



**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

MARKET CONDUCT  
EXAMINATION REPORT

OF

**HUMANA INSURANCE COMPANY  
DE PERE, WI**

As of: June 28, 2012  
Issued: August 23, 2012

**BUREAU OF MARKET ACTIONS  
LIFE AND HEALTH DIVISION**

# **HUMANA INSURANCE COMPANY**

## **TABLE OF CONTENTS**

<b>I.</b>	<b>Introduction</b>	<b>3</b>
<b>II.</b>	<b>Scope of Examination</b>	<b>6</b>
<b>III.</b>	<b>Company History and Licensing</b>	<b>7</b>
<b>IV.</b>	<b>Advertising</b>	<b>8</b>
<b>V.</b>	<b>Forms</b>	<b>9</b>
<b>VI.</b>	<b>Producer Licensing</b>	<b>10</b>
<b>VII.</b>	<b>Consumer Complaints</b>	<b>11</b>
<b>VIII.</b>	<b>Underwriting</b>	<b>13</b>
<b>A.</b>	<b>Underwriting Guidelines</b>	<b>14</b>
<b>B.</b>	<b>Group Vision Certificates Issued</b>	<b>15</b>
<b>C.</b>	<b>Group Accidental Death and Dismemberment Certificates Issued</b>	<b>15</b>
<b>D.</b>	<b>Group Basic Life Certificates Issued</b>	<b>15</b>
<b>E.</b>	<b>Group Vision Master Policies Issued</b>	<b>16</b>
<b>F.</b>	<b>Group Accidental Death and Dismemberment Master Policies Issued</b>	<b>16</b>
<b>G.</b>	<b>Group Basic Life Insurance Master Policies Issued</b>	<b>16</b>
<b>H.</b>	<b>Individual Medicare Supplement Policies Issued 1990</b>	<b>17</b>
<b>I.</b>	<b>Individual Medicare Supplement Policies Issued 2010</b>	<b>18</b>
<b>J.</b>	<b>Individual Medicare Supplement Policies Issued as Replacements 1990</b>	<b>18</b>
<b>K.</b>	<b>Individual Medicare Supplement Policies Issued as Replacements 2010</b>	<b>20</b>
<b>L.</b>	<b>Individual Medicare Supplement Policies Declined 1990</b>	<b>21</b>
<b>M.</b>	<b>Individual Medicare Supplement Policies Declined 2010</b>	<b>22</b>
<b>IX.</b>	<b>Claims &amp; Claims Manuals</b>	<b>23</b>
<b>A.</b>	<b>Group Life Insurance Claims</b>	<b>24</b>
<b>B.</b>	<b>Group Vision Insurance Claims</b>	<b>25</b>
<b>C.</b>	<b>Individual Medicare Supplement Claims Paid 1990</b>	<b>26</b>
<b>D.</b>	<b>Individual Medicare Supplement Claims Paid 2010</b>	<b>26</b>
<b>E.</b>	<b>Individual Medicare Supplement Claims Denied 1990</b>	<b>27</b>

<b>F.</b>	<b>Individual Medicare Supplement Claims Denied 2010</b>	<b>27</b>
<b>G.</b>	<b>Individual Medicare Supplement Adjusted 1990</b>	<b>28</b>
<b>H.</b>	<b>Individual Medicare Supplement Adjusted 2010</b>	<b>28</b>
<b>I.</b>	<b>Individual Medicare Supplement Claims History 1990</b>	<b>29</b>
<b>J.</b>	<b>Individual Medicare Supplement Claims History 2010</b>	<b>29</b>
<b>K.</b>	<b>Individual Medicare Advantage Cross-Selling</b>	<b>30</b>
<b>L.</b>	<b>Group Medicare Advantage Cross-Selling</b>	<b>30</b>
<b>X.</b>	<b>Internal Audit &amp; Compliance Procedures</b>	<b>32</b>
<b>XI.</b>	<b>Recommendations</b>	<b>34</b>
<b>XII.</b>	<b>Company Response</b>	<b>35</b>

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27<sup>th</sup> day of April, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



  
Michael F. Consedine  
Insurance Commissioner

Humana Insurance Company  
Market Conduct Examination as of the  
close of business on May 25, 2012

Docket No.  
MC12-08-015

### **ORDER**

A market conduct examination of Humana Insurance Company (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, et seq., for the period January 1, 2010, through December 31, 2010. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices. Based on the documentation and information submitted by Respondent, the Department is satisfied that Respondent has taken corrective measures pursuant to the recommendations of the Examination Report.

It is hereby ordered as follows:

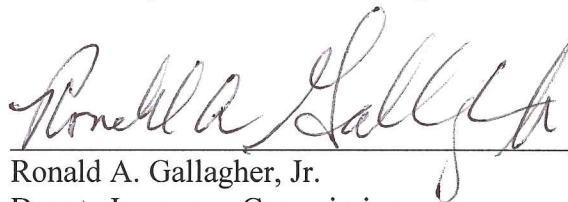
1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.
2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with all recommendations contained in the attached Report.

4. Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: The Pennsylvania Insurance Department

A handwritten signature in dark ink, appearing to read "Ronald A. Gallagher, Jr.", is written over a horizontal line.

Ronald A. Gallagher, Jr.  
Deputy Insurance Commissioner

August 23, 2012

## **I. INTRODUCTION**

The Market Conduct Examination was conducted on Humana Insurance Company; hereafter referred to as “Company,” at the Company’s office located in Daytona Beach, FL from August 21, 2011, through May 25, 2012. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige  
Market Conduct Division Chief

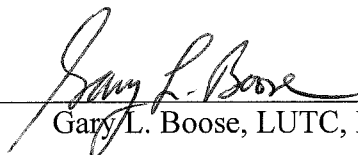
Gary L. Boose, LUTC, MCM  
Market Conduct Examiner

Lonnie Suggs, MCM  
Market Conduct Examiner



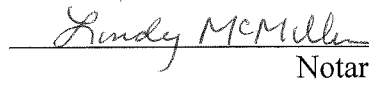
**VERIFICATION**

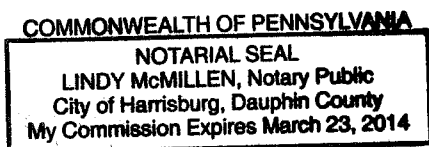
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

  
\_\_\_\_\_  
Gary L. Boose, LUTC, MCM

Sworn to and Subscribed Before me

This 6<sup>th</sup> Day of June, 2012

  
\_\_\_\_\_  
Notary Public



## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2010, through December 31, 2010, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Advertising, Producer Licensing, Consumer Complaints, Forms, Underwriting Practices and Procedures, Rating and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

### **III. COMPANY HISTORY AND LICENSING**

Humana Insurance Company (HIC) commenced business on June 23, 1983, and was incorporated in the State of Wisconsin on December 18, 1968 as Fireman's Fund Employers Insurance Company. It changed its name to Employers Health Insurance Company on April 1, 1986 and then to Humana Insurance Company on December 31, 2001. The company received its certificate of authority to operate in the Commonwealth of Pennsylvania on September 26, 1983. HIC is licensed in all states and the District of Columbia with the exception of except New York.

Humana Insurance Company is one of the many affiliated companies within the Humana health system operating under holding company, Humana, Inc.

Humana Insurance Company product offerings in Pennsylvania include life, accidental death & dismemberment, Medicare Supplement and Medicare Advantage.

As of their 2010 annual statement for Pennsylvania, the Company reported direct premium for life insurance in the amount of \$32,389.00; and direct premium earned for Medicare Supplement in the amount of \$4,179,557.00

#### **IV. ADVERTISING**

The Department, in exercising its discretionary authority requested, received and reviewed the Company's Advertising Certificate of Compliance. The certification was reviewed to ensure compliance with Title 31, Pennsylvania Code, Section 51.5. Section 51.5 provides that "A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth." No violations were noted.

## **V. FORMS**

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law Section 354 and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Notice. No violations were noted.

## **VI. PRODUCER LICENSING**

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of or as a representative of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all producer terminations to the Department.

The Company provided a list of 6,713 active and 2,543 inactive producers. A random sample of 50 active and 50 inactive producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam. No violations were noted.

## **VII. CONSUMER COMPLAINTS**

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2006, 2007, 2008 and 2009. The Company identified 12 consumer complaints received during the experience period. Of the 12 complaints files identified, 4 were forwarded from the Department. All 12 complaint files were requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. The following violations were noted:

**2 Violations - Title 31, Pennsylvania Code, Section 146.5.** (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Verification of the Company's acknowledgement within 10 working days could not be established in the noted complaint files.

**2 Violations – Act 205, Section 5 (40 P.S. §1171.5)(a)(10)(iii)**

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies in the noted files.



## **VIII. UNDERWRITING**

The Underwriting review consisted of 4 general segments:

1. Underwriting Guideline
2. Group Certificates Issued
3. Group Master Policies Issued
4. Individual Policies Issued

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

## **A. Underwriting Guidelines**

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following guidelines were reviewed:

1. Eligibility.
2. Dependent Coverage.
3. Participation/Contribution.
4. Life and Voluntary Life.
5. Basic Life.
6. Voluntary Life.
7. Vision Manual.
8. Underwriting & Application Guide.
9. Process Narrative.

### **B. Group Vision Certificates Issued**

The Company was requested to provide a list of all group certificates issued during the experience period. The Company provided a list of 323 group vision certificates issued. A random sample of 10 group vision certificates issued was requested, received and reviewed. The files were reviewed to ensure compliance with Commonwealth of Pennsylvania Statutes and Regulations. No violations were noted.

### **C. Group Accidental Death and Dismemberment Certificates Issued**

The Company was requested to provide a list of all group certificates issued during the experience period. The Company provided a list of 122 group accidental death and dismemberment certificates issued. A random sample of 10 group certificates issued was requested, received and reviewed. The files were reviewed to ensure compliance with Commonwealth of Pennsylvania Statutes and Regulations. No violations were noted.

### **D. Group Basic Life Certificates Issued**

The Company was requested to provide a list of all group certificates issued during the experience period. The Company provided a list of 122 group basic life certificates issued. A random sample of 10 group life certificates issued was requested, received and reviewed. The certificate files were reviewed to ensure compliance with Commonwealth of Pennsylvania Statutes and Regulations. No violations were noted.

### **E. Group Vision Master Policies Issued**

The Company was requested to provide a list of all group master policies issued during the experience period. The Company identified 4 group vision master policy files issued. All 4 group vision master policy files were requested, received, and reviewed. The group master policy files were reviewed to determine compliance to Commonwealth of Pennsylvania issuance Statutes and Regulations. No violations were noted.

### **F. Group Accidental Death and Dismemberment Master Policies Issued**

The Company was requested to provide a list of all group master policies issued during the experience period. The Company identified 4 group accidental death and dismemberment master policy files issued. All 4 group master policy files were requested, received, and reviewed. The group master policy files were reviewed to determine compliance to Commonwealth of Pennsylvania issuance Statutes and Regulations. No violations were noted.

### **G. Group Basic Life Insurance Master Policies Issued**

The Company was requested to provide a list of all group master policies issued during the experience period. The Company identified 4 group basic life insurance master policy files issued. All 4 group master policy files were requested, received, and reviewed. The group master policy files were reviewed to determine compliance to Commonwealth of Pennsylvania issuance Statutes and Regulations. No violations were noted.

## **H. Medicare Supplement Policies Issued 1990**

The Company was requested to provide a list of all policies issued during the experience period. The Company provided a list of 103 Medicare Supplement policies issued of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. A random sample of 10 policies was requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

### **10 Violations – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted files.

## **I. Individual Medicare Supplement Policies Issued 2010**

The Company was requested to provide a list of all policies issued during the experience period. The Company provided a list of 88 Medicare Supplement policies issued of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. A random sample of 10 policies was requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

## **J. Individual Medicare Supplement Policies Issued as Replacements 1990**

The Company was requested to provide a list of all policies issued during the experience period. The Company provided a list of 7 Medicare Supplement policies issued as replacements of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. All 7 policies were requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

### **7 Violations – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and

in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted files.

**7 Violations – Title 31, Pennsylvania Code, Section 89.783(d)(1).**

(d) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant. Acknowledgment of receipt of the *Outline of Coverage* by the applicant could not be established in the noted files.

**1 Violation – Title 31, Pennsylvania Code, Section 89.784.**

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant

by the insurer upon delivery of the policy. The required replacement statement and question was blank on the noted application.

#### **K. Medicare Supplement Policies Issued as Replacements 2010**

The Company was requested to provide a list of all policies issued during the experience period. The Company provided a list of 19 Medicare Supplement policies issued as replacements of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. All 19 policies were requested, received, and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

##### **1 Violation – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of



receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted file.

**1 Violation – Title 31, Pennsylvania Code, Section 89.783 (d)(1)**

(d) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant. Acknowledgment of receipt of the *Outline of Coverage* by the applicant could not be established in the noted file.

**1 Violation – Title 31, Pennsylvania Code, Section 89.784**

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. The required replacement statement and question was blank on the noted application.

**L. Individual Medicare Supplement Policy Declined 1990**

The Company was requested to provide a list of all policies declined during the experience period. The Company identified 11 Medicare Supplement policies

declined of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. All 11 files were requested, received and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and the proper return of any unearned premium. No violations were noted.

#### **M. Individual Medicare Supplement Policies Declined 2010**

The Company was requested to provide a list of all policies declined during the experience period. The Company identified 1 Medicare Supplement policy declined of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. The 1 file was requested, received and reviewed. The file was reviewed to ensure that the declination was not the result of any discriminatory underwriting practice and that the proper return of premium, if any, was returned. No violation was noted.

## **X. CLAIMS & CLAIMS MANUALS**

The claims review consisted of a review of the Company's claims manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following claims manual material:

Vision Care Plan Claims Procedure Manuals (18 Sections)

Vision Care Routine Training Schedule (for claims)

- Vision Claims Policies and Procedures
- Auditing Processes
- Claims Quality Organization Audit Guidelines
- Claims Routine Training Schedule

Life Claim Guidelines

Medicare Supplement Claims Overview

- Processing Guidelines for Medicare Supplement Claims
- Medicare Crossover
- Medicare Supplement Claims Overview
- Claims Training
- Claims Audit Guidelines

The claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted. The claim file review consisted of 10 areas:

- A. Group Life Insurance Claims
- B. Group Vision Insurance Claims
- C. Individual Medicare Supplement Claims Paid 1990
- D. Individual Medicare Supplement Claims Paid 2010
- E. Individual Medicare Supplement Claims Denied 1990
- F. Individual Medicare Supplement Claims Denied 2010
- G. Individual Medicare Supplement Adjusted 1990
- H. Individual Medicare Supplement Adjusted 2010
- I. Individual Medicare Supplement Claims History 1990
- J. Individual Medicare Supplement Claims History 2010

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

#### **A. Group Life Insurance Claims**

The Company was requested to provide a list of claims received during the experience period. The Company identified 1 group life insurance claim received. The group life insurance claim was requested, received and reviewed. The group life insurance claim file was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

##### **1 Violation – Title 31, Pennsylvania Code, Section 146.5**

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and

dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant who reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so That first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Verification of acknowledgement within 10 working days could not be established in the noted claim file.

### **1 Violation – Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. Verification of a timely status letter could not be established in the noted claim file.

**1 Violation – Act 205, Section 5 (40 P.S. §1171.5(a)(10)(iii))**

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; in the noted file.

**B. Group Vision Insurance Claims**

The company was requested to provide a list of claims received during the experience period. The Company identified a universe of 34 vision insurance claims received.

All 34 vision insurance claims were requested, received and reviewed. The Department identified the claims as group vision insurance claims received during the experience period. The claims that were submitted by providers were reviewed for compliance with Act 68, Prompt Payment of Claims. The claims that were submitted by the insured were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

**2 Violations – Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 157 sampled clean claims paid over 45 days were reviewed to validate the

accuracy of the claim report data provided by the Company. The noted clean claims were not paid within 45 days of receipt.

### **C. Individual Medicare Supplement Claims Paid 1990**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 83,603 Medicare Supplement claims paid of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. A random sample of 20 claims was requested, received and reviewed. All 20 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

### **D. Individual Medicare Supplement Claims Paid 2010**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 1,297 Medicare Supplement claims paid of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. A random sample of 10 claims was requested, received and reviewed. All 10 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files

were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

#### **E. Individual Medicare Supplement Claims Denied 1990**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 349,725 Medicare Supplement claims denied of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. A random sample of 50 claims was requested, received and reviewed. All 50 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

#### **F. Individual Medicare Supplement Claims Denied 2010**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 5,561 Medicare Supplement claims denied of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. A random sample of 50 claims was requested, received and reviewed. All 50 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files



were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

#### **G. Individual Medicare Supplement Claims Adjusted 1990**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 1,335 Medicare Supplement claims adjusted of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. A random sample of 25 claims was requested, received and reviewed. All 25 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

#### **H. Individual Medicare Supplement Claims Adjusted 2010**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 5 Medicare Supplement claims adjusted of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. All 5 claims were requested, received and reviewed. All 5 claims were provider submitted. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166),

Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

### **I. Individual Medicare Supplement Claims History 1990**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 541 Medicare Supplement claims history of the 1990 classification. The 1990 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010. A random sample of 10 claims was requested, received and reviewed. All 10 claims were identified by the Company as “history” because they were re-adjudicated. The claim files were subject to coinsurance based on the Medicare Explanation of Benefits (EOB). The claim files had erroneously applied cost sharing on the coinsurance based on the Medicare Supplement Plans B, C, F and High Deductible F benefit. The claim files were re-adjudicated to reverse the erroneous cost sharing. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **J. Individual Medicare Supplement Claims History 2010**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 8 Medicare Supplement claims history of the 2010 classification. The 2010 classification represents the Standardized Medicare Supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010. All 8 claims were requested, received and reviewed. All 8 claims were identified by the Company as “history” because they were re-adjudicated. The claim files were subject to coinsurance based on the Medicare Explanation of Benefits (EOB). The claim files had erroneously applied cost sharing on the coinsurance based on the Medicare Supplement Plan F benefit. The claim files were re-adjudicated to reverse the erroneous cost sharing. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **K. Individual Medicare Advantage Cross-Selling**

The Company was requested to provide a list of all Medicare Advantage individual policies issued during the experience period. The Company provided a list of 4,021 Medicare Advantage individual policies issued. A random sample of 50 Medicare Advantage individual policies issued files was requested, received, and reviewed. Effective September 18, 2008 marketing to current plan members of Non-Medicare Advantage plan covered health-care products, is subject to the Health Insurance Portability and Accountability Act (HIPPA) rules. Marketing non-health related

products, such as annuities and life insurance to prospective enrollees during Medicare Advantage sales activity or presentations is considered “cross selling” and is prohibited. This sales action is subject to a 48 hour waiting period. The files were reviewed to determine if non-health care related products, such as annuities and life insurance were sold to prospective enrollees during any Medicare Advantage sales activities. No violations were noted.

#### **L. Group Medicare Advantage Cross-Selling**

The Company was requested to provide a list of all Medicare Advantage group certificates issued during the experience period. The Company identified 53 Medicare Advantage group certificates issued. A random sample of 25 Medicare Advantage group certificates issued files was requested, received, and reviewed. Effective September 18, 2008 marketing to current plan members of Non-Medicare Advantage plan covered health-care products, is subject to the Health Insurance Portability and Accountability Act (HIPPA) rules. Marketing non-health related products, such as annuities and life insurance to prospective enrollees during Medicare Advantage sales activity or presentations is considered “cross selling” and is prohibited. This sales action is subject to a 48 hour waiting period. The files were reviewed to determine if non-health care related products, such as annuities and life insurance were sold to prospective enrollees during any Medicare Advantage sales activities. No violations were noted.

## **IX. INTERNAL AUDIT & COMPLIANCE PROCEDURES**

The Company was requested to provide copies of their internal audit and compliance procedures utilized during the experience period. The audits and procedures were reviewed to ensure compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides for the establishment and maintenance of internal audit and compliance procedures which provides for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising, and filing and approval requirements for life insurance and annuities. The procedures shall also provide for the following:

Periodic reviews of consumer complaints in order to determine patterns of improper practices.

They performed regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.

The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

The Company is not a member of The Insurance Marketplace Standards Association (IMSA).

No violations were noted.

## **X. RECOMMENDATIONS**

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise internal control procedures to ensure compliance with prompt and fair claims settlement requirements of Section 5 of the Unfair Insurance Practices Act 205 of 1974 (40 P.S. section 1171).
2. The Company must review and revise internal control procedures to ensure compliance with prompt and fair claims settlement requirements of Section 5 of the Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 PS § 991.2166), Prompt Payment of Provider Claims (A).
3. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
4. The Company must review internal control procedures to ensure compliance with disclosure requirements of Title 31, Pennsylvania Code, Chapter 89.

## **XI. COMPANY RESPONSE**



July 25, 2012

Yonise Roberts Paige  
Chief, Life and Health Division  
Pennsylvania Insurance Department  
Market Action Bureau  
1321 Strawberry Square  
Harrisburg, PA 17120

RE: Response to Draft Report of Examination  
Examination Warrant Number: 11-M24-002  
Humana Insurance Company, NAIC # 73288

Dear Ms. Paige:

Humana Insurance Company ("Humana" or "HIC") is in receipt of the Pennsylvania Insurance Department's DRAFT Report of Examination, by email dated June 28, 2012.

Enclosed, please find HIC's response to the examination report. In accordance with Section 905 (40 P.S. §323.5) of the Insurance Department Act, HIC is filing a written rebuttal to certain findings contained in the examination report.

Humana has outlined the reasons for disagreement in the following document(s). Where the Company has no objection to the finding in the Report, the document will contain a statement to that effect. Understandably, HIC's response will not reference the review segments where no violations were noted.

Humana appreciates the opportunity to submit the rebuttal, and appreciates the Department's careful consideration of our objections to the examination report. We look forward to hearing from you in the near future.

If you have any questions or comments regarding the rebuttal or the attached documentation, please do not hesitate to contact me at (920) 337-5966, or by email at [czimanek@humana.com](mailto:czimanek@humana.com).

Sincerely,

HUMANA INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Craig J. Zimanek".

Craig J. Zimanek, FLMI, AIRC, ACS, AIAA, ARA, ALHC, HIA, MHP, HIPAAA  
Commercial and Specialty Products | Regulatory Compliance

Attachments



**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

**VII. CONSUMER COMPLAINTS**

*(Examination Report page 11)*

**Finding: 2 Violations – Title 31, Pennsylvania code, Section 146.5.**

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Verification of the Company's acknowledgement within 10 working days could not be established in the noted complaint files.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

**Finding: 2 Violations – Act 205, Section 5 (40 P.S. §1171.5)(a)(10)(iii).**

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies in the noted files.

**Response:** Humana Insurance Company respectfully disagrees with the recommended finding for failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

An unfair claim settlement practice is any act committed or performed with such frequency as to indicate a general business practices. For market analysis, absent definition in Pennsylvania Statute, a Company is engaging in a general business practice if:

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

1. *The underlying cause of the problem, regardless of its frequency, can be traced to a company policy or regularly followed procedure as distinguished from an unintentional error.*
2. *The frequency of the problem is significantly greater for the company than the standard determined acceptable.*

*\*NAIC Market Conduct Surveillance handbook*

Under Rule 1, the underlying cause would be traced to the absence of or intentional failure to adhere to a company policy or procedure. As evidenced during the examination, however, HIC has a well-documented policy consistent with PA standards for prompt investigation of claims and consumer complaints arising under insurance policies. Failure to acknowledge two (2) of twelve (12) consumer complaints within ten (10) working days, inconsistent with company policies and procedures, could only be an unintentional error, not a general business practice.

Under Rule 2, the finding cited in the report would have to imply that the error occurred with such frequency that the Company exceeded the acceptable standard (or tolerance level) established by the state. In order to determine whether the Company met or exceeded the standard, however, the examiner must be able to rely on a sufficient population (or sample) large enough to confidently rule out the possibility that the true processing error rate is not misrepresented in the results. Although the entire population was used to determine the error rate, Humana Insurance Company respectfully disagrees that a population of twelve (12) consumer complaints provides a sufficient population to establish a general business practice.

Based on the number of consumer complaints received and reviewed during the examination period, HIC respectfully disagrees that the unintentional (non-systemic) error for two (2) of twelve (12) consumer complaints indicates a general business practice. As such, Humana Insurance Company respectfully requests that this finding be removed from the Report.

## **VIII. UNDERWRITING**

*(Examination Report pages 17 -21)*

### **H. Medicare Supplement Policies Issued 1990**

**Finding: 10 Violations – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuers. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted files.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

HIC agrees that an acknowledgment of receipt was not obtained for the *Guide to Health Insurance for People with Medicare* for the policy samples reviewed; however, HIC maintains that the publication was provided to each applicant at time of application. Because internal system controls prohibit the ordering of any Medicare Supplement sales kit without including the publication, the applicant could not have enrolled without having first obtained the *Guide to Health Insurance for People with Medicare*.

## **J. Individual Medicare Supplement Policies Issued as Replacements 1990**

**Finding: 7 Violations – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuers. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted files.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

HIC agrees that an acknowledgment of receipt was not obtained for the *Guide to Health Insurance for People with Medicare* for the policy samples reviewed; however, HIC maintains that the publication was provided to each applicant at time of application. Because internal system controls prohibit the ordering of any Medicare Supplement sales kit without including the publication, the applicant could not have enrolled without having first obtained the *Guide to Health Insurance for People with Medicare*.

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

**Finding: 7 Violations – Title 31, Pennsylvania Code, Section 89.783(d)(1).**

(d) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant. Acknowledgment of receipt of the *Outline of Coverage* by the applicant could not be established in the noted files.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

HIC agrees that an acknowledgment of receipt was not obtained for the *Outline of Coverage* for the policy samples reviewed; however, HIC maintains that the publication was provided to each applicant at time of application. Because internal system controls prohibit the ordering of any Medicare Supplement sales kit without including the publication, the applicant could not have enrolled without having first obtained the *Outline of Coverage*. In addition, the *Outline of Coverage* would have been utilized when discussing plan options and premiums.

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 89.784.**

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. The required replacement statement and question was blank on the noted application.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

**K. Medicare Supplement Policies Issued as Replacements 2010**

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 89.783(a)(6).**

(a) General rules.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered. Acknowledgment of receipt of the *Guide to Health Insurance for People with Medicare* by the applicant could not be established in the noted file.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

HIC agrees that an acknowledgment of receipt was not obtained for the *Guide to Health Insurance for People with Medicare* for the policy samples reviewed; however, HIC maintains that the publication was provided to each applicant at time of application. Because internal system controls prohibit the ordering of any Medicare Supplement sales kit without including the publication, the applicant could not have enrolled without having first obtained the *Guide to Health Insurance for People with Medicare*.

The current 2010 policy application contains the required acknowledgement.

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 89.783 (d)(1)**

(d) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant. Acknowledgment of receipt of the *Outline of Coverage* by the applicant could not be established in the noted file.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

HIC agrees that an acknowledgment of receipt was not obtained for the *Outline of Coverage* for the policy samples reviewed; however, HIC maintains that the publication was provided to each applicant at time of application. Because internal system controls prohibit the ordering of any Medicare Supplement sales kit without including the publication, the applicant could not have enrolled without having first obtained the *Outline of Coverage*.

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

An acknowledgement of receipt appears on the current 2010 policy application.

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 89.784**

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. The required replacement statement and question was blank on the noted application.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

**X. CLAIMS & CLAIMS MANUALS**

*(Examination Report pages 24 – 26)*

**A. Group Life Insurance Claims**

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 146.5**

- (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.
- (b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.
- (c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant who reasonably suggests that a response is expected.
- (d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so That first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Verification of acknowledgement within 10 working days could not be established in the noted claim file.

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

**Response:** Humana Insurance Company has no objection to the finding in the Report.

**Finding: 1 Violation – Title 31, Pennsylvania Code, Section 146.6**

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. Verification of a timely status letter could not be established in the noted claim file.

**Response:** Humana Insurance Company has no objection to the finding in the Report.

**Finding: 1 Violation – Act 205, Section 5 (40 P.S. §1171.5(a)(10)(iii))**

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; in the noted file.

**Response:** Humana Insurance Company respectfully disagrees with the recommended finding for failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

An unfair claim settlement practice is any act committed or performed with such frequency as to indicate a general business practices. For market analysis, absent definition in Pennsylvania Statute, a Company is engaging in a general business practice if:

1. *The underlying cause of the problem, regardless of its frequency, can be traced to a company policy or regularly followed procedure as distinguished from an unintentional error.*
2. *The frequency of the problem is significantly greater for the company than the standard determined acceptable.*

*\*NAIC Market Conduct Surveillance handbook*

Under Rule 1, the underlying cause would be traced to the absence of or intentional failure to adhere to a company policy or procedure. As evidenced during the examination, however, HIC has a well-documented policy consistent with PA standards for prompt investigation of claims arising under insurance policies. Failure to complete one (1) claim within the required period of time, inconsistent with company policies and procedures, could only be an unintentional error and would not constitute a general business practice.

**Pennsylvania Market Conduct Examination**  
**Humana Insurance Company**

Under Rule 2, the finding cited in the report would have to imply that the error occurred with such frequency that the Company exceeded the acceptable standard (or tolerance level) established by the state. In order to determine whether the Company met or exceeded the standard, however, the examiner must be able to rely on a sufficient population (or sample) large enough to confidently rule out the possibility that the true processing error rate is not misrepresented in the results. Although the entire population was used to determine the error rate, Humana Insurance Company respectfully disagrees that a population of one (1) claim provides a sufficient population to establish a general business practice.

Based on the number of claims received and reviewed during the examination period, HIC respectfully disagrees that failing to complete one (1) claim within the required period of time indicates a general business practice. As such, Humana Insurance Company respectfully requests that this finding be removed from the Report.

**B. Group Vision Insurance Claims**

**Finding: 2 Violations – Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 157 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted clean claims were not paid within 45 days of receipt.

**Response:** Humana Insurance Company has no objection to the finding in the Report.