STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGETED EXAMINATION

OF

HUMANA INSURANCE COMPANY

NAIC# 73288

AS OF

JUNE 30, 2006

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

HUMANA INSURANCE COMPANY

NAIC# 73288

The above examination was conducted by Sandra Lewis, CIE, Examiner-in-Charge, and Mel Mohs, CIE, Senior Market Examiner.

The examination covered the period of July 1, 2005, through June 30, 2006.

As a result of that examination, the following Report of Examination is respectfully submitted.

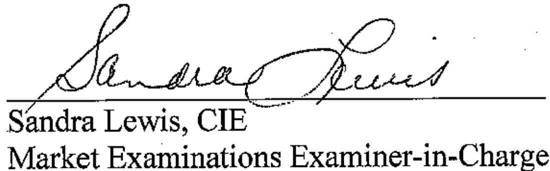
Sincerely yours,

Paul J. Hogan, JD, FLMI, ALHC, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

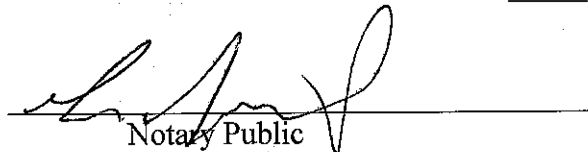
STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Mel Mohs, CIE, Senior Market Examiner, the examination of Humana Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.



Sandra Lewis, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 16 day of November, 2007.



Notary Public

My Commission Expires June 1, 2011

FOREWORD

This targeted market examination of Humana Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following components of the Company's major medical health insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims, and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the line of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 9.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners utilized both examination by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

Denied claim file sampling was based in part on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on a statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Craig Zimanek, Regulatory Compliance Manager. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met". A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report at page 9, and the examination findings are reported beginning at page 3.

1. The Company failed Standard No. 2, in apparent violation of A.R.S. §§ 20-461(A)(15) and 20-2533(D), by misstating the time period for filing an appeal.

2. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a), by failing to provide a reasonable explanation for

the denial of claims in sufficient detail to allow members and providers to appeal an adverse decision. The following categories of denied claims failed Standard No. 2:

a. Eight (34.8%) of 23 files reviewed for claims that involved cesarean sections;

b. Six (15.8%) of 38 files reviewed for claims that involved bone density scans;

c. Twenty eight (50.1%) of 55 files reviewed for claims that involved cosmetic surgery;

d. Forty eight (90.6%) of 53 files reviewed for claims that involved not covered services; and

e. Twenty seven (100%) of 27 files reviewed for claims that involved other carrier primary coverage services.

3. The Company passed Standards 1 and 3.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's Explanation of Benefits (EOB) forms and denied health care claims, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.	A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a)

Procedures Performed:

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted.

The Company provided appeal and complaint logs indicating it had processed 820 appeals and 31 complaints from denied claims during the examination period. The Examiners selected 61 appeals for review from the appeal log. During this review, the Examiners identified potential trends related to the denials of certain procedures without a reasonable explanation for the denials. These potential trends appeared with regard to specific Current Procedural

Technology ("CPT") codes, as well as specific Explanation of Benefits Denial Reason ("EOB") codes assigned by the Company at the time the claims were denied.

The Company provided a population of 269,693 claims denied during the examination period. Using the CPT codes and EOB codes identified during the review of the Company's appeals, the Examiners extracted a sub-population of 16,051 claims from which they selected a stratified random sample of 494 denied claims for review.

As a result of the review of the 494 denied claims, the Examiners identified the following Standard 2 findings:

Forms Review

The Examiners issued a preliminary finding on two Explanation of Benefits ("EOB") forms that failed Standard 2. The EOB forms misstated the time period within which to file an appeal when timeframe for filing language is also presented on the EOB form, as prescribed by A.R.S. § 20-2533(D). In the area of forms review, the Standard is "not met" if any violation is identified. These are apparent violations of Standard 2: A.R.S. § 20-461(A)(15). Reference PF #007.

Form No.	System
ES2400P 01/05	MTV
(not available)	Badger

Subsequent Events

The Company stated that all business was removed from the Badger System, so it no longer contains Arizona business.

The Company has revised appeal language on its EOB forms for the MTV claim system to include the notification of the right to appeal, in an effort to satisfy the requirements of A.R.S. § 20-2533(D). The Company provided copies of the new EOB forms to the Examiners, and these were forwarded to the Department. A review of the revisions by the appropriate division of the Department found certain inadequacies, which are addressed in the following recommendation.

Recommendation 1

Within 90 days of the filed date of this report, the Company should provide documentation that procedures and controls are in place to ensure that the Company uses EOB forms that contain a compliant right to appeal statement as prescribed by A.R.S. §§ 20-

461(A)(15) and 20-2533(D). Specifically, the Company should ensure that the appeal notification complies with the following:

- The notice of appeal rights uses the term "may" in relation to the right to an external review and appears to limit the right to an external review only to cases of medical necessity. The notice of appeal rights must indicate that the insured has a right to an external independent review in all cases, including in cases of coverage issues.
- The EOB notice of appeal rights must provide the rights prescribed by Arizona law. If the notice also includes those rights afforded under the Employee Retirement Income Security Act ("ERISA"), the language must clearly indicate that these rights are available in addition to the rights afforded by Arizona law.

Denied Claims Review

Claims Denied – CPT Code 59514

The Examiners identified a subpopulation of 64 denied claims for services billed under CPT Code 59514 (caesarean section). The Examiners reviewed a sample of 23 of the 64 denied claims billed under CPT Code 59514.

Eight (35%) of 23 claims billed under CPT Code 59514 were denied for the following reason: "No benefits available as eligibility requirements have not been met." These denials failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #001.

Claims Denied – CPT Code 76075

The Examiner identified a subpopulation of 139 denied claims for services billed under CPT Code 76075 (bone density scan). The Examiners reviewed a sample of 38 of the 139 files denied under CPT Code 76075.

Six (16%) of 38 claims billed under CPT Code 76075 were denied for the following reason: "No benefits available as eligibility requirements have not been met." These denials failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in

apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #004.

Subsequent Events

The Company stated, in their response to PF #004 on 5/1/07, that they are enhancing the eligibility denial code to more clearly identify whether the services were received before the policy effective date or after the policy termination date. No other documentation was provided to the Examiner.

Claims Denied Under EOB Reason Code 722

The Examiner identified a subpopulation of 119 denied claims which were denied using EOB Reason Code 722 for the following reason: "This charge is denied because cosmetic surgeries as plan defined are not covered."

The Examiners reviewed a sample of 55 of the 119 files denied using EOB Reason Code 722. Twenty-eight (51%) of 55 claims denied using EOB Reason Code 722, excluding services related to cosmetic surgery, contained CPT codes that indicated therapeutic procedures and child immunizations. These 28 files failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #006.

Subsequent Events

The Company stated, in their response to PF #006, that when their vendor, Healthways, completed the medical necessity investigation they provided the Company with deny instruction codes. The Company then matched the deny instructions with an incorrect denial code that stated that cosmetic surgeries were not covered. The Company stated that this coding discrepancy was corrected on 4/11/07. No other documentation was provided to the Examiner.

Claims Denied Under EOB Reason Codes 723, 940, 91I and 77

The Examiners identified a subpopulation of 8,458 denied claims which were denied under EOB Reason Codes 723, 940, 91I and 77 for the following reasons: "This service is not covered under your plan. Please refer to the limitations & exclusions portion of your benefit plan document;" "Services that are not listed as a covered expense are not covered. Refer to the limitations & exclusions section of your benefit plan document;" and "Your plan does not cover this type of expense."

The Examiners reviewed a sample of 53 of the 8,458 files denied using EOB Reason Codes 723, 940, 91I and 77. Forty-eight (91%) of 53 claims denied under EOB Reason Codes 723, 940, 91I and 77 failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #003.

Claims Denied Under EOB Reason Code 810

The Examiners identified a subpopulation of 256 denied claims which were denied using EOB Reason Code 810, which stated that automobile, home and premise insurance is primary over the group health policy.

The Examiners reviewed a sample of 27 of the 256 files denied using EOB Reason Code 810. Twenty-seven (100%) of 27 claims denied using EOB Reason Code 810 failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.

The 27 files contained denied claims for apparent auto accident injuries, and the claims comprised four policy contract certificates (AZD0005, AZQ00026, AZ100804 and FISCAND1). These four certificates contained Coordination of Benefit ("COB") statements that failed to include a determination of primary order for automobile medical payment coverages. Three certificates (AZD0005, AZQ00026 and AZ100804) contained an exclusion statement that the Company would not pay a claim for sickness or bodily injury for which medical payment coverage benefits are paid or payable under any homeowners, premises or any other similar coverage. However, homeowners/premises coverage is not similar to auto coverage. Therefore, the COB and/or exclusion statement of each certificate fail to adequately provide a basis for denying claims stemming from automobile accidents. The reason stated for the denial of these claims, therefore, is not supported by the policy language.

This is an apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF #002.

Subsequent Events

The Company stated the following in their response to PF #002: "In August 2006 the Company identified a process deficiency with a delegated vendor where auto accident related

claims were being initially rejected. Auto accident related claims, including those for chiropractic related services, should have been paid and coordination of benefits pursued after the initial claim payment. This process was corrected, effective August 31, 2006." No other *documentation was provided to the Examiner.*

Summary of Findings

Files Reviewed	Population	Sample	Exceptions	Error Ratio	PF #
CPT Code 59514	64	23	8	35%	001
CPT Code 76075	139	38	6	16%	004
Reason Code 722	119	55	28	51%	006
Reason Codes 723, 940, 91I, and 77	8,458	53	48	91%	003
Reason Code 810	256	27	27	100%	002
Totals =	**9,036**	**196**	**117**	**60%**	

A 60% error ratio does not meet the standard; therefore a recommendation is warranted.

Recommendation 2

Within 90 days of the filed date of this report, the Company should provide documentation that procedures and controls are in place to ensure that the Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

SUMMARY OF STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. §§ 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).	X	
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).	X	