Illinois Department of Insurance

BRUCE RAUNER
Governor

JENNIFER HAMMER
Director

VIA ELECTRONIC MAIL
VIA USPS MAIL

October 31, 2018

Mr. Bruce Dale Broussard
President
Humana Health Plan, Inc.
PO Box 740036
Louisville, KY 40201

Re: Humana Health Plan, Inc., NAIC 95885
Market Conduct Examination Report Closing Letter

Dear Mr. Broussard:

The Department has reviewed your Company's proof of compliance and deems it adequate and sufficient. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Assistant Deputy Director - Market Conduct
Illinois Department of Insurance
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HUMANA INSURANCE COMPANY

HUMANA HEALTH PLAN, INC.

EXAMINATION REPORT

MARKET CONDUCT EXAMINATION REPORT

DATE OF ONSITE EXAMINATION:	June 1, 2015 through November 25, 2015
EXAMINATION OF:	Humana Insurance Company NAIC Number: 73288 Humana Health Plan, Inc. NAIC Number: 95885
LOCATION:	1100 Employers Blvd. De Pere WI, 54115
PERIOD COVERED BY EXAMINATION:	January 1, 2014 through December 31, 2014
EXAMINERS:	Joan McClain, CIE, MCM, FLMI, AIRC, Examiner-In-Charge Gerry Smith, AIE, CPM, MCM, FLMI, AIS, AIRC Parker Stevens, FLMI, AIRC, CIE, CCP, AMCM, MPM Michael Morrissey, MCM, AES, CISA, CISSP Max Weaver, Illinois DOI Examiner Tiffany Jones, Illinois DOI Examiner Craig L. Leonard, CPCU, CCP, CIE, FLMI, ARC, AIAF, ARM Víctor Negron, CIE, MCM, FLMI, IR

Contents

I. SUMMARY

A targeted market conduct examination of Humana Insurance Group, comprised of Humana Insurance Company (HIC) and Humana Health Plan, Inc. (HHP), or collectively known as the "Companies" or the "Group," was performed to determine compliance with the Patient Protection and Affordable Care Act (PPACA), and Qualified and Non-Qualified Health Plans (QHP and NQHP, respectively).

The following represents general findings, however specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

HUMANA INSURANCE COMPANY

Crit #	Statute/Rule	Description of Violation	Population	Files Reviewed	Number of Violations	Findings Section	Error %
3	45 CFR §147.110(a)	QHP Individual Policy Form Review – Discrimination based on health status	25	25	25	1a	100%
6	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	QHP Individual Policy Form Review – Failure to provide Pediatric vision services at least equal to the Illinois benchmark plan	25	25	25	1a	100%
8	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	QHP Individual Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan	25	25	25	1a	100%
20	45 CFR §147.110(a)	NQHP Individual Policy Form Review – Discrimination based on health status	7	7	7	1a	100%
23	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Individual Policy Form Review – Failure to provide Pediatric services at least equal to the Illinois benchmark plan	7	7	7	1a	100%
25	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Individual Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan	7	7	7	1a	100%
38	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Small Group Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan.	1	1	1	1a	100%

41	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Small Group Policy Form Review – Failure to provide Pediatric Services at least equal to the Illinois benchmark plan.	1	1	1	1a	100%
52	45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8	NQHP Individual Denied prescription drug (RX) Claims Review – Failure to provide preventive services, shingles vaccine	20,374	109	1	6d	1%
53	45 CFR §147.130(a)(1)(i) and 50 Ill. Adm. Code 2001.8	NQHP Small Group Paid Claims Review – Failure to provide preventive services, women's health screenings	435,772	184	1	6a	<1%
54	45 CFR §147.200(a)(3) and 50 Ill. Adm. Code 2001.10	QHP/NQHP Individual and Small Group – Failure to provide accurate SBCs	33	4	4	1a	100%
58	45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8	NQHP Small Group Paid Claims Review – Failure to provide preventive services, DTaP vaccine for pregnant women	435,772	184	1	6a	<1%
64	45 CFR §147.126, 50 Ill. Adm. Code 2001.6, 45 CFR §156.115(a)(1)(i) and 50 Ill. Adm. Code 2001.11	NQHP Small Group Denied Claims Review – Listing annual limits for Essential Health Benefits (EHBs) on Explanations of Benefits (EOBs), and providing only optional benefits for Temporomandibular joint dysfunction (TMJ)	44,249	184	63	6c	34%

HUMANA HEALTH PLAN, INC.

Crit #	Statute/Rule	Description of Violation	Population	Files Reviewed	Number of Violations	Findings Section	Error %
15	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	QHP Individual Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan	19	19	19	1a	100%
17	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	QHP Individual Policy Form Review – Failure to provide Pediatric vision services at least equal to the Illinois benchmark plan	19	19	19	1a	100%

32	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Individual Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan	6	6	6	1a	100%
34	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Individual Policy Form Review – Failure to provide Pediatric vision services at least equal to the Illinois benchmark plan	6	6	6	1a	100%
39	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Small Group Policy Form Review – Failure to provide Pediatric vision services at least equal to the Illinois benchmark plan	1	1	1	1a	100%
44	45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11	NQHP Small Group Policy Form Review – Failure to provide services substantially equal to the Illinois benchmark plan	1	1	1	1a	100%
51	45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8	NQHP Small Group Denied RX Claims Review – Failure to pay for a shingles vaccine, a USPSTF preventive service	6,085	108	1	6d	1%
55	45 CFR §147.200(a)(3) and 50 Ill. Adm. Code 2001.10	QHP/NQHP Individual and Small Group – Failure to provide accurate SBCs	26	3	3	1a	100%
56	45 CFR §147.138(a)(3)	NQHP Denied Small Group Medical Claims Review – Failure to allow female participants to obtain services directly from in-network OB/GYN providers care without a referral or preauthorization	2,356	108	3	6c	3%
57	45 CFR §147.138(b)(2)(i)	NQHP Denied Small Group Medical Claims Review – Failure to provide emergency services without preauthorization	2,356	108	2	6c	2%

TABLE OF INTERRELATED FINDINGS

HUMANA INSURANCE COMPANY

Crit #	Statute/Rule	Description of Findings	Population	Files Reviewed	Number of Findings	Findings Section	Error %
46	215 ILCS 5/154.6(h) and 215 ILCS 5/155.36	NQHP Appeals Review - Failure to conduct a reasonable investigation to determine liability prior to denying claims for emergency services	1,411	113	25	4b	22%
47	215 ILCS 5/154.6(h) and 215 ILCS 5/356z.3a	NQHP Appeals Review - Failure to pay for emergency services by a non-network provider	1,411	113	28	4b	25%

HUMANA HEALTH PLAN, INC.

Crit #	Statute/Rule	Description of Findings	Population	Files Reviewed	Number of Findings	Findings Section	Error %
45	215 ILCS 5/154.6(h) and 215 ILCS 5/155.36	NQHP Appeals - Failure to conduct a reasonable investigation to determine liability prior to denying claims for emergency services	141	79	20	A	25%
48	215 ILCS 5/154.6(h)	QHP Appeals - Failure to conduct a reasonable investigation to determine liability prior to denying claims for no referral or no preauthorization, or for use of a non-network provider when the provider was in network	18	18	8	A	44%
49	215 ILCS 5/368a(c)	QHP Appeals - Failure to pay interest on overturned appeals	18	18	2	A	11%
60	215 ILCS 5/154.6(d)	QHP Individual Paid Claims Review - For reducing claim settlements by a $25 or $35 copayment for network provider office visits, when the individual policy for each subscriber states the plan pays 100% of office visits for network provider services	6,983	109	13	B	12%
63	215 ILCS 125/5-3(a)	NQHP Denied Small Group Medical Claims Review – claims were denied when the services rendered were covered by the plan	2,356	108	2	B	2%

II. LIST OF ACRONYMS

Advisory Committee on Immunization Practices (ACIP)
Affordable Care Act (ACA)
Audit Command Language (ACL)
Code of Federal Regulations (CFR)
Comprehensive Health Insurance Plan (CHIP)
Essential Health Benefits (EHB)
Explanation of Benefits (EOB)
Humana Insurance Company (HIC)
Humana Health Plan, Inc. (HHP)
Illinois Compiled Statutes (ILCS)
National Association of Insurance Commissioners (NAIC)
Non-Qualified Health Plans (NQHP)
Patient Protection and Affordable Care Act (PPACA)
Prescription Drug (RX)
Qualified Health Plans (QHP)
Summary of Benefits and Coverage (SBC)
Temporomandibular Joint Dysfunction (TMJ)
United States Preventive Services Task Force (USPSTF)
Women's Health and Cancer Rights Act (WHCRA)
Office of the Commissioners of Insurance (OCI)

III. BACKGROUND

Humana Insurance Company:

Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc. ("Humana"), is a life, accident and health insurance company domiciled in the state of Wisconsin and is subject to regulation by the federal government and the Wisconsin OCI and the insurance departments of the states in which it is licensed. The Company is authorized to sell life, accident and health products in 49 states and the District of Columbia.

Total Direct Premiums Written in Illinois for Health Insurance and other insurance, for HIC was as follows:

Year	Total Written Premium In Illinois (Per Schedule T of the Annual Statement)	Illinois Market Share
2014	$938,023,747	3%

Humana Health Plan, Inc.:

Humana Health Plan, Inc., a wholly owned subsidiary of Humana, is a health maintenance organization domiciled in the Commonwealth of Kentucky and is authorized to sell health plan products there and in the states of Alabama, Arizona, Arkansas, Colorado, Idaho, Illinois, Indiana, Kansas, Missouri, Nebraska, Nevada, New Mexico, Ohio, South Carolina, Tennessee, Texas, Virginia, Washington and West Virginia.

Total Direct Premiums Written in Illinois for Health Insurance and Annuities, for HHP was as follows:

Year	Total Written Premium In Illinois (Per Schedule T of the Annual Statement)	Illinois Market Share
2014	$723,298,534	2%

IV. METHODOLOGY

The Market Conduct Examination covered the business for the period of January 1, 2014 through December 31, 2014. Specifically, the examination focused on a review of the following areas:

- Policy Forms
- Rescissions
- Declinations
- Cancellations
- Marketing and Sales
- Appeals
- Underwriting and Rating
- Claims

The review of the categories was accomplished through examination of QHP and NQHP policy forms, appeals, cancellations, advertising materials, new business application files, and claim files. The Companies stated they had no rescissions or declinations in 2014. Each of the categories was examined for compliance with the ACA.

The report concerns itself with improper practices performed by HIC and HHP, which resulted in a failure to comply with the ACA. Criticisms were prepared and communicated to each of the Companies addressing violations discovered in the review process. All violations were cited in the report.

Samples were selected in accordance with the NAIC *Market Regulation Handbook* utilizing ACL software. The following procedures were used to ensure a uniform methodology for the sampling and review of documents obtained for the examination period:

Policy Forms

1a. Reviewed all policy forms.
1b. Reviewed all claims manuals.
1c. Reviewed a sample of renewal policies.

Rescissions

The Company stated they had no rescissions in 2014. The examiners discovered no evidence to the contrary.

Declinations

The Company stated they had no declinations in 2014. The examiners discovered no evidence to the contrary.

Cancellations

2a. Reviewed all cancellations.

Marketing and Sales

3a. Reviewed advertising materials used during the examination period.

Appeals

4a. Sampled QHP appeals received during the examination period.
4b. Sampled NQHP appeals received during the examination period.

NOTE: Also see the "Interrelated Findings" section of the report, starting on page 16.

Underwriting and Rating

5a. Sampled new QHP business issued during the examination period.
5b. Sampled new NQHP business issued during the examination period.

Claims

6a. Sampled QHP and NQHP health claims paid during the examination period.
6b. Sampled QHP and NQHP RX claims paid during the examination period.
6c. Sampled QHP and NQHP health claims denied during the examination period.
6d. Sampled QHP and NQHP RX claims denied during the examination period.

All claims were reviewed for compliance with policy contracts and applicable sections of the ACA.

NOTE: Also see the "Interrelated Findings" section of the report, starting on page 16.

V. FINDINGS

A. Policy Forms

1a. A review of 66 policy forms produced 9 criticisms for HIC and 8 criticisms for HHP.

- For discrimination based on health status for excluding coverage for intentionally inflicted bodily harm or suicide in violation of 45 CFR §147.110(a) – 32 plans were reviewed resulting in 32 errors - Criticisms 3 (25 errors) and 20 (7 errors) were issued to HIC. The Company agreed with this finding and stated this was removed from the policies.

- For failure to provide Pediatric Services equal to the Illinois benchmark plan, as required by 45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11 – 33 plans were reviewed resulting in 33 errors - Criticisms 6 (25 errors), 23 (7 errors) and 41 (1 error) were issued to HIC for not providing frames for glasses yearly and for excluding premium lens options. For the NQHP plans, the Company was criticized for not providing or excluding several dental services.

  For Criticism #23 the plan limited:

  a. Panoramic x-ray for covered persons to 12 to 19 years of age, and frequency is limited to a maximum of one per every 5 years. The age limitation is not found in the CHIP dental plan (CHIP), and frequency for the CHIP plan is every 5 years;
  b. Sealants to covered persons 14 years of age or younger;
  c. Amalgam restorations (fillings) to a maximum of one per tooth every 2 years;
  d. Crowns are limited to a maximum of one per tooth every 5 years; and
  e. The initial placement of bridges, complete dentures, immediate dentures and partial dentures to one every 5 years. Immediate dentures are limited to one per lifetime. Pediatric dental services include pontics, inlays, onlays, and crowns and are limited to one per tooth every 5 years.

  These limitations were not found in the CHIP plan.

  For Criticism #41 the plan limited:

  a. Amalgam restorations (fillings) to a maximum of 1 per tooth every year;
  b. Composite restorations (fillings) on anterior teeth to a maximum of 1 per tooth per year;
  c. Crowns to a maximum of one per tooth every 5 years. Additionally, metal/porcelain and porcelain crowns are not mentioned in the HIC plan;
  d. Periodontal scaling and root planing to a maximum of 1 every 2 years and 4 quadrants per visit;
  e. Denture adjustments when done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation to a maximum of 2 every year only after six months after initial installation;
  f. The initial placement of bridges, complete dentures, and partial dentures to 1 every 5 years, and immediate dentures to 1 per lifetime;

g. Dental services for pontics, inlays, onlays and crowns to 1 per tooth every 5 years; and
h. Tissue conditioning and denture relines or rebases to a maximum of 1 every 2 years.

These limitations were not found in the CHIP plan.

- For failure to provide Pediatric Services equal to the Illinois benchmark plan, as required by 45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11 – 26 plans were reviewed resulting in 26 errors - Criticisms 17 (19 errors), 34 (6 errors) and 39 (1 error) were issued to HHP for not providing frames for glasses yearly, and for excluding premium lens options. For the NQHP plans, the Company was criticized for not providing or excluding several dental services.

  For Criticism #34 the plan limited:

  a. Panoramic x-ray for covered persons to 12 to 19 years of age, and frequency is limited to a maximum of one per every 5 years. The age limitation is not found in the CHIP dental plan, and frequency for the CHIP plan is every 3 years;
  b. Sealants to covered persons 14 years of age or younger;
  c. Amalgam restorations (fillings) to a maximum of one per tooth every 2 years;
  d. Crowns are limited to a maximum of one per tooth every 5 years; and
  e. The initial placement of bridges, complete dentures, immediate dentures and partial dentures to one every 5 years. Immediate dentures are limited to one per lifetime. Pediatric dental services include pontics, inlays, onlays, and crowns and are limited to one per tooth every 5 years.

  These limitations were not found in the CHIP plan.

  For Criticism #39 the plan limited:

  a. Oral evaluations to a maximum of 1 per provider per lifetime. Benefit is not available when a periodontal evaluation is performed;
  b. Crowns to a maximum of one per tooth every 5 years. Additionally, metal/porcelain and porcelain crowns are not mentioned in the HHP plan;
  c. Initial placement of bridges, complete dentures, immediate dentures and partial dentures to one every 5 years. Immediate dentures are limited to one per lifetime. Pediatric dental services include pontics, inlays, onlays, and crowns and are limited to one per tooth every 5 years;
  d. Periodontal scaling and root planing to a maximum of 1 every 2 years and 4 quadrants per visit;
  e. Denture adjustments when done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation to a maximum of 2 every year only after six months after initial installation;
  f. Initial placement of bridges, complete dentures (upper and lower), and partial dentures (upper and lower) to 1 every 5 years. Immediate dentures are limited to 1 per lifetime. Pediatric dental services include pontics, inlays, onlays, and crowns. Limited to 1 per tooth every 5 years; and
  g. Page 55 under Class III services states that tissue conditioning, and denture relines or rebases to a maximum of 1 every 2 years.

These limitations were not found in the CHIP plan.

- For failure to provide EHBs substantially equal to the Illinois benchmark plan, as required by 45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11 – 33 plans were reviewed resulting in 33 errors – Criticisms 8 (25 errors), 25 (7 errors) and 38 (1 error) were issued to HIC for not providing frames for glasses yearly; premium lens options; care outside the United States; and pediatric dental, behavioral health, and vision services substantially equal to the benchmark plan.

- For failure to provide EHBs substantially equal to the Illinois benchmark plan, as required by 45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11 – 26 plans were reviewed resulting in 26 errors – Criticisms 15 (19 errors), 32 (6 errors) and 44 (1 error) were issued to HHP for not providing frames for glasses yearly, premium lenses, and pediatric dental and vision services equal to the benchmark plan.

- Four (4) SBCs were reviewed for HIC:
  1. Humana National Preferred Bronze 6300/6300 Plan (Individual Plan);
  2. Humana National Preferred Silver 500/750 Plan (Individual Plan);
  3. Humana National Preferred Gold 2500/3500 Plan (Individual Plan); and
  4. Humana Insurance Company: IL SG PPO 14 (Small Group Plan).

  The review produced one (1) criticism as follows for failure to provide an accurate SBC as required by 45 CFR § 147.200(a)(3) and 50 Ill. Adm. Code 2001.10 and the Instructions for Completing the SBC – Individual Health Insurance and the Instructions for Completing the SBC – Group Health Insurance (SBC Instruction Guide). Criticism 54 was issued to HIC.

  The Company changed or altered the required template language or formatting as follows (applies to all four [4] SBCs unless otherwise noted):

  a. Page one and eight, the footer is centered and is to be left justified;
  b. Page five, in the "The Services Your Plan Does NOT Cover" box, "Dental Check-Up" should read as "Dental check-up" and "Hearing Aids" should read as "Hearing aids (applies to the three [3] Individual Plans);"
  c. Page five, in the "The Other Covered Services" box, "Private-duty Nursing" should read as "Private-duty nursing."
  d. Page six, for the Minimum Essential Coverage and Minimum Value Standard disclosures; the term "does provide" is not underlined. (applies only to the HIC Small Group plan).

  On page three of the Bronze SBC, for the "If you need drugs to treat your illness or condition" row, the "Limitations & Exceptions" column fails to indicate that specialty and self-injectable RXs are not covered under the mail order benefit;

  Page one of the SBC, for "Does this plan use a network of providers?" row, under the "Why this Matters" column, the SBCs list the terms "network" and "non-network" instead of the required terms of "in-network" and "out-of-network" (applies to the three [3] Individual Plans);

On the Company website preauthorization list "Chiropractic Therapy" is required to have preauthorization in the state of Illinois, and preauthorization is not indicated in the SBCs on page two in the "Limitations & Exceptions" column (applies to the three [3] Individual Plans);

On page seven of the SBCs for the coverage examples, the "Patient pays" dollar values were not rounded to the nearest $10/$100 contrary to the SBCs' *Instruction Guide for Individual Health Insurance Coverage* and the *Instruction Guide for Group Coverage* (applies to the three [3] Individual Plans);

On page seven of the SBCs, for the coverage examples for "Managing type 2 diabetes," the SBCs do not reflect accurate information based on the plans' information and the manual calculations (applies to all but the Silver Individual SBC);

On page five, in the "Services Your Plan Does NOT Cover" box the Company failed to include Dental check-up and eye glasses for children, as these are noted as "Not covered" in the "Your Cost" columns, page five (applies to Small Group SBC only.)

Note: EHB pediatric vision benefits are to be covered by the plan, per the ACA. The SBC should be changed to include eye exams and glasses for children.

- Three (3) SBCs were reviewed for HHP:
  1. Humana Connect Bronze 6300/6300 Plan (Individual Plan);
  2. Humana Connect Platinum 1000/1500 Plan (Individual Plan); and,
  3. Humana Health Plan, Inc.: IL SHMO CNS 14 (Small Group plan).

  The review produced one (1) criticism as follows for failure to provide an accurate SBC as required by 45 CFR § 147.200(a)(3) and 50 Ill. Adm. Code 2001.10 and the Instructions for Completing the SBC – Individual Health Insurance and the Instructions for Completing the SBC – Group Health Insurance (SBC Instruction Guide). Criticism 55 was issued to HHP:

  The Company changed or altered the required template language or formatting as follows (applies to all three [3] SBCs unless otherwise noted):

  a. Page one and eight, the footer is centered and is to be left justified;
  b. Page five, in the "The Services Your Plan Does NOT Cover" box, "Dental Check-Up" should read as "Dental check-up" and "Hearing Aids" should read as "Hearing aids;" (applies to the two [2] Individual Plans only), and
  c. Page five, in the "The Other Covered Services" box, "Private-duty Nursing" should read as "Private-duty nursing."

  On page three of the Bronze SBC, for the "If you need drugs to treat your illness or condition" row the "Limitation & Exceptions" column fails to indicate that specialty and self-injectable RXs are not covered under the mail order benefit (applies to the Bronze plan only);

Page one of the SBC, for "Does this plan use a network of providers?" row, under the "Why this Matters" column, the SBCs list the terms "network" and "non-network" instead of the required terms of "in-network" and "out-of-network" (applies to the two [2] Individual Plans);

On the Company website preauthorization list "Chiropractic Therapy" is required to have preauthorization in the state of Illinois, and preauthorization is not indicated in the SBCs (applies to all three [3] SBCs);

On page seven of the SBCs for the coverage examples, the "Patient pays" dollar values were not rounded to the nearest $10/$100 contrary to the SBCs' *Instruction Guide for Individual Health Insurance Coverage* and the *Instruction Guide for Group Coverage* (applies to the two [2] Individual Plans);

On page seven of the SBCs, for the coverage examples for "Managing type 2 diabetes," the SBCs do not reflect accurate information based on the plans' information and the manual calculations (applies to the Bronze Individual SBC);

1b. A review of 18 claims manuals produced no criticisms.

1c. A review of 102 Renewals for HIC produced no criticisms.
A review of 15 Renewals for HHP produced no criticisms.

B. Cancellations

2a. A review of 2 Small Group cancellation requests (one group, two members) produced no criticisms.

C. Marketing and Sales

3a. A review of 29 pieces of advertising materials that (per the Company) applied to both QHP and NQHP plans produced no criticisms.

D. Appeals

4a. A review of 46 QHP appeals files produced no criticisms under the ACA.

4b. A review of 192 NQHP appeals files produced no criticisms under the ACA.

NOTE: Also see the Appeals section under "Interrelated Findings" section of the report, starting on page 16.

E. Underwriting and Rating

5a. A review of 228 QHP applications and 228 premium rate files for Individuals produced no criticisms. The Company stated there were no QHP Small Group applications in 2014.

5b. A review of 176 NQHP applications and 176 premium rate files for Small Group produced no criticisms. The Company stated there were no new NQHP Individual applications in 2014.

F. Claims

6a. A review of 807 Paid Medical Claims produced two (2) criticisms as follows:

- For failure to provide preventive services for women's health screenings–as required by 45 CFR §147.130(a)(1)(i) and 50 Ill. Adm. Code 2001.8 – one (1) claim - Criticism 53 was issued to HIC.

- For failure to provide preventive services for immunizations recommended by the ACIP for the DTaP vaccine, as required by 45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8 – one (1) claim - Criticism 58 was issued to HIC.

6b. A review of 650 Paid RX Claims produced no criticisms.

6c. A review of 776 Denied Medical Claims produced three (3) criticisms as follows:

- For failure to allow female participants to obtain services directly from in-network providers specializing in OB/GYN care without first obtaining a referral or preauthorization from the plan as required by 45 CFR §147.138(a)(3) – three (3) claims – Criticism 56 was issued to HHP.

- For failure to provide coverage for emergency services because no referral or preauthorization was on file as required by 45 CFR §147.138(b)(2)(i) – two (2) claims – Criticism 57 was issued to HHP.

- For listing annual limits for EHBs on the EOBs in violation of 45 CFR §147.126 and 50 Ill. Adm. Code 2001.6, and for providing only "optional" benefits for TMJ, treatment for TMJ is an EHB covered under the Illinois benchmark plan, and therefore HIC is in violation of 45 CFR §156.115(a)(1)(i) and 50 Ill. Adm. Code 2001.11 – 63 claim EOBs – Criticism 64 was issued to HIC.

6d. A review of 625 Denied RX Claims produced two (2) criticisms as follows:

- For failure to provide preventive services for immunizations recommended by the ACIP for the Shingles vaccine, as required by 45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8 – one (1) claim - Criticism 51 was issued to HHP.

- For failure to provide preventive services for immunizations recommended by the ACIP for the Shingles vaccine, as required by 45 CFR §147.130(a)(1)(ii) and 50 Ill. Adm. Code 2001.8 – one (1) claim - Criticism 52 was issued to HIC.

NOTE: Also see the Claims section under "Interrelated Findings" section of the report, starting on page 16.

VI. INTERRELATED FINDINGS

A. Appeals

A review of 46 QHP appeals files produced two (2) criticisms under Illinois law as follows:

- For failure to conduct a reasonable investigation to determine liability prior to denying claims for no referral or no preauthorization, or for use of a non-network provider when the provider was in network as required by 215 ILCS 5/154.6(h) - 8 appeals – Criticism 48 was issued to HHP. The Company agreed with these findings.

- For failure to pay interest on overturned claims as required by 215 ILCS 5/368a(c) - 2 appeals – Criticism 49 was issued to HHP. The Company agreed with these findings.

A review of 192 NQHP appeals files produced three (3) criticisms under Illinois law as follows:

- For failure to conduct a reasonable investigation to determine liability prior to denying claims for emergency services as required by 215 ILCS 5/154.6(h) and 5/155.36 - 20 appeals – Criticism 45 was issued to HHP. The Company agreed with these findings.

- For failure to conduct a reasonable investigation to determine liability prior to denying claims for emergency services as required by 215 ILCS 5/154.6(h) and 5/155.36 - 25 appeals – Criticism 46 was issued to HIC. The Company agreed with these findings.

- For failure to conduct a reasonable investigation to determine liability prior to denying claims for non-network providers in an emergency room setting as required by 215 ILCS 5/154.6(h) and 5/356z.3a - 28 appeals – Criticism 47 was issued to HIC. The Company agreed with these findings.

B. Claims

A review of 807 Paid Medical Claims produced one (1) criticism under Illinois law for engaging in activity which does not result in fair and equitable settlement of claims as required by 215 ILCS 5/154.6(d) (failure to provide at no cost sharing, in-network health care practitioner office visits when the individual policy for each subscriber states the plan pays 100% of office visits for health care practitioner services. 11 claim EOBs noted an incorrect $25 copay, and two (2) claim EOBs noted a $35 copay). Criticism 60 was issued to HHP. The Company agreed with the findings.

A review of 776 Denied Medical Claims produced one (1) criticism under Illinois law as for engaging in activity which does not result in fair and equitable settlement of claims. Two (2) claims were denied when the services rendered were covered by the plan in violation of 215 ILCS 125/5-3(a). Criticism 63 was issued to HHP. The Company agreed with the findings.

In the Company's response to Information Request Form 42 and Criticism 64, HIC stated that the annual dollar limits were removed from the EOBs in 2015, and provided an example as evidence. However, it was noted on this 2015 EOB that HIC imposed therapy visit limits for autism, physical, occupation and speech therapies which are not in the EHB Illinois benchmark plan. In addition, HIC imposes a ten visit limit for inpatient Behavioral/Mental

Health stays. Since the therapies and inpatient Behavioral/ Mental Health benefits are EHBs, HIC should follow the Illinois benchmark plan and not impose visit limits for the above noted benefits in order to be in compliance (no criticism was issued).

C. 2015 SBC Review

HHP Small Group SBC REVIEW

1. The following formatting errors were noted:
   a. Pages one through eight, the footer is centered on the pages and should be left justified;
   b. Page three, row shading is off starting with "Level 3" prescriptions;
   c. Page six, in the "Your Rights to Continue Coverage" disclosure, second line, the term "premium" is not bolded as per the guidelines; and
   d. Page six, Minimum Essential Coverage disclosure, the closing quotation is missing after "coverage."
2. For the "Does this plan use a network of providers?" row under the "Why this Matters" column, lines one through three, the terms "network" and "non-network" are used in place of the required terms "in-network" and "out-of-network." Also, on line four, the term "participating" is underlined and should not be and the term "provider" should be underlined and is not.
3. Page five, in the "Other Covered Services" box, "Private duty nursing" should read as "Private-duty nursing." Also, an additional bullet point is used without a service provided.
4. Page five, in the "Services Your Plan Does NOT Cover" box, "Long term care" should read as "Long-term care."
5. Page six, Minimum Essential Coverage disclosure, the terms "does provide" are not underlined as per the guidelines.
6. Page six, Minimum Value Standard disclosure, the terms "does provide" are not underlined as per the guidelines.
7. The "Patient pays" amounts under the "Having a baby" example is $2,170 for copays and under the "Managing type 2 diabetes" example is $2,090 for copays. The dollar limits were not rounded to the nearest $100 contrary to the SBCs' *Instruction Guide for Group Coverage*.
8. Page eight, "Managing type 2 diabetes" example, the SBC shows the plan to pay $3,290 and the manual calculation shows the plan to pay $4,470 with a difference of $1,180.
9. Page two (Limitations & Exceptions column) for "Chiropractic care," the SBC does not list the preauthorization requirement noted on the website.

HIC Small Group SBC REVIEW

1. The following formatting errors were noted:
   a. The footer must appear at the bottom left of the page and is centered on pages one and eight; and
   b. Page two, "Preventive care/screening/immunization" row should be shaded and is not.
2. For the "Does this plan use a network of providers?" row, under the "Why this Matters" column, fourth line, the term "network" is used in place of the required term "in-network."

3. Page five, in the "Other Covered Services" box, "Private duty nursing" should read as "Private-duty nursing" as per the guidelines.
4. Page five, in the "Services Your Plan Does NOT Cover" box, "Non Emergent Care received from foreign providers" is used in place of the required language "Non-emergency care when traveling outside the U.S."
5. Page six, Minimum Essential Coverage disclosure, the terms "does provide" are not underlined as per the guidelines.
6. Page two (Limitations & Exceptions column), the SBC does not list the preauthorization requirement noted on the website.

HIC BASIC Individual SBC REVIEW

1. The following formatting errors were noted:
    a. Pages one and eight, the footer is centered on the pages and it belongs on the bottom left of the page;
    b. Page one, the "Answers" and "Why this Matters" columns are not centered justified as per the guidelines;
    c. Pages two through four, the "Services You May Need," "Your Cost" and "Limitations & Exceptions" columns are not centered justified as per the guidelines;
    d. Pages one and eight, additional text of "IL IC-CHI HMOx" appears below the table; and
    e. Page three, row shading is not replicated as per the guidelines.
2. For the "Does this plan use a network of providers?" row under "Why this Matters" column, lines one through three, the terms "network and "non-network" are used in place of the required terms "in-network" and "out-of-network."
3. Page five, in the "Other Covered Services" box, "Private-duty Nursing" should read as "Private-duty nursing" as per the guidelines.
4. Page five, in the "Services Your Plan Does NOT Cover" box, "Hearing Aids" should read as "Hearing aids" as per the guidelines.
5. Page two (Limitations & Exceptions column) for "Chiropractic care," the SBC does not list the preauthorization requirement noted on the website.
6. Page 23, item 9 of the policy, it states that one set of Hearing aids every 3 years are provided for a covered person through 18 years of age. However, "Hearing aids" are excluded on page five of the SBC in the excluded services box.

HHP Bronze 4850/Chicago HMOx Individual SBC Review

1. The following formatting errors were noted:
    a. Pages one and eight, the footer is centered on the pages and it belongs on the bottom left of the page;
    b. Page one, the answers and why this matters columns are not centered justified as per the guidelines;
    c. Pages two through four, the "Services You May Need," "Your cost" and "Limitations & Exceptions" columns are not centered justified as per the guidelines;
    d. Pages one and eight, additional text of "IL IC-CHI HMOx" appears below the table; and
    e. Page two and four, the row shading is not replicated.
2. The website link listed does not provide easy access to the plan documents. The website requires registration or entering personal info to access cost sharing, etc.

3. For the “Does this plan use a network of providers?” row under “Why this Matters” column, lines one through three, the terms “network” and “non-network” are used in place of the required terms “in-network” and “out-of-network.”
4. Page five, in the “Other Covered Services” box, “Private-duty Nursing” should read as “Private-duty nursing” as per the guidelines.
5. Page five, in the “Services Your Plan Does NOT Cover” box, “Hearing Aids” should read as “Hearing aids” as per the guidelines.
6. Page two (Limitations & Exceptions column), for “Chiropractic care,” the SBC does not list the preauthorization requirement noted on the website.
7. Page 24, item 9 of the policy, it states that one set of Hearing aids every 3 years are provided for a covered person through 18 years of age. However, “Hearing aids” are excluded on page five of the SBC in the excluded services box.
8. Page seven, “Managing type 2 diabetes” example, the SBC shows the plan to pay $3,080 and the manual calculation shows the plan to pay $940 with a difference of $2,140.

The noted items were communicated to the Company and corrected.

STATE OF FLORIDA)
) ss
COUNTY OF LEON)

Joan McClain being first duly sworn upon his/her oath deposes and says:

That she was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Humana Insurance Company of Illinois, and Humana Health Plan, Inc. (the "Companies"), NAIC #73288 and 95885 (respectively);

That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Companies' business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she/he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Company.

Joan McClain
Examiner-In-Charge

Subscribed and sworn to before me
this 2nd day of December, 2015.

John Paul Sinclair, Jr.
Notary Public

JOHN PAUL SINCLAIR, JR.
MY COMMISSION # EE 855472
EXPIRES: March 30, 2017
Bonded Thru Notary Public Underwriters

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HUMANA INSURANCE COMPANY
HUMANA HEALTH PLAN, INC.
500 WEST MAIN STREET
LOUISVILLE, KY 40202

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Humana Insurance Company ("HIC"), NAIC 73288, and Humana Health Plan, Inc. ("HHP"), NAIC 95885 (collectively the "Companies"), are authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Companies was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Companies were not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), Department Regulations (50 Ill. Adm. Code 101 *et seq.*), the federal Patient Protection and Affordable Care Act (42 U.S.C. § 18001 *et seq.*), and related federal regulations (45 CFR §§ 147, 156).

WHEREAS nothing herein contained, nor any action taken by the Companies in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Companies; and

WHEREAS, the Companies are aware of and understand their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Companies understand and agree that by entering into this Stipulation and Consent Order, they waive any and all rights to notice and hearing; and

WHEREAS, the Companies and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS AGREED by and between the Companies and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Companies were not in compliance with provisions of the Illinois Insurance Code and Department Regulations, as well as the federal Patient Protection and Affordable Care Act and related federal regulations; and

2. The Director and the Companies consent to this Order requiring the Companies to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations, as well as the federal Patient Protection and Affordable Care Act and related federal regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Companies shall:

1. Institute and maintain policies and procedures whereby HIC shall ensure it will not discriminate based on health status by excluding coverage for inflicted bodily harm or suicide as required by 45 CFR §147.110(a).

2. Institute and maintain policies and procedures whereby HIC and HHP will provide services substantially equal to the Illinois benchmark plan as required by 45 CFR §156.115(a)(1) and 50 Ill. Adm. Code 2001.11.

3. Institute and maintain policies and procedures whereby HIC and HHP shall provide accurate Summaries of Benefits and Coverage as required by 45 CFR §147.200(a)(3) and 50 Ill. Adm. Code 2001.10.

4. Institute and maintain policies and procedures whereby HIC shall refrain from listing annual limits for Essential Health Benefits on Explanations of Benefits, and refrain from providing only optional benefits for Temporomandibular Joint Dysfunction as required by 45 CFR §147.126 and 50 Ill Adm. Code 2001.6, and 45 CFR §156.115(a)(1)(i) and 50 Ill. Adm. Code 2001.11 respectively.

5. Institute and maintain policies and procedures whereby HIC and HHP shall conduct a reasonable investigation to determine liability prior to denying claims for emergency services as required by 215 ILCS 5/154.6(h) and 5/155.36.

6. Institute and maintain policies and procedures whereby HIC shall conduct a reasonable investigation to determine liability prior to denying claims for emergency services provided by a non-network provider as required by 215 ILCS 5/154.6(h) and 215 ILCS 5/356z.3a.

7. Institute and maintain policies and procedures whereby HHP shall conduct a reasonable investigation to determine liability prior to denying claims for no referral or no preauthorization, or for use of a non-network provider when the provider was in network as required by 215 ILCS 5/154.6(h).

8. Institute and maintain policies and procedures whereby HHP shall pay interest on claims denied but later overturned on appeal as required by 215 ILCS 5/368a(c).

9. Institute and maintain policies and procedures whereby HHP shall refrain from engaging in activity which does not result in the fair and equitable settlement of claims, and shall not apply copays to office visits where the policy at issue states the plan pays 100% of office visits for health care practitioner services, as required by 215 ILCS 5/154.6(d).

10. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above nine (9) orders within 30 days of execution of this Order.

11. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $77,750.00 ($53,000 -- HIC, $24,750 -- HHP) to be paid within 30 days of execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to, levying additional forfeitures, should the Companies violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations, or the Patient Protection and Affordable Care Act and related regulations under the Department's jurisdiction.

On behalf of **Humana Insurance Company and Humana Health Plan, Inc.**

Signature

Christopher H. Hunter
Name

President, Employer Group + Military
Title

Subscribed and sworn to before me this
17th day of October 2018.

Notary Public

ALICE M. ROBINSON
Notary Public -
State of Kentucky
Notary ID # 549803
My Commission Expires Feb. 2, 2020

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 10/18/18

Jennifer Hammer
Director