State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

Humana Who Insurance Corporation
PO Box 740036
Louisville KY 40201-7436

dated August 23-27, 2004 and September 20-28, 2004, and served upon the company on November 15, 2005, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 28th day of February, 2006.

Jorge Gomez
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION
WAUKESHA, WISCONSIN

AUGUST 23-27, 2004, AND SEPTEMBER 20-28, 2004

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November 4, 2004

Honorable Jorge Gomez
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conduct August 23-28 and September 20-28, 2004, of:

HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE COMPANY
Waukesha, Wisconsin and Louisville, Kentucky

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Humana Wisconsin Health Organization Insurance Corporation (Humana WHO) was incorporated in May 1985 as a for-profit model health maintenance organization (HMO) insurer. It commenced business in September 1985 under its former name, Wisconsin Health Organization Insurance Corporation. It is a wholly owned subsidiary of CareNetwork, Inc. Effective December 20, 1994, control of CareNetwork, Inc., was acquired by Humana, Inc. The name change from Wisconsin Health Organization to Humana Wisconsin Health Organization Corporation was effective June 1, 1995.

The company is licensed to write business only in the state of Wisconsin. The company expanded its service area in September 2001 to include six counties in western Wisconsin, including Dodge, Dunn, Eau Claire, Pierce, Polk, and St. Croix counties. In addition, the company writes business in the counties of: Fond du Lac, Green, Jefferson, Kenosha,

Manitowoc, Milwaukee, Ozaukee, Racine, Rock, Sheboygan, Walworth, Washington, and Waushara.

The company contracts with provider networks and independent provider associations for the provision of physician services, including specialty services. The company is a domestic insurer that offers HMO and point-of-service (POS) products. Its POS policy is offered jointly with an affiliate, Humana Insurance Company (HIC). Employer groups are issued two benefit contracts, one from the HMO covering the traditional HMO benefits and an indemnity contract from HIC covering self-referred out-of-network claims. The employers are charged one premium per certificate holder for both policies. The premium is split 90% to the HMO and 10% to HIC. The POS product is administered by the HMO and HIC pays 8% of its share of the premium to the HMO as compensation for the administrative services.

Humana does not write Medicare supplement business. However, its affiliate, HIC, has a contract with CMS to offer a Medicare+Choice (Medicare Advantage) plan, called Humana Gold Choice.

The company markets to groups using independent producers and has no salaried producers. The company also has no employees. It has administrative service agreements with affiliates for necessary operational functions.

In 2002, the company ranked 8th in the group accident and health insurance business in Wisconsin, with 3.6% of the market. In 2001, the company ranked 12th in group accident and health insurance business in Wisconsin with 2.3% of the market. It wrote .7% of small employer business in Wisconsin during 2002 and 2003.

The following tables summarize the premium written and incurred losses in Wisconsin for 2002 and 2003.

Premium and Loss Ratio Summary

Line of Business		2003 Direct Premiums Earned	% of Total Premium	Direct Losses Incurred	Pure Loss Ratio
Medical Only		$288,687,572	100%	$275,451,871	95%
	Total	$288,687,572		$275,451,871	

Line of Business		2002 Direct Premiums Earned	% of Total Premium	Direct Losses Incurred	Pure Loss Ratio
Medical Only		$246,295,333	100%	$223,653,279	91%
	Total	$246,295,333		$223,653,279	

Complaints

The Office of the Commissioner of Insurance received 85 complaints against the company between July 1, 2002, through June 30, 2004. A complaint is defined as a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent. The company did not appear on the 2003 or 2002 complaint summary for group accident and health insurance as only companies with an above-average ratio of complaints per premium volume appear on the summary. The majority of the company's complaints involved the claim issues of claim handling delays or claim denials.

The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

	2003					
Reason Type	Total	Underwriting	Marketing & Sales	Claims	Plcyhldr Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
HMO	49	1	0	47	1	0

Grievances

The company submitted annual grievance experience reports to OCI for 2002 and 2003 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as, "any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan, or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured."

The grievance report for 2003 indicated the company received 701 grievances, 584 or 83% were reversed. The majority of the grievances filed with the company were related to the category identified as "Other."

The grievance report for 2002 indicated the company received 365 grievances, 251 or 69% were reversed. The majority of the grievances filed with the company were related to the request for referral category.

The following table summarizes the grievances for the company for the last two years:

Category	2002 No.	2003 No.
Access to Care	0	8
Continuity of Care	0	2
Prescription Drug	51	36
Emergency Services	44	3
Experimental Treatment	1	1
Prior Authorization	41	52
Noncovered Benefit	33	178
Not Medically Necessary	30	132
Other	50	253
Plan Administration	4	1
Request for Referral	111	1
Plan Providers	0	34
Total	365	701
Resolution Categories		
Plan Administration	52	8
Benefit Denial	311	659
Quality of Care	2	34
Total	365	701

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from July 1, 2002, through June 30, 2004. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of the company's operations in the areas of group health claims, company operations/management, complaints/grievances, marketing and sales, managed care, small employer rates, policy forms, small employer marketing and underwriting, electronic commerce, producer licensing and privacy activities. The examination also included a review of compliance with the prior managed care desk audit recommendations.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous managed care desk audit of the company, as adopted January 10, 2000, contained six recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Second Opinions

1. It is recommended that Humana WHO submit to OCI and obtain approval of language in its policies and certificates regarding coverage of second opinions that complies with s. 609.22 (5), Wis. Stat.

   Action: Non-Compliance

2. It is recommended that Humana WHO develop a procedure to provide an enrollee with coverage for a second opinion from another participating provider, as required by s. 609.22 (5), Wis. Stat.

   Action: Non-Compliance

Access Standards

3. It is recommended that Humana WHO modify the access plan to include specific procedures designed to ensure that the needs, with respect to covered benefits, of its enrollees who are members of underserved populations are met, as required by s. 609.22 (8), Wis. Stat.

   Action: Compliance

Continuity of Care

4. It is recommended that Humana WHO submit to OCI and obtain approval of language in the certificates of coverage and policies regarding an enrollee's right to continuity of care in order or comply with s. 609.24 (1), Wis. Stat.

   Action: Compliance

5. It is recommended that Humana modify its provider contracts to include a provision addressing reimbursement to providers for services provided to pregnant women and infants through the postpartum period in order to comply with s. 609.24 (1) (e), Wis. Stat.

   Action: Compliance

Formularies and Experimental Treatment

6. It is recommended that Humana WHO develop a process through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan that complies with s. 632.853, Wis. Stat.

   Actions: Non-Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claims administration processes and procedures, ANSI codes, claims methodology, explanation of benefits (EOB) and remittance advice (RA) forms, administrative service and vendor agreements.

Humana WHO used Humana, Inc.'s claim processing system for processing the majority of its medical claims. However, the company contracted with Mental Health Network (MHNet) and APS Healthcare for processing mental health claims. It contracted with ChiroTech of America for processing chiropractic claims. It contracted with EyeMed for processing vision claims and with Advance PCS for processing pharmaceutical claims. The company had a contract with St. Joseph's Physicians Association, which ended December 31, 2003, whereby St. Joseph's Physicians Association paid claims for Humana WHO insureds who utilized the association's network. Effective January 1, 2004, the company assumed responsibility for processing these claims.

The examiners reviewed a random sample of 100 paid and 100 denied medical claims, and 25 paid and 25 denied mental health claims. The examiners found that the EOBs produced by MHNet for Humana WHO insureds did not comply with the standardized EOB minimum information requirements under s. Ins 3.651 (4) (a) 4; 5. d, e, g, h, i, Wis. Adm. Code. The EOBs did not include the last name, followed by the first name and middle initial of each patient insured under the policy or certificate for whom claim information was being reported, the patient account number; the amount charged by the health care provider if the insured was liable for any of the difference between the amount charged and the amount allowed by the insurer; the amount allowed by the insurer; the applicable deductible amount, if any; the applicable co-pay amount, if any; and the amount paid by the insurer toward the charge.

The examiners found that none of the EOBs produced by the company's vendors provided the total deductible amount remaining for the policy period, the total out-of-pocket amount remaining for the policy period, the remaining amount of the policy's lifetime limit or the annual benefit limit.

The examiners found that the EOBs produced by the Humana, Inc., for the company did not include information regarding the total deductible amount remaining for the policy period; the remaining amount of the policy's lifetime limit; and the annual benefit limit. The company indicated that although the information was not included on the EOBs, it made this information available at an 800 number. The company indicated that as its parent company, Humana, Inc., operated multiple companies, offered health plans in multiple states and offered several product lines, Humana Inc., had made a business decision to utilize universal standardized EOB and RA forms nationwide.

1. **Recommendation:** It is recommended that the company require its vendors to utilize explanation of benefits (EOB) forms that comply with all the standardized information requirements in s. Ins 3.651 (4), Wis. Adm. Code.

2. **Recommendation:** It is recommended that the company change its explanation of benefits (EOB) forms produced by Humana, Inc., to comply with all of the standardized information requirements in s. Ins 3.651 (4), Wis. Adm. Code.

3. **Recommendation:** It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company use explanation of benefits (EOB) forms that comply with s. Ins 3.651 (4), Wis. Adm. Code.

The examiners found that the remittance advice (RA) forms produced by vendors for the company's providers varied from the order shown in s. Ins 3.651, Wis. Adm. Code, Appendix A. The examiners also found that the remittance advice (RA) forms produced by Humana, Inc., for the company to send to providers included columns that varied from the order shown in s. Ins 3.651, Wis. Adm. Code, Appendix A. Section Ins 3.651 (3) (d), Wis. Adm. Code, provides that a remittance advice form need not include a column for any item specified in

par. (b) 4., which is not applicable, but the order of the columns that are included may not vary from the order shown in Appendix A, except as provided in subd. 3.

4. **Recommendation:** It is recommended that the company require its vendors to use remittance advice (RA) forms in the standardized format required by s. Ins 3.651 (3) (d), Wis. Adm. Code.

5. **Recommendation:** It is recommended that the company change the format of the remittance advice (RA) forms produced by Humana, Inc., to the standardized format required by s. Ins 3.651 (3) (d), Wis. Adm. Code.

6. **Recommendation:** It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company use a remittance advice (RA) form that complies with s. Ins 3.651 (3) (d), Wis. Adm. Code.

The examiners found that neither the company nor its claim processing vendors, including MHNet, APS Healthcare, ChiroTech, EyeMed, Advance PCS and St. Joseph Physician Association, used American national standards institute accredited standards committee X12 (ANSI) codes as claim adjustment reason codes on the EOBs furnished to insureds nor on the RAs furnished to health care providers. Sections Ins 3.651 (3) (b) 4. i and (4) (a) 7, Wis. Adm. Code, provide that the company's RA and EOB forms include claim adjustment reason codes, identified as ANSI codes.

7. **Recommendation:** It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company utilize ANSI codes as claim adjustment reason codes on explanation of benefits (EOB) forms in order to comply with s. Ins 3.651 (4) (a) 7, Wis. Adm. Code.

8. **Recommendation**: It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company utilize ANSI codes as claim adjustment reason codes on remittance advice (RA) forms in order to comply with s. Ins 3.651 (3) (b) 4. i, Wis. Adm. Code.

The examiners reviewed both the company's and its vendors**'** claims processing methodology. The company's policies and certificates of coverage provided that out-of-network point-of-service (POS) claims were paid based on the usual, customary and reasonable (UCR) claim methodology. The examiners reviewed a random sample of 25 claims that were subject

to UCR. The examiners found that MHNet reviewed UCR data on an annual basis and updated the fees as needed based on the information it received from Humana WHO. The examiners found that APS Healthcare did not utilize a specific database to determine UCR reimbursement. APS Healthcare paid claims based on a formula providing for an additional 20% above its contracted amount for a specific network provider category. APS Healthcare stated that it had purchased a UCR database and would begin using the UCR claim methodology effective January 1, 2005. Section Ins 3.60 (4) (c) and (d), Wis. Adm. Code, provide that any insurer that issues a policy or certificate shall base its specific methodology on a database that meets specific conditions. The database shall be capable of being updated at least every 6 months and no data in the database at the time of update may be older than 18 months.

9. **Recommendation:** It is recommended that the company develop and implement written audit procedures to verify that all vendors that process claims comply with the claim settlement methodology requirements by updating its database at least every 6 months in order to comply with s. Ins 3.60 (4) (c), Wis. Adm. Code.

10. **Recommendation:** It is recommended that the company develop and implement written audit procedures to verify that all vendors that process claims comply with the claim settlement methodology requirements by ensuring that no data in the database at the time of update is older than 18 months in order to comply with s. Ins 3.60 (4) (d), Wis. Adm. Code.

11. **Recommendation:** It is recommended that the company within 90 days of the adoption of the examination report provide to OCI a listing of claims processed by APS Healthcare during the period of review that were not paid equivalent to the UCR amount, and document that additional benefits were paid on these claims.

During the review of the claims interrogatory for APS Healthcare, the examiners noted that the APS did not have procedures for the disclosure of health care settlement practices to provide insureds upon their request with the amount allowable for a specific procedure. Section Ins 3.60 (6) (a) 2, Wis. Adm. Code, provides that an insurer shall, upon request, provide the insured with specific information regarding its specific methodology for paying claims.

12. **Recommendation:** It is recommended that the company develop a process and written procedures for its claim processing vendors that requires that they disclose upon request a description of the company's specific claim methodology as required by s. Ins 3.60 (6) (a) 2, Wis. Adm. Code

The examiners reviewed the company's agreement with ChiroTech America Inc., and ChiroTech's claim processing practices and procedures. ChiroTech contracts with individual chiropractors and provides claims administration services. ChiroTech stated that all claims processed were received electronically and it did not have written procedures nor claim adjusters responsible for the reviewing chiropractic claims.

The examiners reviewed a random sample of 50 paid chiropractic claims. Although ChiroTech initially reported that it only processed electronic claims, the examiners found that it had processed 354 paper claims during the period of review, including 258 paid claims and 96 denied claims. The examiners found that ChiroTech did not have written procedures for the processing of paper or electronic claims. Section Ins 6.11, Wis. Adm. Code, requires that fair and equitable treatment of policyholders, claimants and insurers is used by defining certain claim adjustment practices which are considered to be unfair methods and practices such as inadequate claim handling, personnel, systems, procedures and communication.

13. **Recommendation:** It is recommended that the company require ChiroTech or its chiropractic claim vendor to draft and implement procedures for claims processing, to ensure all claims are handled consistently and in compliance with s. Ins 6.11, Wis. Adm. Code.

The examiners requested for review a sample of 50 denied chiropractic claims. The examiners found that the denied claim sample included only claims for patients who were found not to be current Humana WHO enrollees. The examiners found that ChiroTech's policies and procedures allowed network providers to handle their own medical management. Network providers required that company enrollees complete a "Non-covered Services Agreement" when therapeutic care was being transitioned to maintenance/wellness/custodial care. The agreement informed company enrollees that they would be financially responsible for care that was not covered by their HMO insurance plan. The examiners found that ChiroTech could not

produce a denied claim sample because there were no declines under the company's insurance policies as providers were doing the medical management and enrollees were signing the payment agreement. The examiners were unable to document that the company's chiropractic claims that were eligible for independent chiropractic review were in fact submitted for review. Section 632.87 (3) (b), Wis. Stat., provides that no insurer may restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor. Section 632.875 (2), Wis. Stat., provides that if, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for the treatment of a condition or complaint by a chiropractor acting within the scope of his or her license and the restriction or termination of coverage results in the patient becoming liable for payment for his or her treatment, the insurer shall provide to the patient and the treating chiropractor a written statement regarding the denial and how the patient may appeal the decision.

14. **Recommendation:** It is recommended that the company or its chiropractic claim vendor develop a process including written procedures for ensuring that any restrictions to or terminations of coverage of treatment by a licensed chiropractor within the scope of the chiropractor's professional license are subject to independent evaluation by a licensed chiropractor or a peer review committee that includes a licensed chiropractor in order to comply with s. 632.87 (3) (b), Wis. Stat.

15. **Recommendation:** It is recommended that the company develop and implement procedures to ensure that the company or its chiropractic claim vendor provides to enrollees a written statement regarding the denial and how the patient may appeal the decision in order to comply with s. 632.875 (2), Wis. Stat.

Grievance and Independent Review

The examiners reviewed the company's response to OCI's grievance interrogatory, its grievance procedures, grievance committee minutes, annual grievance experience reports for 2002 and 2003, company and vendor EOB and RA forms, and its procedures for handling independent review requests from Wisconsin insureds. The examiners also interviewed the company's market relations manager for Milwaukee and its grievance and appeals manager.

The examiners found that the company reported 336 more grievances in 2003 than 2002. The company indicated that in late 2002, it relocated its grievance operation from Wisconsin to Louisville, Kentucky, as part of Humana, Inc.'s plan to standardize the processes for its family of companies. The company reported that the decision to relocate all customer services and appeal functions encouraged insureds to utilize a more formalized process of submitting written grievances when the company's customer service personnel were unable to satisfactorily resolve its insureds' concerns.

Grievance

The examiners reviewed a random sample of 50 grievance files, 19 grievances filed during 2003 and 31 grievances filed during 2004. The examiners found that 5 of the company's grievance files included acknowledgment letters that were not sent within 5 days of receipt by the company. Section Ins 18.03 (4), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall within 5 business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment confirming receipt of the grievance. The company stated that it had instituted a new process in March 2004 requiring that grievances were to be faxed directly to the Louisville Service Center to insure quicker service. The company stated that previous to this date grievance mail was processed by its mail vendor, which caused a delay at the Louisville Service Center.

16. **Recommendation:** It is recommended that the company follow its procedures to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

The examiners found that the EOBs produced by Humana, Inc., for the company's insureds did not contain information on how to file a grievance. Section Ins 18.03 (2), Wis. Adm. Code, provides that if an insurer offering a health benefit plan denies a claim or benefit it shall notify the insured of the right to file a grievance by either directing the insured to the policy or certificate section that delineates the procedure for filing a grievance or shall describe in detail the grievance procedure to the insured.

The examiners found that the EOBs provided by the company's vendor, EyeMed, did not include either a detailed description of the grievance procedure nor did it direct the insured to the specific section in the policy or certificate that delineated the procedure for filing a grievance as required by s. Ins 18.03 (2) (b), Wis. Adm. Code.

17. **Recommendation:** It is recommended that the company and its vendors revise their explanation of benefits (EOB) forms to contain a detailed description of Wisconsin's grievance procedure in order to comply with s. Ins 18.03 (2) (b), Wis. Adm. Code.

The examiners found that the company's and its vendors' EOBs required that an appeal be filed with 180 days. The company stated that a business decision was made to utilize a universal standardized EOB form nationwide. The EOBs also indicated that grievances would be responded to within 60 days. Section Ins 18.03 (6), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall resolve a grievance within 30 calendar days of receiving the grievance. It does not include a time limit for filing a grievance.

18. **Recommendation:** It is recommended that the company and its vendors revise their explanation of benefits (EOB) forms to include timeframes for filing grievances in order to comply with s. Ins 18.03 (6), Wis. Adm. Code.

The examiners found that the company's grievance process allowed the company to downcode grievances to complaints. The company reported that it downcoded a grievance to a complaint when the claim in question was paid after the grievance letter was written but prior to the company receiving the letter. The process was formalized by the company in January 2004 but had been in use informally since 2002. Section Ins 18.01 (4), Wis. Adm. Code, defines a

grievance as any dissatisfaction that is expressed in writing to the insurer. Section Ins 18.01 (2), Wis. Adm. Code, defines a complaint as any expression of dissatisfaction expressed to the insurer about the insurer or its providers with whom the insurer has a direct or indirect contract.

19. **Recommendation:** It is recommended that the company cease its process known as downcoding and develop and implement a procedure to ensure that all written expressions of dissatisfaction are handled as grievances to ensure compliance with s. Ins 18.01 (4), Wis. Adm. Code.

The examiners found that 14 written expressions of dissatisfaction had been downcoded and treated as complaints. The examiners further found that 8 of these grievances had not been reported by the company in its Grievance Experience Report for 2002 or 2003. The examiners found that 6 of the grievances were not included in the company's grievance log for 2004. Section Ins 18.06 (1), Wis. Adm. Code, requires that an insurer offering a health benefit plan shall keep and retain each record of each complaint and grievance for a period of at least 3 years at the insurer's home or principal office. Section Ins 18.06 (2), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall submit a grievance experience report to the commissioner by March 1 of each year including information on all grievances received during the previous calendar year.

20. **Recommendation:** It is recommended that the company develop and implement a procedure to keep and maintain all complaints and grievances in separate logs to show compliance with s. Ins 18.06 (1), Wis. Adm. Code.

21. **Recommendation:** It is recommended that the company refile its 2002, 2003 and 2004 Grievance Summary Reports, to include those grievances that had been downcoded in order to comply with s. Ins 18.06 (2), Wis. Adm. Code.

The examiners found two grievances that the company had not resolved within 60 days. Section Ins 18.03 (6), Wis. Adm. Code, provides that if the insurer offering a health benefit plan is unable to resolve a grievance within 30 calendar days, the period may be extended an additional 30 calendar days if the insurer provides a written notification to the insured indicating that the grievance has not been resolved, when the resolution may be expected and the reason the additional time is needed.

22. **Recommendation**: It is recommended that the company develop safeguards to ensure that all grievances are resolved within 60 days in order to comply with s. Ins 18.03 (6), Wis. Adm. Code.

Independent Review

The examiners found that the company's IRO process stated that the company must provide a covered person the opportunity to request an independent review if the internal grievance process has been exhausted or if both parties agree to waive the internal grievance process. The IRO process did not provide that the grievance process may be bypassed in an urgent care situation. Section 632.835 (2) (d), Wis. Stat., states that an insured may not be required to exhaust the internal grievance procedure if the insured submits the review request to the IRO along with the request to the insurer and the IRO determines that an expedited review is required or if both parties agree that the matter may proceed directly to independent review.

23. **Recommendation:** It is recommended that the company modify its Wisconsin IRO process to ensure the opportunity to bypass the grievance process and to obtain independent review in order to comply with s. 632.835 (2) (d), Wis. Stat.

The examiners found that the company had established procedures to provide its members with a complete independent review notice each time it made an adverse determination or an experimental treatment determination regarding a medical procedure requiring preauthorization. This notice was also provided with the grievance resolution letter. However, the examiners found that the company did not provide a complete independent review notice with its explanation of benefits (EOB) forms when a claim settlement resulted in an adverse determination or an experimental treatment determination. Section 632.835 (2) (bg), Wis. Stat., provides that the complete notice may be sent only with the grievance resolution letter if specific information is provided in the certificate of coverage, explanation of benefits forms, and other notices of adverse determinations and experimental treatment determinations.

24. **Recommendation:** It is recommended that the company establish a procedure either to comply with the complete independent review notice requirements in s. 632.835 (2) (b), Wis. Stat., or s. 632.835 (2) (bg), Wis. Stat.

The examiners reviewed six independent review requests that Humana WHO received during the period of review. The examiners found one file in which the letters notifying OCI and the IRO of Humana WHO's receipt of the review request were not sent within two business days. Section Ins 18.11 (3) (a), Wis. Adm. Code, requires an insurer to provide the commissioner and the IRO written notice of an independent review request within two business days of receipt.

The examiners found one file contained a copy of the IRO's determination letter and a copy of the IRO's bill and did not contain any further documentation. The company stated that it could not locate the complete file. Section Ins 6.80 (4), Wis. Adm. Code, requires that records of insurance company operations be maintained and available to the commissioner for the preceding three years.

The examiners found that Humana WHO delegated responsibility for making some adverse determinations to Mental Health Network (MHN), Aurora Behavioral Health Services (ABHS), ChiroTech America Inc. (ChiroTech), and Preferred One. The examiners found that MHN did not include the complete notice of the right to independent review on its EOB forms nor in its benefit denial letters.

The examiners requested copies of the benefit denial letters used by the company's vendors that made adverse determinations on behalf of Humana WHO. The company provided copies of letters used by ABHS and Preferred One. The examiners found that the letters did not include the complete independent review notice. In response to further questions, ABHS and Preferred One provided revised copies of the letters but did not indicate the date that the letters were revised and did not provide any procedures for use. The examiners were not able to verify that ABHS or Preferred One provided Humana WHO members with a complete independent review notice each time an adverse determination was made. Section 632.835 (2) (b), Wis. Stat., requires an insurer to provide notice to the insured of the right to request an independent review, information explaining how to request the review and the time within which the review

must be requested, and to provide a current listing of certified IROs each time an adverse determination or an experimental treatment determination is made.

25. **Recommendation:** It is recommended that the company develop and implement oversight procedures that include regular audits of all entities that are authorized to make adverse determinations or experimental treatment determinations on the company's behalf to ensure that the entities comply with s. 632.835 (2), Wis. Stat.

Managed Care

The examiners reviewed the company's response to OCI's managed care interrogatory, its policies and procedures regarding plan administration, compliance program, quality assurance and improvement, access to care, credentialing and recredentialing. Humana WHO reported that it planned to seek accreditation from the National Committee for Quality Assurance (NCQA) in the fourth quarter of 2005.

The examiners reviewed the company's plan administration activities including its organization charts, board of directors meeting minutes, medical director position description, provider directories and provider agreements. The examiners found that the company's organization charts and its medical director position description indicated that the medical director was responsible for the oversight of quality improvement and chaired the company's health services, credentialing and peer review committees, as required by s. 609.34, Wis. Stat.

The examiners reviewed the company's quality assurance process, including its quality improvement program description, quality assurance plan and quality assurance program evaluations for 2002 and 2003. The examiners also reviewed the minutes of the company's quality and utilization management committee, and the credentialing/peer review committee. The examiners verified that the company had filed with OCI its quality assurance plan, as required by s. Ins 9.40 (2), Wis. Adm. Code. The examiners found that the company's quality assurance standards met the requirements set forth in s. 609.32 (1), Wis. Stat. The examiners also verified that the company's quality of care grievances were sent through the regular grievance process and were recorded in the annual grievance report sent to OCI.

The examiners reviewed the company's credentialing and recredentialing activities, including its credentialing and recredentialing policies and procedures, provider agreements and minutes for its credentialing committee and peer review committee. The company's practitioner appeal process for resolving provider quality of care issues required that disciplinary actions with duration of more than 30 days be reported to the National Practitioner Data Bank.

The examiners reviewed the company's compliance plan outline and procedures. The examiners found that the company delegated responsibility for compliance regarding access, continuity of care, provider agreements, and quality assurance to Humana, Inc.

The examiners reviewed the access standards plan provided by the company. The examiners found that the committee that had oversight of access standards was disbanded in 2002 when the function was relocated to Humana, Inc., in Louisville, Kentucky. The committee was not reformed until July 2004. The interdisciplinary action committee and the quality improvement committee of Humana, Inc., had oversight of the plan for Humana WHO. The examiners found that the company submitted a certification of access standards report dated July 29, 2004, as required by s. Ins 9.34, Wis. Adm. Code, to show compliance with s. 609.22, Wis. Stat.

The examiners' review of the company's activities regarding continuity of care included a review of its continuity of care policy and procedure, claim processing policies and procedures and provider agreements. The examiners found that the company's procedures regarding continuity of care did meet the requirements of s. 609.23, Wis. Stat., which provides that, if the company represented that a provider was or would be a participating provider in marketing materials, it continue to provide coverage to enrollees for services of the provider for the time periods specified. Responsibility for Humana WHO guidelines was moved from Wisconsin to Humana, Inc., in Louisville, Kentucky, in March 2004 to centralize the process for all markets.

The examiners reviewed the process the company's vendors that pay claims for Humana WHO used to reimburse terminated providers for services rendered to enrollees. The examiners found that only one of the five provider contracts with the vendors that pay claims for the company had written procedures that addressed reimbursement to providers for services rendered after termination.

26. **Recommendation:** It is recommended that the company revise its outside vendor contracts to include provisions addressing reimbursement to terminated providers to ensure compliance with s. 609.24 (1) (e), Wis. Stat.

The examiners found that that the company's compliance plan did not require that the company conduct regular internal audits. The examiners did find that the company had conducted regular audits of its outside vendors. Section Ins 9.42 (3), Wis. Adm. Code, requires that insurer's compliance programs shall include regular internal audits, including regular audits of any contractors or subcontractors who perform functions relating to compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36 and 632.83, Wis. Stat., and s. Ins 9.07, Wis. Adm. Code.

27. **Recommendation:** It is recommended that the company include in its compliance plan a written procedure requiring regular internal audits in order to comply with s. Ins 9.42 (3), Wis. Adm. Code.

The examiners found that the company was not in compliance with recommendations made in the 1999 desk audit managed care report regarding the development of a procedure to provide an enrollee with coverage for a second opinion from another participating provider. The language in the company's policies and certificates provided for a second surgical opinion. Section 609.22 (5), Wis. Stat., requires that a defined network plan shall provide an enrollee with coverage for a second opinion from another participating provider.

28. **Recommendation:** It is again recommended that the company submit to OCI and obtain approval of language in its policies and certificates regarding coverage of second opinions that complies with s. 609.22 (5), Wis. Stat.

29. **Recommendation:** It is again recommended that the company develop a procedure to provide an enrollee with coverage for a second opinion from another participating provider, as required by s. 609.22 (5), Wis. Stat.

The examiners reviewed the company's procedures that allowed physicians to present medical evidence for coverage of prescriptions not routinely covered. The examiners found that the company's policies and procedures developed by Humana health plans national pharmacy & therapeutics committee did not include the timelines for urgent and nonurgent review. Section 632.853, Wis. Stat., provides that a health care plan shall develop a process

through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan and shall include timelines for both urgent and nonurgent review.

30. **Recommendation:** It is again recommended that the company develop and implement a process including timelines through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan that complies with s. 632.853, Wis. Stat.

Policyholder Service & Complaints

The examiners reviewed the company's response to OCI's policyholder service and complaints interrogatory, its complaint handling policies and procedures and its complaint log.

The examiners requested a copy of the company's complaint log for the period of July 1, 2002, through June 30, 2004. The examiners found that the complaint log did not include complaints from or regarding activities of its outside vendors. The company indicated it had a process to receive reported complaints but had no system to track them. Section Ins 18.06 (1), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall keep and retain for a period of at least 3 years a record of each complaint and grievance submitted to the insurer. These records shall be maintained at the insurer's home or principal office and shall be available for review during examinations by or on request of the commissioner or office.

31. **Recommendation:** It is recommended that the company develop a process to maintain a log for all complaints received, including those involving outside vendors to ensure compliance with s. Ins 18.06 (1), Wis. Adm. Code.

Prior to the examination, the examiners completed a complaint analysis of 50 of the 100 complaints received by OCI involving the company during the period of review. During the examination, the examiners reviewed a random sample of 10 OCI complaint files selected from the company's complaint log. The examiners found two OCI complaint files did not document that the company responded to the complaint within the 10 days as requested by the OCI 51-11 form letter. The examiners found that three of the OCI complaint files did not indicate if the insured's policy involved a self-funded plan or a fully insured plan as required by OCI's form 51-11. Additionally, the examiners found one OCI complaint file did not respond to OCI's special requests in OCI form 51-11. The company reported that during the transition of its business from Milwaukee to Louisville, Kentucky, a template from another state was used. The company indicated it corrected the template in March 2003. Section 601.42 (4), Wis. Stat., provides that the commissioner may require statements, reports, answers to questionnaires and other information, and evidence thereof, in whatever reasonable form the commissioner

designates, and at such reasonable intervals as the commissioner chooses, or from time to time.

32. **Recommendation:** It is recommended that the company revise OCI Complaint procedures to ensure compliance with s. 601.42, Wis. Stat.

The examiners also reviewed a random sample of 100 complaints from the company's complaint log. The examiners found the company had not resolved three of the complaints and the files did not document that the company offered the complainant the right to file a grievance. Section Ins 18.03 (2), Wis. Adm. Code, provides that each time an insurer offering a health benefit plan denies a claim or benefit or initiates disenrollment proceedings, the health benefit plan shall notify the affected insureds of the right to file a grievance.

33. **Recommendation:** It is recommended that the company follow its written procedures to ensure all complainants are notified of their right to a grievance, pursuant to s. Ins 18.03 (2), Wis. Adm. Code.

Small Employer

The examiners reviewed the company's response to OCI's small employer interrogatory, its underwriting requirements, and participation requirements, rating methodology, new business rates, renewal system, actuarial certifications, and waiver and disclosure forms. The examiners found that the company's underwriting requirements did not include information defining the minimum size of the small employer or the minimum participation requirements for small employers in the state of Wisconsin. Section 635.02 (7), Wis. Stat., provides that a small employer is an employer that employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year or that is reasonably expected to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year and that employs at least 2 employees on the first day of the plan year.

34. **Recommendation:** It is recommended that the company update its written underwriting procedures to include in its definitions information regarding minimum size and minimum participation for small employer groups in order to document compliance s. 635.02 (7), Wis. Stat.

The examiners reviewed a random sample of 25 small employer issued files. The examiners found 4 small employer issued files contained employer applications that did not indicate the number of eligible employees and the number of employees enrolling. Section Ins 8.65 (1), Wis. Adm. Code, provides that a small employer insurer shall require each small employer that applies for a policy, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees of the small employer. The small employer insurer shall require the small employer to provide appropriate supporting documentation, such as the state unemployment or worker's compensation quarterly reporting forms, to verify the information required.

35. **Recommendation:** It is recommended that the company require each small employer application be fully completed and indicate the number of employees and number of enrolling employees in order to comply with s. Ins 8.65, (1), Wis. Adm. Code.

The examiners found 19 small employer issued files did not document that the employers had received a copy of the small employer notice regarding the loss of small employer protections. The company reported that the information was on the employer group application under the section titled "The Following Applies to All Products." Section Ins 8.44 (2), Wis. Adm. Code, provides that a small employer insurer shall notify each employer in writing when a policy is issued that if the employer employs less than 2 or more than 50 during at least 50% of the number of weeks in any 12-month period, or moves the business enterprise outside this state, the protections provided under ch. 635, Wis. Stat., and this subchapter will cease to apply to the employer on renewal of its health benefit plan.

36. **Recommendation:** It is recommended that the company develop and provide at the time a policy is issued notification regarding required eligibility for small employer coverage in order to comply with s. Ins 8.44 (2), Wis. Adm. Code.

The examiners found one small employer issued file contained an employer application that included an hourly work requirement of 40 hours for insurance eligibility, even though the application referenced the fact that an employer could choose a different hourly requirement of not less than 20 or more than 30 hours. Section 632.745 (5), Wis. Stat., provides that an eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours.

37. **Recommendation**: It is recommended that the company take steps to ensure that it does not accept business from small employers when the application indicates that the employer's eligibility requirements do not meet the definition of eligible employee in order to comply with s. 632.745 (5), Wis. Stat.

The examiners found that three small employer issued files contained rating and renewability forms that were signed after the completion of the employer application. The examiners found an additional two files did not contain the rating and renewability form. Section Ins 8.48, Wis. Adm. Code, provides that before completing an application for a policy, an agent shall provide the small employer or representative of the small employer or the individual applicant with a form stating the information required under s. 635.11 (1m), Wis. Stat. The

agent shall sign and date the form certifying that he or she made the required disclosure and shall obtain the signature of the small employer or representative of the small employer or the individual applicant on the form. The agent shall give one copy of the completed form to the person who signed it. The agent or small employer insurer shall retain one copy of the completed form.

38. **Recommendation:** It is recommended that the company ensure that all small employer applicants receive a copy of the rating and renewability form in order to document compliance with s. Ins 8.48, Wis. Adm. Code.

39. **Recommendation:** It is recommended that the company require the small employer applicant's signature on the rating and renewability disclosure form at the time the application is taken as required by s. Ins 8.48, Wis. Adm. Code.

Section 635.10, Wis. Stat., required that beginning no later than August 1, 2003, every small employer insurer use the uniform employee application form developed by the OCI when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. The OCI promulgated s. Ins 8.49, Wis. Adm. Code, pursuant to s. 635.10, Wis. Stat., creating the format for uniform employee application form identified as form OCI 26-501 (C 08/2003).

The examiners found one small employer issued file where the coverage was issued after January 2, 2004, that did not contain the uniform employee application. Section 635.10, Wis. Stat., provides that beginning no later than August 1, 2003, every small employer insurer shall use the uniform employee application form developed by the commissioner by rule under s. 601.41 (8) (b), Wis. Stat., when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer.

40. **Recommendation:** It is recommended that the company establish a process and procedures to ensure that it utilizes the Uniform Employee Application Form OCI 26-501, in order to comply with s. 635.10, Wis. Stat.

The examiners found three small employer issued files contained employee enrollment and waiver forms that did not correspond to number of eligible employees listed on the employer application. Section Ins 3.31 (3) (a) 3. a, Wis. Adm. Code, provides that an

insurer shall make provision for adequate underwriting personnel and procedures as to process without undue delay each enrollment form for insurance.

41. **Recommendation:** It is recommended that the company develop and implement written procedures that require its underwriters to document that the employee information on the small employer application corresponds with the number of enrollment and waiver forms in order to document compliance with s. Ins 3.31 (3) (a) 3. a, Wis. Adm. Code.

The examiners' review of the small employer issued files included comparing agents' listing dates with the application dates of the small employer groups. The examiners found that three small employer applications were written by three agents who were not listed with OCI as Humana WHO agents at the time the applications for the small employer groups were written. The examiners found that the company paid the three agents $10,026.36 in commissions. The company reported that the commissions were not paid to the agents until after the agents were listed with the company. The agents wrote the applications on April 1, 2004, November 1, 2002, and November 1, 2002, and were listed July 29, 2004, December 6, 2002, and December 6, 2002, respectively. Section Ins 6.57 (5), Wis. Adm. Code, provides that no insurer shall accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent listed with that insurer.

42. **Recommendation:** It is recommended that the company develop and implement procedures for the underwriting of small employer groups that ensures that the selling agent is listed with the company to comply with s. Ins 6.57 (5), Wis. Adm. Code.

The examiners requested a random sample of 25 small employer quotes made by the company during the period of review. The company was unable to provide copies of 2 of the quotes. The examiners found that the company only stored quotes for up to 6 months after the initial quote request. Section Ins 6.80 (4) (b), Wis. Adm. Code, provides that records of insurance company operations and other financial records reasonably related to insurance operations for the preceding 3 years shall be maintained and be available to the commissioner.

43. **Recommendation:** It is recommended that the company maintain small employer quotes for 3 years pursuant to s. Ins 6.80 (4) (b), Wis. Adm. Code.

The examiners reviewed the company's procedures for rating of its small employer business to ensure compliance with s. 635.05, Wis. Stat. The examiners documented that the company had a process for reviewing all small employer groups for compliance and for bringing into compliance at the time of renewal. The company stated that small employer groups that were undercharged were brought up to at least the minimum allowable rate level as of the next renewal date. Rates for small groups that were overcharged were brought within the compliance range as of the next billing date. The examiners found that the company's procedure did not require that refunds be issued when small groups were overcharged. Section 635.05, Wis. Stat., provides restrictions on premium rates that a small employer insurer may charge a small employer such that the premium rates charged to small employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those small employers by more than 35% of the midpoint rate.

44. **Recommendation:** It is recommended that the company revise its small employer rating procedures to ensure refunds are issued to groups that are issued rates above those permitted by s. 635.05, Wis. Stat.

The examiners reviewed the company's 2002 and 2003 small employer insurer actuarial certifications filed with OCI. The examiners found that both reports had been filed and no exceptions were noted.

Marketing, Sales & Advertising

The examiners reviewed the company's response to OCI's marketing, sales and advertising interrogatory, its marketing sales and advertising activities and its advertising files.

The examiners requested that the company document its process for communicating changes in insurance laws to its agents. The company responded that it did not communicate changes to its agents.

45. **Recommendation:** It is recommended that the company develop written procedures to communicate changes in state insurance law to its agent force on a regular basis.

The examiners found that the company did not have a process for reviewing or maintaining a listing of agents who had their own websites nor a process regarding advertisements of a general nature that may involve agents. The company indicated that its agent contracts required that advertisements using the Humana name needed to be approved by the director of sales. The examiners found that the company did not have a process for verifying whether its agents' websites included links to the company's website or whether agents included information on their websites that was not authorized by the company. Section Ins 3.27 (27), Wis. Adm. Code, provides that the content, form and method of dissemination of all advertisements, regardless of by whom designed, created, written, printed or used, shall be the responsibility of the insurer whose policy is advertised. An insurer shall require its agents and any other person or agency acting on its behalf in preparing advertisements to submit proposed advertisements to it for approval prior to use.

46. **Recommendation:** It is recommended that the company develop a process for periodic review of agent websites in order to document compliance with s. Ins 3.27 (27), Wis. Adm. Code.

The examiners reviewed a random sample of 24 advertisements in the company's advertising file. The advertising file contained only company advertisements, not those for its parent company. The examiners found one advertisement in the company's advertising file was an advertisement referencing Employers Wisconsin Insurance Company (EWIC), which was

merged with Humana WHO June 30, 2002. The company indicated that the advertisement should not have been part of the sample and should have been removed from its active files after EWIC left the market. Section Ins 3.27 (28), Wis. Adm. Code, provides that each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its policies disseminated in this state.

Electronic Commerce

The examiners reviewed the company's response to OCI's electronic commerce interrogatory, its website, security process, and online provider directories. The company reported that its parent company's department, Strategic Consultancy, was responsible for its website. The Humana, Inc., website included only parent company information, and did not advertise nor market Humana WHO products.

The examiners found that the Humana, Inc., website was a resource for all Humana members, employers, agents and providers regardless of the company they were covered under. The site contained provider directories, pharmacy formularies, plan details, health and wellness resources but did not contain information specifically related to an individual company.

The examiners requested from the company a listing of those providers whose contracts had terminated within the past 24 months, in order to document that the company's website provider directories were current and accurate. The examiners reviewed a sample of 10 terminated providers of the 138 identified terminated providers. The examiners found that the 10 terminated providers had been removed from the company's electronic provider directory.

Producer Licensing

The examiners reviewed the company's response to OCI's producer licensing interrogatory, agency agreements, producer listing and termination procedures, and producer training.

The examiners requested from Humana WHO a listing of all Wisconsin agents that represented the company as of the end date of the period under review. The agent licensing data provided by the company was compared to the agent database maintained by OCI. No exceptions were noted during the data match.

The examiners reviewed a random sample of 50 active agent files and 50 terminated agent files. No exceptions were noted regarding the file review.

Forms & Rates

The examiners reviewed the company's response to OCI's interrogatory questions, group policy forms and disclosure forms.

The examiners found that three group policy forms included a prescription drug rider [form number RX4-WIGP (1) 08/02.] that did not contain language regarding coverage for drugs for the treatment of HIV infection. Section 632.895 (9), Wis. Stat., provides that every disability insurance policy that provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following: 1. Is prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; 2. is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; 3. if the drug is an investigational new drug described in subd. 2. is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug. Coverage of a drug may be subject to any co-payments and deductibles that the disability insurance policy applies generally to other prescription medication covered by the disability insurance policy.

47. **Recommendation:** It is recommended that the company amend and file for approval with OCI its prescription drug rider and include in the rider language specifying coverage for drugs for the treatment of HIV infection as required in s. 632.895 (9), Wis. Stat.

Privacy and Confidentiality

The examiners reviewed the company's response to OCI's privacy of consumer financial and health information interrogatory, its privacy policies and procedures manual, confidentiality agreement for employees, process for notifying customers of privacy policy, privacy notice and authorization for disclosure of health information. The examiners also interviewed the company's privacy officer.

The examiners found that the company had developed a privacy program, including oversight by the board of directors and corporate compliance committee. It had appointed a privacy officer in 2001 who was responsible for oversight of corporate privacy policy. Humana, Inc., had an HIPAA steering committee that consisted of managers from all functional areas of the corporation that developed new procedures and manuals. Humana, Inc., had identified the types of information that it maintained that met the definition of nonpublic personal information. The company also had developed procedures regarding terminating electronic and security access in the event of employee termination.

The examiners documented that the company had a process for orientation of new employees to its privacy and confidentiality process, and that it had a formal, scheduled training program for new and existing employees. The company had developed and required that its employees sign a confidentiality agreement annually.

The examiners documented that the company required its listed insurance agents to sign a business associate agreement regarding the confidentiality of medical and personal information in order to meet HIPAA requirements. The company also required its outside vendors sign the business associate agreement, which was attached to the vendor contracts.

The examiners documented that the company provided to its customers a copy of its privacy notice. The company included the notice in its enrollee open enrollment kits. The company provided the initial privacy notice at the time of enrollment regardless if the group

accepted a quote. The company provided the annual notice of privacy rights through the member newsletter or mailed the notice to enrollees who did not receive the newsletter.

The examiners documented that the company had conducted internal audits of its privacy and confidentiality process. It routinely audited throughout the year by physically assessing the work area, conducting detailed interviews with area leadership, reviewing area procedures and reports; reviewing business associate contracts and by onsite desk review of area associates.

The examiners reviewed the company's records storage and shredding agreement. The agreement included a business associate agreement that was effective April 14, 2003. No exceptions were noted regarding the company's compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code.

Company Operations/Management

The examiners reviewed the company's response to OCI's company operations and management interrogatory, network, provider and administrative service agreements, and board of directors meeting minutes**.**

The examiners requested copies of all PPO network agreements. The company uses two marketing names for its Humana WHO provider network, Advantage and Premier. Humana contracts with providers for a line of business (i.e., HMO) and then determines which providers are to be included in or excluded from the two networks.

The examiners reviewed 18 provider agreement templates for compliance with Wisconsin insurance laws. No exceptions were noted regarding the language in the templates reviewed.

The company had an administrative service agreement with its parent company whereby all administrative and operational functions were provided by Humana, Inc., and its affiliates. The examiners found that the company's policies and procedures were policies and procedures established by Humana, Inc., for use by its companies nationwide. As a result, the examiners found that the company did not consistently comply with requirements under Wisconsin insurance law that are specific to its Wisconsin insurance business.

48. **Recommendation:** It is recommended that the company develop and implement procedures across all functional areas of the company that are responsible for the oversight of complying with Wisconsin insurance law.

V. CONCLUSION

The examiners found that Humana WHO did not comply with three of the six recommendations in the managed care desk audit examination that was adopted in 2000. This compliance examination resulted in 45 additional recommendations in the areas of claims, company operations and management, managed care, producer licensing, small employer, grievance and IRO, marketing, sales and advertising, policyholder services and complaints, forms and rates.

The company had an administrative service agreement with its parent company whereby all administrative and operational functions were provided by Humana, Inc., and its affiliates. The company's policies and procedures were policies and procedures established by Humana, Inc., for use by its companies nationwide. The company changed many of its processes and procedures when it moved its operations from Wisconsin to Louisville, Kentucky. The examiners found that this resulted in the company's operations being streamlined to meet its parent company's standards but also resulted in the loss of oversight. As a result, the examiners found that the company did not consistently comply with requirements under Wisconsin insurance law that are specific to its Wisconsin insurance business.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 09 1. It is recommended that the company require its vendors to utilize explanation of benefits (EOB) forms that comply with all the standardized information requirements in s. Ins 3.651 (4), Wis. Adm. Code.

Page 09 2. It is recommended that the company change its explanation of benefits (EOB) forms produced by Humana, Inc., to comply with all of the standardized information requirements in s. Ins. 3.651 (4), Wis. Adm. Code.

Page 09 3. It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company use explanation of benefits (EOB) forms that complies with s. Ins 3.651 (4), Wis. Adm. Code.

Page 10 4. It is recommended that the company require its vendors to use remittance advice (RA) forms in the standardized format required by s. Ins 3.651 (3) (d), Wis. Adm. Code.

Page 10 5. It is recommended that the company change the format of the remittance advice (RA) forms produced by Humana, Inc., to the standardized format required by s. Ins 3.651 (3) (d), Wis. Adm. Code

Page 10 6. It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company use a remittance advice (RA) form that complies with s. Ins 3.651 (3) (d), Wis. Adm. Code.

Page 10 7. It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company utilize ANSI codes as claim adjustment reason codes on explanation of benefits (EOB) forms in order to comply with s. Ins 3.651 (4) (a) (7), Wis. Adm. Code.

Page 10 8. It is recommended that the company develop and implement procedures to ensure that the company and any vendors that process claims for the company utilize ANSI codes as claim adjustment reason codes on remittance advice (RA) forms in order to comply with s. Ins 3.651 (3) (b) 4. i, Wis. Adm. Code.

Page 11 9. It is recommended that the company develop and implement written audit procedures to verify that all vendors that process claims comply with the claim settlement methodology requirements by updating its database at least every 6 months in order to comply with s. Ins 3.60 (4) (c), Wis. Adm. Code.

Page 11 10. It is recommended that the company develop and implement written audit procedures to verify that all vendors that process claims comply with the claim settlement methodology requirements by ensuring that no data in the

database at the time of update is older than 18 months in order to comply with s. Ins 3.60 (4) (d), Wis. Adm. Code.

Page 11 11. It is recommended that the company within 90 days of the adoption of the examination report provide to OCI a listing of claims processed by APS Healthcare during the period of review that were not paid equivalent to the UCR amount, and document that additional benefits were paid on these claims.

Page 12 12. It is recommended that the company develop a process and written procedures for its claim processing vendors that requires that they disclose upon request a description of the company's specific claim methodology as required by s. Ins 3.60 (6) (a) 2, Wis. Adm. Code.

Page 12 13. It is recommended that the company require ChiroTech or its chiropractic claim vendor to draft and implement procedures for claims processing, to ensure all claims are handled consistently and in compliance with s. Ins 6.11, Wis. Adm. Code.

Page 13 14. It is recommended that the company or its chiropractic claim vendor develop a process including written procedures for ensuring that any restrictions to or terminations of coverage of treatment by a licensed chiropractor within the scope of the chiropractor's professional license are subject to independent evaluation by a licensed chiropractor or a peer review committee that includes a licensed chiropractor in order to comply with s. 632.87 (3) (b), Wis. Adm. Code.

Page 13 15. It is recommended that the company develop and implement procedures to ensure that the company or its chiropractic claim vendor provides to enrollees a written statement regarding the denial and how the patient may appeal the decision in order to comply with s. 632.875 (2), Wis. Stat.

Grievance

Page 14 16. It is recommended that the company follow its procedures to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

Page 15 17. It is recommended that the company and its vendors revise their explanation of benefits (EOB) forms to contain a detailed description of Wisconsin's grievance procedure in order to comply with s. Ins 18.03 (2) (b), Wis. Adm. Code.

Page 15 18. It is recommended that the company and its vendors revise their explanation of benefits (EOB) forms to include timeframes for filing grievances in order to comply with s. Ins 18.03 (6), Wis. Adm. Code.

Page 16 19. It is recommended that the company cease its process known as downcoding and develop and implement a procedure to ensure that all written expressions of dissatisfaction are handled as grievances to ensure compliance with s. Ins 18.01 (4), Wis. Adm. Code.

Page 16 20. It is recommended that the company develop and implement a procedure to keep and maintain all complaints and grievances in separate logs to show compliance with s. Ins 18.06 (1), Wis. Adm. Code.

Page 16 21. It is recommended that the company refile its 2002, 2003 and 2004 Grievance Summary Reports, to include those grievances that had been downcoded in order to comply with s. Ins 18.06 (2), Wis. Adm. Code.

Page 17 22. It is recommended that the company develop safeguards to ensure that all grievances are resolved within 60 days in order to comply with s. Ins 18.03 (6), Wis. Adm. Code.

Page 17 23. It is recommended that the company modify its Wisconsin IRO process to ensure the opportunity to bypass the grievance process and to obtain independent review in order to comply with s. 632.835 (2) (d), Wis. Stat.

Page 18 24. It is recommended that the company establish a procedure either to comply with the complete independent review notice requirements in s. 632.835 (2) (b), Wis. Stat., or s. 632.835 (2) (bg), Wis. Stat.

Page 19 25. It is recommended that the company develop and implement oversight procedures that include regular audits of all entities that are authorized to make adverse determinations or experimental treatment determinations on the company's behalf to ensure that the entities comply with s. 632.835 (2), Wis. Stat.

Managed Care

Page 22 26. It is recommended that the company revise its outside vendor contracts to include provisions addressing reimbursement to terminated providers to ensure compliance with s. 609.24 (1) (e), Wis. Stat.

Page 22 27. It is recommended that the company include in its compliance plan a written procedure requiring regular internal audits in order to comply with s. 9.42 (3), Wis. Adm. Code.

Page 22 28. It is again recommended that the company submit to OCI and obtain approval of language in its policies and certificates regarding coverage of second opinions that complies with s. 609.22 (5), Wis. Stat.

Page 22 29. It is again recommended that the company develop a procedure to provide an enrollee with coverage for a second opinion from another participating provider, as required by s. 609.22 (5), Wis. Stat.

Page 23 30. It is again recommended that the company develop and implement a process including timelines through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan that complies with s. 632.853, Wis. Stat.

Policyholder Service & Complaints

Page 24 31. It is recommended that the company develop a process to maintain a log for all complaints received, including those involving outside vendors to ensure compliance with s. ins 18.06 (1), Wis. Adm. Code.

Page 25 32. It is recommended that the company revise OCI Complaint procedures to ensure compliance with s. 601.42, Wis. Stat.

Page 25 33. It is recommended that the company follow its written procedures to ensure all complainants are notified of their right to a grievance, pursuant to s. Ins 18.03 (2), Wis. Adm. Code.

Small Employer

Page 26 34. It is recommended that the company update its written underwriting procedures to include in its definitions information regarding minimum size and minimum participation for small employer groups in order to document compliance with s. 635.02 (7), Wis. Stat.

Page 26 35. It is recommended that the company require each small employer application be fully completed and indicate the number of employees and the number of enrolling employees in order to comply with s. Ins 8.65 (1), Wis. Adm. Code.

Page 27 36. It is recommended that the company develop and provide at the time a policy is issued notification regarding required eligibility for small employer in order to comply with s. Ins 8.44 (2), Wis. Adm. Code.

Page 27 37. It is recommended that the company take steps to ensure that it does not accept business from small employers when the application indicates that the employer's eligibility requirements do not meet the definition of eligible employee in order to comply with s. 632.745 (5), Wis. Stat.

Page 28 38. It is recommended that the company ensure that all small employer applicants receive a copy of the rating and renewability form in order to document compliance with s. Ins 8.48, Wis. Adm. Code.

Page 28 39. It is recommended that the company require the small employer applicant's signature on the rating and renewability disclosure form at the time the application is taken as required by s. Ins 8.48, Wis. Adm. Code.

Page 28 40. It is recommended that the company establish a process and procedures to ensure that it utilize the Uniform Employee Application Form OCI 26-501, in order to comply with s. 635.10, Wis. Stat.

Page 29 41. It is recommended that the company develop and implement written procedures that require its underwriters to document that the employee information on the small employer application corresponds with the number of enrollment and waiver forms in order to document compliance with s. Ins 3.31 (3) (a) 3. a, Wis. Adm. Code.

Page 29 42. It is recommended that the company develop and implement procedures for the underwriting of small employer groups that ensures that the selling agent is listed with the company to comply with s. Ins 6.57 (5), Wis. Adm. Code.

Page 29 43. It is recommended that the company maintain small employer quotes for 3 years pursuant to s. Ins 6.80 (4) (b), Wis. Adm. Code.

Page 30 44. It is recommended that the company revise its small employer rating procedures to ensure refunds are issued to groups that are issued rates above those permitted by s. 635.05, Wis. Stat.

Marketing, Sales & Advertising

Page 31 45. It is recommended that the company develop written procedures to communicate changes in state insurance law to its agent force on a regular basis.

Page 31 46. It is recommended that the company develop a process for periodic review of agent websites in order to document compliance with s. Ins 3.27 (27), Wis. Adm. Code.

Forms & Rates

Page 35 47. It is recommended that the company amend and file for approval with OCI its prescription drug rider and include in the rider language specifying coverage for drugs for the treatment of HIV infection as required in s. 632.895 (9), Wis. Stats.

Company Operations/Management

Page 38 48. It is recommended that the company develop and implement procedures across all functional areas of the company that are responsible for the oversight of complying with Wisconsin insurance law.

VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

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Kristy Jacobson	Insurance Examiner
John Kitslaar	Insurance Examiner
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Jamie Key	Advanced Insurance Examiner

Respectfully submitted,

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Examiner-in-Charge