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

***In Re*:**	)	
	)	
HUMANA HEALTH PLAN, INC.	)	**Market Conduct Exam No. 1308-23-TGT**
(NAIC #95885)	)	

ORDER OF THE DIRECTOR

NOW, on this 5 day of April, 2017, Acting Director, Chlora Lindley-Myers, after consideration and review of the market conduct examination report of Humana Health Plan, Inc. (NAIC #95885) (hereafter "Humana"), report number 1308-23-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a)[1] and of the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation"), entered into by the Division of Insurance Market Regulation (hereinafter "Division") and Humana, does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant work papers, and any written submissions or rebuttals, and the findings and conclusions of such report are deemed to be the Acting 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 RSMo (Cum. Supp. 2013), and §374.046.15. RSMo (Cum. Supp. 2013), is in the public interest.

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

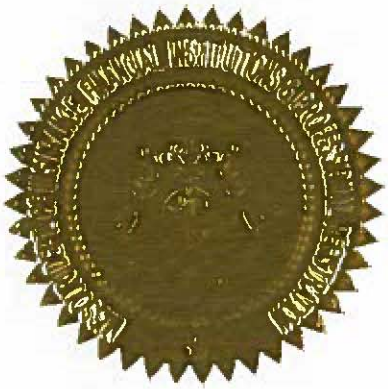
IT IS FURTHER ORDERED that Humana shall not engage in any of the violations of law and regulations set forth in the Stipulation, shall implement procedures to place Humana in full compliance with the requirements in the Stipulation and the statutes and regulations of the

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

State of Missouri, and to maintain those corrective actions at all times, and shall fully comply with all terms of the Stipulation.

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 5 day of April, 2017.



Chlora Lindley-Myers
Acting Director

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

***In Re*:**	)	
	)	
HUMANA HEALTH PLAN, INC.	)	**Market Conduct Exam No. 1308-23-TGT**
(NAIC #95885)	)	

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 "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;

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

WHEREAS, the Division conducted a Market Conduct Examination of Humana and prepared report number 1308-23-TGT; and

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

1. In one instance, Humana committed errors in the processing and handling of denied emergency room and ambulance services claim in violation of §376.1367[1] and 20 CSR 100-8.040(3)(B), and implicating the provisions of §375.1007(6), §374.205.2(2), RSMo.

2. In one instance, Humana misrepresented relevant facts regarding a participating

[1] All references, unless otherwise noted, are the Missouri Revised Statutes 2000, as amended.

provider and subsequently denied a legitimate podiatry claim implicating the provisions of §375.1007(1) and §375.1007(6), RSMo.

3. In four instances, Humana committed errors in the processing of denied emergency room claims in violation of §376.1367, §376.383.5, RSMo Supp. 2009, §376.383.6, RSMo Supp. 2013, and 20 CSR 100-1.050(1)(A) and implicating the provisions of §375.1005 (1), §375.1007 (3) and §375.1007 (4).

4. In two instances, Humana committed errors in the processing of denied emergency room claims in violation of §376.1367, §376.383.5, RSMo Supp. 2009, 20 CSR 100-1.050(1)(A) and implicating the provisions of §375.1007 (3), §375.1007 (4) and §375.1007 (6).

5. Humana failed to provide timely responses to some information requests in violation of §374.205.2(2) and 20 CSR 100-8.040(6).

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 that it will comply with the interest and penalty provisions of §376.383 RSMo Supp. 2013 for any claim received on or after January 1, 2011.

2. Humana agrees to provide member claimants with an Explanation of Benefits (EOB's).

C. **Compliance.** Humana agrees to file documentation with the Division within 30 days of the entry of a final order of all remedial action taken to implement compliance with the terms of this Stipulation.

D. **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.

E. **Changes.** No changes to this Stipulation shall be effective unless made in writing and agreed to by representatives of the Division and Humana.

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

G. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation of Settlement and Voluntary Forfeiture, on behalf of the Division and Humana respectively.

H. **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 (hereinafter the "Director") approving this Stipulation.

I. **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: 3/21/2017

Angela L. Nelson
Director, Division of Insurance
Market Regulation

DATED: 3/15/17

Stewart Freilich
Senior Regulatory Affairs Counsel
Division of Insurance Market Regulation

DATED: 3/10/17

[Name and Title] Director / Advisor
Humana Health Plan, Inc.

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

FINAL MARKET CONDUCT EXAMINATION REPORT
of the Health Maintenance Organization Business of

Humana Health Plan, Inc.
NAIC #95885

MISSOURI EXAMINATION #1308-23-TGT

NAIC EXAM TRACKING SYSTEM #MO341-M122

March 21, 2017

Home Office
321 West Main Street
Louisville, KY 40202

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FOREWORD

This is a targeted market conduct examination report of Humana Health Plan, Inc., (NAIC #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:

- "Company" refers to Humana Health Plan, Inc.;
- "CPT" refers to "Current Procedural Terminology." CPT codes are used to identify medical procedures and are published by the American Medical Association;
- "CSR" refers to the Missouri Code of State Regulations;
- "Department" or "DIFP" 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 a Health Maintenance Organization;
- "ICD-9" refers to the International Classification of Diseases, Ninth Revision;
- "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.

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, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2010, through December 31, 2012, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: underwriting, claims handling and the handling of complaints for HMO health benefit plan coverage.

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 that applied 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, the examiners reviewed some 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.

COMPANY PROFILE

Humana Health Plan, Inc is licensed by the DIFP under Chapter 354, RSMo, to write Health Maintenance Organization (HMO) business 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 an 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).

EXECUTIVE SUMMARY

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

I. CLAIMS PRACTICES

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

From reviewing the claim files for a sample of 105 claim numbers out of a field of 618 claim numbers, the examiners found one claim number where the Company underpaid and mishandled emergency room and ambulance services claims. This resulted in an error ratio of 0.95%. *(Page 8)*.

II. COMPLAINTS

A. Complaints Sent Directly to the Company

From a review of all 35 complaints the Company received directly from members, the examiners found errors in the initial handling of the claims involved in six complaints. *(Pages 9-11)*.

B. DIFP Consumer Complaints

The examiners noted no errors in the handling of four complaints received from the Department's Division of Consumer Affairs. *(Page 11)*.

III. CRITICISMS AND FORMAL REQUESTS TIME STUDY

The Company was late in responding to three Formal Requests. *(Page 12)*.

Various non-compliant 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 laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

EXAMINATION FINDINGS

I. CLAIMS PRACTICES

This section of the report details the examiners' review of the Company's claims handling practices. Examiners reviewed how the Company handled claims to determine the timeliness of handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

For the claims handling practices review in this examination, the examiners initially reviewed all of the Company's complaints (which included grievances and appeals) to identify particular types of claims needing further scrutiny. Based on the examiners' observation during the review of the complaint files that the overwhelming majority of the complaints and overturned claim denials involved claims for hospital emergency room visits for an emergency medical condition, the examiners requested the Company provide a listing of all denied claims for emergency room and ambulance services that were submitted, reviewed or processed by the Company from January 1, 2010, through December 31, 2012. A preliminary review of claims selected from this listing revealed that a significant number of the claims were for coverage under the Federal Employees Health Benefit Program ("FEHBP"), which is outside the scope of this examination, so the examiners requested an updated claim listing that excluded the FEHBP claims.

A claim file 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 to 375.1018, RSMo, and §375.445, RSMo Supp. 2013) and compared with the NAIC benchmark error rate of seven percent (7%). Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to the law. Examples of an error include, but are not limited to: (1) any unreasonable delay in the acknowledgment, investigation, or payment/denial of a claim; (2) the failure of the Company to calculate claim benefits or interest payments accurately; or (3) the failure of the Company to comply with Missouri law regarding claim settlement practices.

The examiners reviewed the claim files for timeliness. In determining timeliness, the examiners looked at the duration of time the Company used to acknowledge the receipt of the claim, the time for investigation of the claim, and the time to make payment or provide a written denial.

Missouri statutes 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 must be given to the claimant in writing, and the Company must maintain a copy in its claim files.

A. **Unfair Claim Practices – Denied Claims for Emergency Room and Ambulance Services**

Emergency medical services are required as part of the "basic health care services" provided by HMOs. In addition, §376.1367, RSMo, requires health carriers to provide benefits for emergency services in managed care plans. The examiners extracted 618 claim numbers (representing 2,702 claim lines) from the data provided by the Company that were identified in the data as being "denied." From the 618 claim numbers, the examiners extracted 105 claim numbers and requested copies of the claim files for the 105 claims numbers to review for errors in claim processing.

Field Size:	618
Type of Sample:	Random
Sample Size:	105
Number of Errors:	1
Error Ratio:	0.95%

The examiners found the following errors in this review:

Criticism #11: The Company denied three claim lines submitted under a single claim number. The revenue and CPT codes for these claim lines indicated that treatment was in an emergency room, and the CPT and ICD-9 codes showed that the treatment was for burns. Despite these indications that the claim lines submitted were for treatment of an emergency medical condition, which would be covered regardless of the network status of the provider, the explanation given by the Company to the member for the denial was that: "The Servicing Provider/Facility is Not Recognized as Participating; Therefore, This Service is Not Covered."

The provider appealed the denials. The Company asked the provider to provide an emergency room medical report to support the request for claims payment. The provider complied, but the examiners could not tell from the claim documentation supplied whether there had been any final disposition of the claim lines after this additional documentation was submitted.

By denying a claim for emergency services and making a first request for additional information only after the provider appealed the denial, the Company appears to have engaged in the type of behavior prohibited by §§376.1007(6) and 376.1367, RSMo. In addition, the Company's failure to maintain its claim files in a manner that would allow the examiners to ascertain the final disposition of the claim appears contrary to the requirements of §374.205.2(2), RSMo, and 20 CSR 100-8.040 (2).

Reference: §§374.205.2(2), 375.1007(6), and 376.1367, RSMo, and 20 CSR 100-8.040 (2)

In response to the criticism, the Company agreed with the examiners' findings and paid $1,137.90 plus $675.63 in interest for the claim during the course of the examination.

II. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Included within this review are complaints termed "grievances" or "appeals" under Missouri's utilization review statutes in §§376.1350 to 376.1389, RSMo and Supp. 2013. The examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations. In this review, the examiners also attempted to identify issues indicating possible market conduct trends that would necessitate further examination into other areas of the Company's operations and/or practices within the scope of the examination warrant.

Sections 375.936(3) and 376.1375, RSMo, and regulations 20 CSR 400-7.110 and 20 CSR 100-8.040(3)(D) require HMOs to maintain a registry of all written complaints, grievances and appeals received. The registry must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company.

The examiners verified the Company's complaint registry for the period January 1, 2010, through December 31, 2012. The registry contained 39 complaint cases. The examiners requested copies of the complaint files for all 39 complaints and reviewed the files for compliance. The review consisted of a review 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) and 376.1375, RSMo, and regulations 20 CSR 400-7.110 and 20 CSR 100-8.040(3)(D).

A. Complaints Sent Directly to the Company

The examiners reviewed 35 complaints the Company received directly from members in calendar years 2010 through 2012. The examiners noted the following issues of concern in the review:

1. Criticism #01: After consulting the Company's online provider directory, a member visited a podiatrist listed as being in the member's HMO network. The Company subsequently denied the claim on the basis that the provider was not a participating provider.

   The member filed an appeal of the denial that included a screen print of the Company's online provider directory showing the provider as participating in the member's HMO network. As a result, the Company reversed its initial denial and paid the claim in accordance with the member's plan.

   In reviewing this complaint, the examiners felt that the Company's handling of the original claim evidenced a refusal to pay claims without conducting a reasonable investigation and a misrepresentation of relevant facts or policy provisions relating to the coverage at issue contrary to §375.1007(1) and (6), RSMo.

   Reference: §375.1007(1) and (6), RSMo.

In response to the criticism, the Company stated that it "agrees with the examiner's findings regarding the accuracy of current participating provider information listed at Humana.com at the time of service" and "partially agrees with the examiner's findings that Humana misrepresented to the claimant relevant facts or policy provisions by denying a legitimate claim that could have been paid under the policy." The Company further explained that the initial denial was the result of the provider billing under two different tax identification numbers, only one of which was recognized as being in-network by the Company's system.

2. Criticisms #03, #07, #09 & #10: In the four complaints cited in these criticisms, the members all received care in an emergency room under circumstances the members' believed were emergencies. When the claims were filed, however, they were all denied with the explanation that: "NON-EMERGENT SERVICES IN THE EMERGENCY ROOM ARE NOT A COVERED BENEFIT."

   Each member appealed their claim denial. After further review, the Company overturned each member's denial and paid the claims. The examiners noted, however, that the Company failed to pay any interest on the delayed payments and did not issue revised EOBs describing the disposition of the claims.

   Sections 354.400(5) and 376.1350(12), RSMo Supp. 2013, both define an "emergency medical condition" as "the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required . . . ." It appeared to the examiners that the circumstances involved in the claims for all four complaints met this definition. Consequently, it appeared to the examiners that: (a) the Company's initial denial of these claims was the type of conduct prohibited by §375.1007(3), (4) and (6), RSMo, and contrary to §376.1367, RSMo; (b) the Company's failure to include interest when it subsequently paid the claims upon appeal was contrary to the requirements of §376.383.5, RSMo Supp. 2009, or §376.383.6, RSMo Supp. 2013 (depending upon the date of submission); and (c) the Company's failure to provide updated EOBs was contrary to the requirements of 20 CSR 100-1.050 (1) (A).

   Reference: §§375.1007(3), (4) and (6), and 376.1367, RSMo, §376.383.5, RSMo Supp. 2009, §376.383.6, RSMo Supp. 2013, and 20 CSR 100-1.050 (1) (A).

   In response to the four criticisms, the Company agreed with the examiners and paid a total of $65.05 in interest during the course of the examination for the claims involved in the four complaints.

3. Criticism #06: The member incurred two emergency room charges for treatment of a cut to his hand. Both the hospital and the treating physician submitted claims to the Company with CPT and ICD-9 codes indicating treatment for an emergency medical condition. The Company denied both the hospital's and the physician's claims on the basis that they were out-of-network providers.

   The member appealed. The Company overturned the denials and paid both claims, but it neither paid interest to the provider, nor provided an updated EOB to the member. In reviewing the complaint file, the examiners noted the Company did not make a request for medical records until the providers inquired about the claims after the denials. In addition, the file notes indicate the Company's system was supposed to automatically pay emergency claims for the submitted ICD-9 code regardless of whether the provider was out-of-network.

   By denying the initial claims for emergency services, making a first request for additional information only after the denial, failing to follow its own procedures for handling emergency claims, failing to pay interest, and failing to provide the member with an updated EOB, it appeared to the examiners that the Company handled these claims in a manner prohibited by §375.1007(3), (4) and (6), RSMo, and contrary to the requirements of §376.1367, RSMo, §376.383.5, RSMo Supp. 2009, and 20 CSR 100-1.050 (1) (A).

   Reference: §§375.1007(3), (4) and (6), and 376.1367, RSMo, §376.383.5, RSMo Supp. 2009, and 20 CSR 100-1.050 (1) (A)

   In response to the criticism, the Company agreed with the examiners and paid $21.37 in interest during the course of the examination.

B. DIFP Consumer Complaints

The examiners reviewed four complaints made through the DIFP's Division of Consumer Affairs for calendar years 2010 through 2012 to determine the Company's handling of the complaints and its adherence to requirements of Missouri law regarding complaints or related issues.

The examiners discovered no issues or concerns in the review.

III. CRITICISM AND FORMAL REQUEST 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 law requires companies to respond to criticisms and formal requests within 10 calendar days. Please note that in the event an extension 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 that time period, the response was not considered timely.

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
Received w/in time-limit, incl. any extensions	11	100.00%
Received outside time-limit, incl. any extensions	0	0.00%
No Response	0	0.00%
Total	11	100.00%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
Received w/in time-limit, incl. any extensions	10	76.92%
Received outside time-limit, incl. any extensions	3	23.08%
No Response	0	0.00%
Total	13	100.00%

The examiners noted the following errors.

The Company took more than 10 days to respond to Formal Requests #03, #08, and #09 even though no request for an extension of the due date was received.

Reference: § 374.205.2(2), RSMo, and 20 CSR 100-8.040

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Human Health Plan, Inc. (NAIC #95885), Examination Number 1308-23-TGT. This examination was conducted by Bunlue Ushupun, John Clubb, Walter Guller, Randy Kemp, and Donald Wilson. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated October 25, 2016. 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.

3/21/2017
Date

Jim Mealer
Chief Market Conduct Examiner