previously denied chiropractic claims beyond the 26th visit totaling \$3,996.52.

Reference: §§375.1007(3) and (4), RSMo, and 376.1230, RSMo Supp. 2012

I. Unfair Claims Practices – Chiropractic Copayments

All health carriers are prohibited from imposing copayments for chiropractic services exceeding fifty percent of the total cost of providing the service pursuant to §376.391, RSMo Supp. 2012. This statute, which was enacted in 2009 by HB 577, became effective on August 28, 2009, which is during the scope of the examination.

In response to Formal Request (FR) 13 and FR 17, the Company explained that it had implemented a process for complying with the copayment limitations of §376.391 effective July 6, 2011, but some claims for chiropractic services prior to this date may have been processed incorrectly. To address this issue, the Company conducted a review of all chiropractic claims incurred between the effective date of this process and the effective date of §376.391 during the course of the examination, and issued refunds, with interest, to any members that may have paid an excessive copayment. Included in this review were 251 claims incurred during the scope of the examination for which the Company issued total refunds of \$3,246.25.

While the Company did take remedial measures during the course of the examination, its initial processing of the 251 claims for chiropractic services incurred during the scope of the examination in a manner inconsistent with the requirements of §376.391 appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §§375.1007(3) and (4), RSMo, and 376.391, RSMo Supp. 2012

J. Unfair Claims Practices – Copayments for Basic Health Care Services

As stated in Regulation 20 CSR 400-7.100, "An HMO may not impose copayment charges exceeding fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services." The total cost of a single service is the amount of cost sharing paid by the member plus the payment by the HMO. Member

copayments exceeding the Company payment amounts do not comply with the 50% rule set forth in 20 CSR 400-7.100.

Examiners requested detailed information in FR 13 about how the Company calculates copayments, monitors excessive copayments collected by providers and processes copayment refunds if an excessive copayment is collected. When responding to FR 13, the Company readily admitted it had been deficient in claims processing in respect to the 50 % copayment limitation in 20 CSR 400-7.100 during the entire examination time frame. In response to the examiners' inquiry, the Company conducted an internal review during the course of the examination. This internal review found 651 instances of excessive copayments being applied to the Company's members resulting in the Company making refunds to members, including interest, for the excessive copayments in the amount of \$6,679.86 for claims occurring in 2009. The Company also made adjusted payments for subsequent claims up to 2011 and modified its claim procedures to properly process claims going forward from 2011.

As noted above, while the Company did take remedial action during the course of the examination, its actions in initially processing these claims without taking steps to insure that members were not charged excessive copayments appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §§375.1007(3) and (4), and 354.410.1(2), RSMo; and 20 CSR 400-7.100

III. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

Section 375.936(3), RSMo requires companies to maintain a registry of all written complaints received for the last three years. The registry must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company.

Examiners verified the Company's complaint registry, dated January 1, 2009 through December 31, 2009. The registry contained a total of 9 complaints. Examiners reviewed all complaints filed with the DIFP and all complaint files maintained by the Company for complaints it received directly from members or other interested parties.

The review consisted of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint as required by §375.936(3), RSMo and 20 CSR 100-8.040(3)(D).

Examiners found the following exception during their review:

Incorrect Information Provided to the DIFP

While reviewing the Departmental inquiries and complaints related to Humana Health Plan, further information on file 86771 was requested. According to the Department's records, the Department had closed this file for no jurisdiction as the Company's response reflected the insured member was part of a self-insured group. Additional information revealed the Company had provided incorrect information as the inquiring member was covered by a fully insured group. As a result of the examination, the Company submitted a revised communication amending its previous response to the Department, dated December 8, 2009. In initially handling this complaint, however, the Company does not appear to have fulfilled its statutory obligation to provide true and complete information to the Department when responding to a request for information.

Reference: §§374.210.1(2) and 375.936(5), RSMo and 20 CSR 100-4.100(2)(A)

IV. EXAMINER FINDINGS 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 Examiner Findings. Missouri statutes and regulations require companies to respond to findings and formal requests within 10 calendar days. Please note, in the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within the allotted time, the response was not considered timely.

A. Examiner Findings Time Study

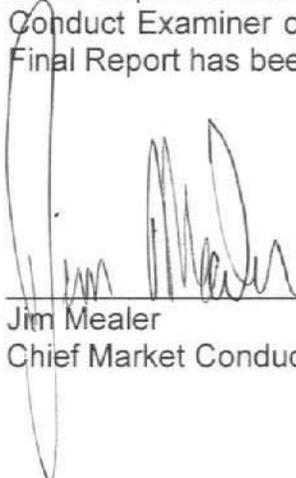
<u>Calendar Days</u>	<u>Number of Findings</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	6	100%
Received outside time-limit, incl. any extensions	0	0%
<u>No Response</u>	<u> </u>	<u>0 %</u>
Total	6	100 %

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	22	100%
Received outside time-limit, incl. any extensions	0	0%
<u>No Response</u>	<u>0</u>	<u>0%</u>
Total	22	100 %

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 1003-08-TGT. This examination was conducted by John Korte, Rita Heimericks-Ash, John Clubb and Mike Woolbright. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 30, 2013. 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.



Jim Mealer
Chief Market Conduct Examiner

1/7/2014
Date

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I. UNDERWRITING AND RATING PRACTICES

(Draft Proposed Report pages 7-9)

Findings: Forms and Filings Violations of Sections 376.1230, RSMo Supp.2012 and Section 354.430.3(1).

1. The Department's Life and Healthcare Section approved form number "HSCH2MO 05/06" as indicated in SERFF filing number 0601270001 based upon a letter from the Company in SERFF filing number 0606190009, this approval appears to have been mistaken since the terms applicable to the "Chiropractic services" or "Spinal manipulations, adjustments and modalities therapy" do not appear to comply with the requirements of Sections 376.1230 and 354.430 because:
 - a. Limiting chiropractic service visits to 26 visits without allowing or considering prior authorization requests by the member for additional service visits in inconsistent with Section 376.1230, RSMo Supp. 2012.
 - b. The terms and limitations applicable to "spinal manipulations, adjustments and modalities therapy" appear to be contrary to the requirements of an evidence of coverage in Section 354.430.3(1) RSMo.

HHP Response: HHP has no objection to the finding in the Report pertaining to the language applicable to "Chiropractic services" or "Spinal manipulations, adjustments and modalities therapy". In November of 2009, HHP filed an amendment to comply with this mandate as a corrective action. The SERFF filing # was HUMA-126397460 and it was approved by the DIFP on 03/26/2010. The amendment was revised in 2011 and filed under SERFF HUMA-127618633 on 09/08/2011 and was approved by the DIFP on 09/14/2011.

2. Information provided to the DIFP Life and Healthcare analyst in the August 10, 2006 correspondence misrepresented the Company's intended claims adjudication processes since the process actually implemented by the Company denied all chiropractic claims beyond 26 visits rather than merely requiring prior notice for "Spinal manipulations, adjustments and modalities therapy" beyond 26 visits as the Company said in its letter. Filing incorrect information with the DIFP appears to be the type of conduct prohibited in Sections 374.210.0(2) and 375.936(5) RSMo.

HHP Response: HHP has decided not to state any objection to the finding in the Report that the information provided to the DIFP was confusing and unintentionally inconsistent with the actual claims adjudication process. HHP no longer files forms using matrix numbers or Variable Options sheets in Missouri and has reduced the variability in the forms to the minimum required to support our HMO products in Missouri. In addition, the actual claims processing has been corrected to follow the certificate language as outlined above. See Claims section – Limitations on Chiropractic Benefits for additional information.

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II. CLAIMS PRACTICES

(Draft Proposed Report pages 10 - 19)

A. Findings: Failure to issue an Explanation of Benefits (EOB) as required by Sections 20 CSR 100-1.050(1)(A) and 375.1007(3) and (4).

20 CSR 100-1.050(1)(A) states: "Purpose: This rule effectuates or aids in the interpretation of section 375.1007(4), RSMo.

(1) Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers.

(A) Within fifteen (15) working days after the submission of all forms necessary to establish the nature and extent of any claim, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny any claim on the grounds of a specific policy provision, condition or exclusion unless reference to that provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial."

This violation was cited in the following areas of the draft exam report – Denied Emergency Room and Ambulance Claims, Denied Childhood Immunization Claims, Denied Diabetes Benefit Claims, Denied Chemotherapy Claims, Denied Mental Health and Chemical Dependency Benefit Claims, Denied Mammography Claims and Denied Chiropractic Claims.

In each instance the company initially denied and subsequently reprocessed and paid the claims, but did not send the members EOBs explaining the processing of the claims. The Company's failure to issue EOB communications as required by 20 CSR 100-1.050(1)(A) appears to be the type of claims settlement practice prohibited by Sections 375.1007(3) and (4).

Response: HHP has decided not to state any objection to the finding in the Report. As agreed during this examination, corrective action was taken by the Company to address this finding. The Company's claims payment system (CAS) now issues an EOB for adjusted claims, even when the member liability is \$0. This was implemented in September 2012.

A. Finding: Failure to pay the interest required by Sections 376.383.6, RSMo Supp. 2009 and 375.1007(3) and (4).

376.383.6 states: "6. If the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day. The interest and penalty shall be calculated based upon the unpaid balance of the claim as of the forty-fifth processing day. The interest and penalty paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest and penalty. A health carrier may combine interest payments and make payment once the aggregate amount reaches one hundred dollars. Any claim which has been properly denied before the forty-fifth processing day under this section and section 376.384 shall not be subject to interest or penalties."

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This violation was cited in the following areas of the draft exam report – Denied Childhood Immunization Claims, Denied Diabetes Benefit Claims, Denied Chemotherapy Claims, Denied Mental Health and Chemical Dependency Benefit Claims, and Denied Chiropractic Claims.

The Company failed to pay the interest required by Section 376.383, RSMo Supp. 2009 when it reprocessed and paid the claims that it initially denied.

Response: HHP agreed that it had incorrectly failed to pay interest on the identified reprocessed claims. The Company reprocessed the claims and paid the appropriate interest during the course of this market conduct examination. The interest calculation process for reprocessed claims has been updated to pay interest correctly.

B. Findings: Denied Childhood Immunization Claims required by Sections 376.1215, RSMo and 375.1007(3) and (4).

376.1215 RSMo states: "1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization and all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description shall provide coverage for immunizations of a child from birth to five years of age as provided by department of health and senior services regulations."

This violation was cited in the following areas of the draft exam report – Denied Childhood Immunization.

Examiners noted expenses submitted for immunizations provided to twin children on the same day, by the same provider that were not correctly processed. The provider submitted a separate claim for each child, one was correctly processed and the second claim was denied as a duplicate submission.

Response: HHP has decided to not state any objection to the finding in the Report. During the course of the examination the Company reprocessed and paid the claim with the appropriate interest. The Company reviewed existing procedures for suspected duplicate claims and determined correct steps are in place to adjudicate claims correctly. This claim was processed incorrectly due to an associate's error. The associate has been instructed in the correct procedures.

C. Findings: Limitations on Chiropractic Benefits required by Sections 376.1230, RSMo Supp. 2012.

376.1230 RSMo Supp. 2012 states: "1. Every policy issued by a health carrier, as defined in section 376.1350, shall provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice as defined in chapter 331, RSMo. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the policy. The coverage may be

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limited to chiropractors within the health carrier's network, and nothing in this section shall be construed to require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within the network for a total of twenty-six chiropractic physician office visits per policy period, but may be required to provide the health carrier with notice prior to any additional visit as a condition of coverage. A health carrier may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a health carrier shall clearly state the availability of chiropractic coverage under the policy and any limitations, conditions, and exclusions."

All health carriers are required to provide their members with coverage for up to 26 Chiropractic office visits per policy period without the need to obtain a prior authorization. The Company maintained policies and procedure manuals during the examination period to systematically deny all claims for chiropractic benefits after the 26th visit.

Response: HHP has decided to not state any objection to the finding in the Report. The Company implemented a process to comply with the chiropractic visit requirements of Section 376.1230 and conducted a review of all chiropractic claims incurred between January 1, 2008 and December 31, 2009 that were previously denied in error due to the 26 visit limitation. During the examination the Company made adjusted payments to the providers, with interest for the previously denied chiropractic claims beyond the 26th visit.

D. Findings: Chiropractic Copayments required by Sections 376.391, RSMo Supp. 2012 and 375.1007(3) and (4).

376.391 RSMo states: "A health benefit plan or health carrier, as defined in section 376.1350, including but not limited to preferred provider organizations, independent physicians associations, third-party administrators, or any entity that contracts with licensed health care providers shall not impose any co-payment that exceeds fifty percent of the total cost of providing any single chiropractic service to its enrollees."

This violation was cited in the following areas of the draft exam report – Chiropractic Copayments.

All health carriers are prohibited from imposing copayments for chiropractic services exceeding fifty percent of the total cost of providing the service pursuant to Section 376.391 RSMo Supp. 2012. While the Company did take remedial measures during the course of the examination, its initial processing of the chiropractic services incurred during the scope of the examination in a manner inconsistent with the requirements of Section 376.391.

Response: HHP has decided to not state objection to the finding in the Report. The Company implemented a process to comply with the copayment limitations of Section 376.391 effective July 6, 2011 and conducted a review of all chiropractic claims incurred between the effective date of the process and the effective date of Section 376.391. The Company issued refunds,

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with interest to any members who may have paid a copayment greater than the specified limitation.

E. Findings: Copayments for Basic health Care Services required by 20 CSR 400-7.100.

20 CSR 400-7.100 states: "An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services. An HMO may not impose copayment charges for basic health care services on any enrollee in any calendar year after the copayments made by the enrollee in that calendar year for basic health care services total two hundred percent (200%) of the total annual premium which is required to be paid by, or on behalf of, that enrollee and shall be stated as a dollar amount in the group contracts. Copayments shall be the only allowable charge, other than premiums, assessed to enrollees for basic and supplemental health care services."

This violation was cited in the following areas of the draft exam report – Copayments for Basic Health Care Services.

All health carriers are prohibited from imposing copayments that exceed fifty percent of the total cost of providing the service pursuant to Section 20 CSR 400-7.100. While the Company did take remedial measures during the course of the examination, its actions in initially processing these claims without taking steps to insure that members were not charged excessive copayment is in violation of 20 CSR 400-7.100.

Response: HHP has decided to not state any objection to the finding in the Report. The Company implemented a process to comply with the copayment limitations and conducted a review of all claims incurred from 2009 up to the effective date of the modified claim procedures to meet the requirements of 20 CSR 400-7.100. The Company issued refunds, with interest to any members that may have paid an excessive copayment.

III. Complaints

(Proposed Draft Examination Report page 20)

Finding: Section 375.936(3), RSMo Incorrect Information Provided to the DIFP.

Section 375.936(3) states: "1. It is unlawful for, any person in any investigation, examination, inquiry, or other proceeding under this chapter, chapter 354, RSMo, and chapters 375 to 385, RSMo, to:

(2) Make any false certificate or entry or memorandum upon any of the books or papers of any insurance company, or upon any statement or exhibit offered, filed or offered to be filed in the department, or used in the course of any examination, inquiry, or investigation, under this chapter, chapter 354, RSMo, and chapters 375 to 385, RSMo.

2. If a person does not appear or refuses to testify, file a statement, produce records, or otherwise does not obey a subpoena as required by the director, the director may apply to the circuit court of

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any county of the state or any city not within a county, or a court of another state to enforce compliance."

The Department closed a file for no jurisdiction as the Company's response reflected the insured member was part of a self-insured group. Additional information revealed the Company provided incorrect information as the inquiring member was covered by a fully insured group and the Company submitted a revised communication amending its previous response to the Department. In the initial response, the Company appears to have not fulfilled its statutory obligation to provide true and complete information to the Department when responding to a request for information.

Response: HHP has no objection to the finding in the Report that DIFP received a non-intentional false statement by HHP. An associate error led to the misinformation in the identified file. In the Company's response to the criticism, HHP noted this as well and advised that guidelines and letter templates are in place to guide associates in determining the appropriate information to include in responses to the DIFP.

The Company's management met with the associate who made the error and re-educated the associate when the criticism was received.