State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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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 INSURANCE COMPANY
1100 EMPLOYERS BLVD
GREEN BAY WI 54115

dated November 21, 2007, and served upon the company on July 1, 2008, 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 15th day of August, 2008.

Sean Dilweg
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

HUMANA INSURANCE COMPANY
GREEN BAY, WISCONSIN

SEPTEMBER 10-26, 2007

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November 21, 2007

Honorable Sean Dilweg
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conduct September 10, 2007 to September 26, 2007 of:

HUMANA INSURANCE COMPANY
Green Bay, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Humana Insurance Company is a Wisconsin-domiciled life and health insurer. It initially was organized in 1968 under the name Classified Life Insurance Company, which was acquired by Wisconsin Employers Group Inc (WEG) in 1977. The name of the company was changed to Wisconsin Employers Insurance Company. American Express purchased the company in 1983 and changed the company's name to Fireman's Fund Employers Insurance Company. Lincoln National Corporation (LNC) purchased the company in 1986 and changed the company's name to Employer's Health Insurance Company (EHIC). LNC eventually formed a company called EMHPESYS Financial Group (EFG) to act as a holding company for EHIC and related affiliates. In 1995 all stock of EMPHESYS was purchased by Humana, Inc. Effective December 31, 2001. Humana Insurance Company (HIC), a then existing Missouri domiciled life and health insurance subsidiary of Humana Inc, merged with EHIC. The resulting

company after the merger was EHIC, which subsequently changed its name to Humana Insurance Company.

The company is licensed in all states and the District of Columbia. The company writes group and individual health insurance, including preferred provider organization (PPO) policies. It markets its HumanaOne individual health insurance policy, a PPO product, in Wisconsin and 25 other states.

The company does not write Medicare supplement business. However, its parent company, Humana Inc., has had a contract with the Centers for Medicare and Medicaid Services (CMS) since the 1990s to offer Medicare health maintenance organization (HMO) and Medicaid managed care organization (MCO) plans. Humana Inc. has contracted with CMS to offer Medicare Advantage private fee for service (PFFS) plans (Humana Gold Choice) since January 1, 2002. Humana Inc. ranked 2nd nationally for market share of Medicare Advantage plans and Medicare Part D prescription drug plan enrollment as of March 2007. The company marketed two Medicare Advantage PFFS plans with prescription drug coverage; two Medicare Advantage preferred provider organization (PPO) plans, one with prescription drugs, and three prescription drug plans (PDPs).

In 2006 and 2005 the company reported written premium in all states where it is licensed. The following table summarizes the total direct national premium written in 2006 and 2005 as compared to the total direct premium written in Wisconsin.

National Direct Business to Wisconsin Direct Business Summary

2006	**Life Insurance Premiums**	**A&H Insurance Premiums**
Wisconsin	$ 1,432,420	$ 512,867,326
National	$ 33,527,000	$9,081,130,000
Wisconsin As a % of National	*.0427%*	5.65%

	Life Insurance Premiums	A&H Insurance Premiums
2005		
Wisconsin	$ 1,293,172	$ 299,173,699
National	$33,761,000	$3,208,487,000
Wisconsin As a % of National	*.038%*	*1%*

The majority of the premium written by the company in both 2005 and 2006 was for group health insurance.

The following tables summarize the premium written and benefits paid in Wisconsin for 2006 and 2005:

Wisconsin Premium and Loss Ratio Summary

			2006		
Line Of Business		**Direct Premiums Earned**	**% of Total Premium**	**Direct Losses Incurred**	**Pure Loss Ratio**
Group Health		250,575,515	93.34%	201,685,110	80.49%
Individual Health		17,889,434	6.66%	12,112,275	67.71%
	Total	268,464,949	100%	213,797,385	

			2005		
Line Of Business		**Direct Premiums Earned**	**% of Total Premium**	**Direct Losses Incurred**	**Pure Loss Ratio**
Group Health		187,108,590	92.36%	148,527,328	79.38%
Individual Health		15,482,989	7.64%	11,009,324	71.11%
	Total	202,591,579	100%	159,536,652	

In 2005, the company ranked as the 14th largest writer of group health insurance in Wisconsin with 2.3% of the market share. It ranked 12th in 2006 with 3% of the market share. In addition, the company ranked as the 2nd largest writer of individual health insurance with 8% of the market share in 2005 and remained 2nd in 2006 with an increase of the market share to 12.6%. The company ranked 5th for 2005 and 2006 as a small employer insurer with 6.7% share of the market in 2005 and 7.6% in 2006.

Complaints

The Office of the Commissioner of Insurance received 220 complaints involving the company between July 1, 2005 through June 30, 2007. 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's complaints primarily involved claims administration.

The company ranked 7th on the 2006 complaint summary for group accident and health insurance with 77 complaints and a complaint ratio of .04 compared to a Wisconsin average of .02 per $100,000 of written premium. It ranked 20th on the 2005 complaint summary for group accident and health insurance with 53 complaints and a complaint ratio of .03 compared to a Wisconsin average of .02 per $100,000 per written premium. The company ranked 8th on the 2006 complaint summary for individual accident and health insurance with 38 complaints and a complaint ratio of .07 compared to a Wisconsin average of .06 per $100,000 of written premium. It did not rank on the 2005 complaint summary for individual accident and health.

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.

2007						
Reason Type	**Total**	**Under writing**	**Marketing & Sales**	**Claims**	**Plcyhlder Service**	**Other**
Coverage Type	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Individual A&H	7	2	1	1	3	
Group A&H	42	0	5	34		
Other	0					
Total	109	2	6	35	3	0

2006						
Reason Type	Total	Under writing	Marketing & Sales	Claims	Plcyhlder Service	Other
Coverage Type	No.	No.	No.	No.	No.	No.
Individual A&H	20	6		7	5	
Group A&H	80	6		72	6	
Other	0					
Total	100	12	0	81	11	

Grievances

The company submitted annual grievance summary reports to OCI for 2005 and 2006 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 2005 indicated the company received 459 grievances; 285 or 62% were reversed. The majority of the grievances filed with the company in 2005 were related to plan administration in the category identified as "Other".

The grievance report for 2006 indicated the company received 714 grievances; 432 or 61% were reversed. The majority of the grievances filed with the company in 2006 were related to the categories identified as "Other " and "No covered Benefit".

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

Category	2005 No.	2006 No.
Access to Care	0	1
Continuity of Care	0	2
Prescription Drug	8	13
Emergency Services	54	112
Experimental Treatment	1	6
Prior Authorization	3	13
Noncovered Benefit	70	219
Not Medically Necessary	9	4
Other	238	284
Plan Administration	63	45
Request for Referral	1	0
Plan Providers	12	15

Category	2005 No.	2006 No.
Total	459	714
Resolution Categories		
Plan Administration	346	220
Benefit Denial	113	494
Quality of Care	0	0
Total	459	714

Independent Review Organization

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the OCI annual reports for the prior calendar year's experience indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent review include adverse and experimental treatment determinations. The IRO reports indicate that for both 2005 and 2006 the company had two IRO requests filed involving Humana Insurance Company.

The following tables summarize the IRO review requests for the company for the last two years:

2005*

Independent Review Organizations						Number of Decisions		
Review Requests Received	IPRO	Maximus-CHDR	Medical Review Inst of America	Permedion	Prest	Upheld	Reversed	Average Number of Days to Resolve
2		1		1		1	1	20

2006

Independent Review Organizations						Number of Decisions		
Review Requests Received	IPRO	Maximus-CHDR	Medical Review Inst of America	Permedion	Prest	Upheld	Reversed	Average Number of Days to Resolve
2*		2					1	30

*Total review requests received does not equal total number of decisions because Independent Review Organization declined one or more cases.

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, 2005 through June 30, 2007. 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 and practices in the areas of claims; company operations/management; electronic commerce; grievance and IRO; managed care; marketing; sales and advertising; policyholder service and complaints; privacy; producer licensing; rates and policy forms; small employer and underwriting and rating. The examination also included a review of the company's Medicare Advantage and Medicare Part D agent marketing activities.

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 market conduct examination of the company, as adopted November 7, 2002, contained 24 recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Advertising

1. It is recommended that Employers Health maintain in its advertising file only those items that pertain to Employers health products and are advertisements as defined in s. Ins 3.27 (5), Wis. Adm. Code.

   Action: Compliance

Producer Licensing

2. It is recommended that Employers Health revise its procedures and systems to ensure that business is not accepted from an intermediary agent until the intermediary agent is listed with the company in accordance with s. Ins 6.57 (1), Wis. Adm. Code. It is further recommended that the company revise its procedures to ensure that applications received from intermediary agents who are not appointed with the company are not accepted and promptly returned to the agent.

   Action: Non-Compliance

3. It is recommended that Employers Health promptly terminate agents pursuant to s. Ins 6.57 (2), Wis. Adm. Code.

   Action: Non-Compliance

4. It is recommended that Employers Health review and revise its procedures accordingly to ensure that agents whose licenses have been suspended and/or revoked by OCI are promptly terminated in accordance with s. Ins 6.57 (2), Wis. Adm. Code.

   Action: Compliance

5. It is recommended that Employers Health carefully review and compare the annual renewal billing sent by OCI to the company's records, promptly initiate an investigation into the reason(s) an agent does not appear on the annual renewal billing when the company's records show the person is an active agent appointed to represent the company and take the appropriate action to rectify the situation.

   Action: Non-Compliance

Claims

6. It is again recommended that Employers Health improve its claims handling procedures to better ensure the identification of claims subject to payment of interest and promptly pay interest as required by s. 628.46, Wis. Stat.

Action: Non-Compliance

7. It is recommended that Employers Health revise letters sent to providers and patients per the requirements of s. 632.875 (2), Wis. Stat., include a statement that an independent evaluation has been conducted, provide in the body of the letter an address to appeal the determination and provide information on Employers Health's grievance procedure rather than ERISA appeal guidelines.

   Action: Compliance

Grievance and IRO

8. It is again recommended that Employers Health revise all of its provider contracts to require that providers identify complaints and grievances, and to require that providers forward complaints and grievances to the company, in a timely manner, for recording and resolution as required by s. Ins 9.33 (7) (b), Wis. Adm. Code [repealed and created as s. Ins 18.03 (2) (c) 2, Wis. Adm. Code].

   Action: Non-Compliance

9. It is recommended that Employers Health revise its provider contracts to identify Employers Health as a contracting party.

   Action: Compliance

10. It is again recommended that Employers Health order medical records as soon as grievances are received, if medical records are necessary to the grievance review, in order to provide for timely resolution of the grievance within 30 days, as required by s. Ins 9.33 (4), Wis. Adm. Code [repeated and created as s. Ins 18.03 (6), Wis. Adm. Code].

    Action: Compliance

11. It is again recommended that Employers Health designate a person within the company who is responsible for the handling and monitoring of grievances, to ensure the grievance requirements of s. Ins 9.35 (5), Wis. Adm. Code, are met [repealed and created as s. Ins 18.03, Wis. Adm. Code].

    Action: Compliance

12. It is again recommended that Employers Health resolve all grievances within 30 days and that the company provide written notice to the grievant, if a grievance will not be resolved within 30 days, why additional time is necessary, and when the grievance will be resolved, as required by s. Ins 9.33 (4) Wis. Adm. Code [repealed and created as s. Ins 18.03 (6), Wis. Adm. Code].

    Action: Non-Compliance

13. It is again recommended that Employers Health maintain all information pertaining to a grievance in the grievance file, including letters sent to the grievant, in order to comply with

s. Ins 9.33 (7) (a) Wis. Adm. Code [repealed and created as s. Ins 18.06 (1), Wis. Adm. Code].

Action: Compliance

14. It is recommended that Employers Health retain all grievance information and documentation for a period of three (3) years as required by s. 632.83 (3) (e), Wis. Stat.

    Action: Compliance

15. It is again recommended that Employers Health revise its internal procedures for handling grievances to indicate the time frames within which specific actions must be taken to ensure compliance with s. Ins 9.33 (3) and (6), Wis. Adm. Code [repealed and created as s. Ins 18.03 (4) and 18.05, Wis. Adm. Code].

    Action: Compliance

16. It is recommended that Employers Health improve its existing procedures to ensure that grievance committee meeting notices are sent to grievants pursuant to the requirements of s. Ins 9.33 (5) (b) Wis. Adm. Code [repealed and created as s. Ins 18.03 (3) (b), Wis. Adm. Code], and that a copy of the notice be kept in the grievance file.

    Action: Non-Compliance

17. It is recommended that Employers Health revise its claim denial letters to disclose that some states, including Wisconsin, may have time frame requirements that differ from the ERISA guidelines, pursuant to s. Ins 9.33 (2), Wis. Adm. Code [repealed and created as s. Ins 18.03 (2) (a) and (b), Wis. Adm. Code].

    Action: Non-Compliance

Small Employer

18. It is again recommended that Employers Health provide rating and renewability information as a separate written notice, to the small employer group before an application for coverage is taken, as required by s. Ins 8.48 (1) Wis. Adm. Code.

    Action: Non-Compliance

19. It is recommended that Employers Health develop procedures to ensure information on employer applications that applications is complete, in order to comply with s. Ins 8.65, Wis. Adm. Code.

    Action: Compliance

Group Life

20. It is again recommended that Employers Health revise its AD Administrative Processing Manual to provide life conversion coverage to individuals who are no longer eligible for coverage under a group contract or who are no longer eligible because the group terminated, after having provided coverage to the employee for at least five years, as

required by s. 632.57, Wis. Stat.

Action: Compliance

21. It is again recommended that Employers Health revise its AD Administrative Processing Manual by removing language that states life conversion coverage is not available to individuals with less than $2000 of group coverage, in order to comply with s. 632.57 (4) Wis. Stat.

Action: Compliance

Managed Care

22. It is recommended that Employers Health Insurance Company implement a compliance program to ensure that the company complies with all applicable provisions of ch. 609, Wis. Stat. regarding its preferred provider plans.

Action: Non-Compliance

E-Commerce

23. It is recommended that Employers Health develop written procedures regarding the use of personal websites by agents for insurance related business, including advertising, and that any prohibitions be reflected in the agent's contract.

Action: Non-compliance

24. It is recommended that Employers Health replace existing letters and letterheads that do not clearly and adequately identify the company as the insurer, to comply with s. 628.34 (1),Wis. Stat. and s. Ins 3.27 (12), Wis. Adm. Code.

Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

CLAIMS

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

The company's insurance policies typically provide that benefits are limited to the maximum allowable fee (MAF) claim payment methodology. For claims filed by non-participating providers, the company contracted with Ingenix as its third party vendor to provide fee information for current procedural terminology (CPT) codes for medical and surgical services. The Ingenix prevailing healthcare charges system (PHCS) is a national database of physician charges by area, which Ingenix collects from participating payors. The Ingenix data calculations were based on both actual and derived charges. Actual charges included those where there were nine or more occurrences of a procedure in a particular geographical area. Ingenix then arrayed and calculated percentiles based on these actual charges. Derived charges included a blended methodology of a relative value scale and charge data in determining conversion factors. The Ingenix actual and derived charge data is a rolling 12 month period that the company updated on a semi-annual basis. The examiners reviewed the company's agreements with Ingenix, and manuals from Ingenix that described its method for determining the reimbursable charge for services.

The examiners selected from the claim data a random sample of 25 paid health claims. The examiners also requested from the company data files for the entire population of non-participating chiropractor claims submitted between July 1, 2007 and August 31, 2007 for three commonly billed chiropractic CPT procedure codes for the 531 zip code area, and selected a random sample of 25 submitted chiropractic claims. The examiners reviewed the files to verify that the MAF claim determination was current and accurate. The review included

documenting that the CPT code data for each claim, including the date of service, provider zip code, amount billed by the provider, fee information obtained from Ingenix, payment percentile and amount paid by the company to verify that the data met the requirements of s. Ins 3.60 (4), Wis. Adm. Code. The examiners verified that the charge data obtained from Ingenix was based on the actual charged amounts, not the paid amounts. No exceptions were noted.

The examiners found that the company offered employers group contracts with options regarding how the percent and percentile of claim payment are calculated. For example, it offered group contracts that allowed claims for non-participating providers to be paid at 70% of the 50th percentile of PHCS data. For each CPT code, the 50th percentile was determined based on zip code area. No exceptions were noted regarding the company's claim payment methodology.

The examiners reviewed the company's procedures for explaining usual and customary claim payments to consumers. The examiners found that the company's internal procedures provided that it would not release the actual usual and customary amount to the insured but would inform them if the charge was over or under the usual and customary amount. In order to ensure compliance with s. Ins 3.60 (6) (a) 2, Wis. Adm. Code, the insurer must disclose upon request the specific amount allowable under the company's guidelines.

1. **Recommendation:** It is recommended that the company revise its internal policies, procedures and process to provide that it disclose to the insured upon request the specific amount allowable under the company's guidelines as required by s. Ins 3.60 (6) (a) 2, Wis. Adm. Code.

The examiners reviewed a random sample of 50 paid health claims and 50 denied claims processed during the period of review. The examiners verified that the company's EOBs and RAs included appropriate information regarding claim payment or denial of payment, and that it used ANSI codes as claim adjustment reason codes.

The examiners reviewed a random sample of 50 unpaid claims and found one claim that the company adjusted based on a company error but where it failed to pay interest on

the claim. The company agreed that interest was due and paid the interest on the claim. The company stated that its procedure for paying interest on adjusted claims changed effective May 22, 2007.

The examiners found during the review of the company's complaint log that the company received 11 complaints involving the company adjusting claim payments, but that it failed to pay interest on five of these claims. The company agreed that it should have paid interest on these claims. The examiners found that the remaining six complaint files were processed timely based on additional information provided by the company.

The company provided a copy of its written procedures for paying interest on adjusted claims. The examiners found that during the period May 5, 2004 to September 7, 2005, the company procedures stated that interest on adjusted claims was not a specific provision under Wisconsin law. The company's procedure manual in use during the period September 8, 2005 to January 5, 2007, included a manual process whereby claim processing specialists calculated any interest due on adjusted claims. The company updated its procedure effective January 5, 2007, and added a computer generated interest calculator and a system edit code to flag those adjusted claims where there was the potential that interest was owed. The examiners found that the company's procedures continued to reference that "There are no known requirements [in Wisconsin] to apply interest to adjusted claims." The company's procedure manual in use during the period April 4, 2007 to May 21, 2007, stated that the state [Wisconsin] had no known interest on adjusted claims requirements so the edit code did not apply. A May 22, 2007, update to the company's procedure manual stated that interest on adjusted claims was paid on claims that were adjusted as a direct result of Humana error. The edit code again was used to flag adjusted claims where there was the potential that interest was owed. The examiners documented that the company changed its procedures on May 22, 2007, to ensure compliance. The examiners found that company procedures regarding paying interest on delayed claims did not consistently comply with s. 628.46, Wis. Stat., which states

that an insurer shall promptly pay every insurance claim. A claim shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of the loss. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer.

2. **Recommendation:** It is again recommended that the company improve its claim handling process to ensure identification of claims subject to payment of interest and promptly pay interest as required by s. 628.46, Wis. Stat.

3. **Recommendation:** It is recommended that within 90 days of adoption of the report, that the company provide written documentation that it has reviewed the claims that were readjusted during the period of review and has paid interest where owed.

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 2005 and 2006, company EOB and RA forms, and its procedures for handling independent review requests from Wisconsin insureds.

The company reported in its grievance summary report for 2006, 255 more grievances than it reported in its grievance summary report for 2005. The company reported 459 grievance for 2005, with 62% reversed and 714 grievances for 2006 with 62% reversed. The number of grievances regarding emergency room services doubled between 2005 and 2006. The company indicated that it implemented an internal audit work group in October 2006, to determine why it received so many complaints and grievances regarding claim denials in relation to emergency room services. The company indicated that many of these grievances involved physicians telling their insured patients to go to the emergency room, but that the company's claim system did not captured this information. The company noted that in June 2007, it added additional questions to its call center guidelines to assist in appropriately identifying potential emergency room situations.

Grievance

The examiners reviewed a random sample of 50 grievance files filed during the period of review. The examiners found that seven of the company's grievance files did not contain a copy of the grievant acknowledgement letter. The company agreed that the acknowledgement letters were not sent within 5 business days of receipt of the grievance as required by s. Ins 18.03 (4), Wis. Adm. Code. The company provided written procedures that indicated it required that grievance acknowledgment letters be sent within 5 business days of receipt of the grievance.

4. **Recommendation:** It is recommended that the company develop a process to ensure that its written procedures are followed, including periodic scheduled reviews, in order to comply with s. Ins. 18.03 (4), Wis. Adm. Code.

The examiners found two grievance files where the company did not send an extension letter to the grievant when the grievance was not completed within 30 days of receipt. The company indicated that it did not send extension letters because the files were misrouted to the wrong department and the dates used for managing the file were not correct. Section Ins 18.03 (6), Wis. Adm. Code, provides that insurers are required to send extension letters for grievances where the final resolution will not be reached within 30 days of receipt of the grievance.

5. **Recommendation:** It is again recommended that the company resolve all grievances within 30 days and that the company provide written notice to the grievant, if a grievance will not be resolved within 30 days, to ensure compliance with s. Ins 18.03 (6), Wis. Adm. Code.

6. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to document that it sends an extension letter to the grievant when a grievance will not be resolved within 30 days and to document compliance with s. Ins 18.03 (6), Wis. Adm. Code.

The examiners found four grievance files indicated that the grievance meeting notice was not sent within 7 days of the meeting. The company provided written procedures that indicated it did require that the grievance meeting notice be sent within 7 days of the meeting. The company agreed that the letters were not sent within the required time frame. Section Ins 18.03 (3) (b), Wis. Adm. Code, provides that the insurer send the grievant a notice of the time and place of the grievance meeting at least 7 calendar days before the grievance meeting.

7. **Recommendation:** It is again recommended that the company improve its existing procedures to ensure that grievance committee meeting notices are sent to grievants pursuant to the requirements of s. Ins 18.03 (3) (b), Wis. Adm. Code.

8. **Recommendation:** It is recommended that the company conduct periodic schedule reviews to document that it sends to the grievant a notice of the time and place of the grievance meeting at least 7 calendar days before the grievance meeting and to document compliance with s. Ins 18.03 (3) (b), Wis. Adm. Code.

The examiners requested that the company show compliance with the prior examination recommendation that required that the company revise its claim denial letters to include a disclosure that some states, including Wisconsin, may have time frame requirements

that differ from the ERISA appeal guidelines. The company provided template copies of eleven letters that the examiners found did not include the disclosure. The company stated that its letter writing system had the functionality to include state specific grievance information when generating a letter to a Wisconsin member, but that the letters were inadvertently entered into the letter writing system without the appropriate information. Section Ins 18.03 (2) (a) and (b), Wis. Adm. Code, provides that each time an insurer denies a claim or benefit, they shall notify the insured of the right to file a grievance. The notice shall direct 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 notification shall also state the specific reason for the denial, determination or initiation of disenrollment.

9. **Recommendation:** It is again recommended that the company revise its claim denial letters to disclose that some states, including Wisconsin, may have time frame requirements that differ from the ERISA guidelines to ensure compliance with s. Ins 18.03 (2) (a) and (b), Wis. Adm. Code.

Independent Review

The examiners reviewed the company's written procedure entitled Wisconsin mandate for adverse determination notice of appeal and independent review organization options, the independent review procedures in its grievance and appeal training online reference tool, sample EOBs and benefit denial letters, and its certificate of coverage language regarding the independent review process. The examiners also interviewed the parent company's grievance and appeal managers for the Cincinnati and Green Bay offices.

The examiners' review of the random sample of 50 grievance files found one file that indicated the company failed to advise the grievant of his IRO rights. The company stated that the written procedures in use at the time of the grievance indicated that denials for experimental/investigational issues were not handled the same as grievances involving medical necessity. The examiners documented that the company changed the written procedures in July 2006, to show compliance with s. Ins 18.11 (2), Wis. Adm. Code, which requires an insurer

to provide a notice of the right to independent review with denials for experimental/investigational issues and medical necessity.

The examiners found that the company had developed and implemented policies and procedures to notify insureds of the right to request and obtain an independent review each time it made an adverse determination or an experimental treatment determination. The policies and procedures required review by a regional medical director each time the company made an adverse determination or an experimental treatment determination requiring a review. The examiners documented that the notice to request independent review was provided with the grievance resolution letter. The examiners also documented that the company's current EOB forms contained a statement regarding the right to request an independent review.

The examiners documented that the company had developed written policies and procedures to notify the OCI and the independent review organization (IRO) when it received an insured's request for an independent review and to submit all relevant documents to the IRO within the required timeframes.

The examiners reviewed the files for the two independent review requests that the company received during the period of review. The examiners found one file where the insured's initial request for an independent review was returned by the company with a notice stating that the check was not made payable to Humana. Section 632.835 (3) (a), Wis. Stat., provides that to request an independent review, an insured or his or her authorized representative shall provide timely written notice to the insurer and include a $25 fee payable to the IRO. The examiners documented that the insured made three phone calls to the company regarding the returned request, but they did not receive an explanation of why the request was returned or why the company did not provide accurate information regarding Wisconsin's independent review process. Section 632.835 (3) (b), Wis. Stat., provides that an insurer submit copies of all relevant documents to the independent review organization within five business days of receiving a written request for independent review.

10. **Recommendation:** It is recommended that the company develop and implement a process, including written procedures, to ensure compliance with s. 632.835 (3) (b), Wis. Stat.

MANAGED CARE

Chapter 609, Wis. Stat., was amended by 2001 Wis. Act 16, to create and define defined network plans and relaxed some of the requirements applicable to preferred provider plans, when the preferred provider plan did not require or impose financial incentives related to referrals for access to a participating or non-participating provider. Chapter Ins 9, Wis. Adm. Code, was amended effective January 1, 2007, for policies or certificates newly issued and effective January 1, 2008, for renewed policies or certificates, to correspond with the statutory requirements of ch. 609, Wis. Stat., as amended by 2001 Wis. Act 16. These amendments required disclosure notice to the applicant at the time of solicitation, and disclosure in the group or individual policy that limited benefits would be paid when the insured uses the services of nonparticipating providers.

The examiners reviewed the company's response to OCI's managed care interrogatory, policy forms filed during the period of review, its policies and procedures regarding plan administration, compliance program, quality assurance and improvement, access standards, credentialing and recredentialing. 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 company had not sought credentialing with the National Committee for Quality Assurance (NCQA) but indicated that it was considering pursuing credentialling for its PPO business.

The examiners reviewed the company's policy forms filed during the period of review to verify that the coinsurance and co-payment differentials for participating and nonparticipating providers were compliant with s. Ins 9.25 (5), Wis. Adm. Code. The examiners also documented that the company filed amendments for its existing policies regarding and that its new policy form filings included the disclosure regarding the costs associated with seeing nonparticipating providers.

The examiners verified that the board of directors of the company's parent had oversight of the quality assurance and improvement aspects of its plans. The board delegated to its quality steering committee which in turn delegated to its local market's quality improvement committee. The examiners verified that the company had filed with the 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 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 examiners requested that the company explain how it reported disciplinary actions taken against a participating provider. No exceptions were noted.

The examiners reviewed the company's access standards. The board of directors of the company's parent assigned oversight of its access standards to its interdisciplinary action and its quality improvement committees. The examiners verified that the company had a process in place for updating its provider list on an ongoing basis and for disseminating the list to enrollees. The examiners found that the company submitted a certification of access standards report dated July 30, 2007, as required by s. Ins 9.34, Wis. Adm. Code, to show compliance with s. 609.22, Wis. Stat. The company reported that it printed new provider directories quarterly and that the online tool for checking providers was updated in "real time."

The examiners reviewed the company's continuity of care policies and procedures, including its 2006 quality improvement program description, work plan and annual evaluation documents, claim processing policies and procedures, provider agreements, company complaint log and OCI complaints. The examiners found that the company's written procedures regarding continuity of care met the requirements of s. 609.24, Wis. Stat., which provides that, if an insurer 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.

The examiners reviewed a random sample of 50 company provider agreements. The examiners found that 10 provider agreements did not comply with the requirements of s. 609.24, Wis. Stat., which states that a defined network plan shall provide coverage to an enrollee for the services of a provider if the defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee. The company agreed that the contracts were not compliant and indicated that it would be taking corrective action by adding an amendment to the contracts.

11. **Recommendation:** It is recommended that the company revise its provider agreements at the time of their next renewal date but no later than one year after the adoption of the examination report to ensure the agreements are compliant with the requirements of s. 609.24, Wis. Stat.

The examiners identified nine provider agreements that did not contain language meeting the requirements of s. 609.30, Wis. Stat., which states that a defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition. The company indicated that it would include this language in its provider agreements to ensure compliance.

12. **Recommendation:** It is recommended that the company include language in each of its provider agreements at the time of their next renewal date but no later than one year after the adoption of the examination report to ensure the agreements are compliant with the requirements of s. 609.30, Wis. Stat.

The examiners found that 10 provider agreements did not contain language that demonstrated that the company required providers to record and forward complaints and grievances to the company to ensure compliance with s. Ins 18.03 (2) (c) (2), Wis. Adm. Code.

The examiners reviewed the company's agreements with its two PPO networks, HealthEOS and PreferredOne. The examiners found that neither network agreement contained language to ensure compliance with s. Ins 18.03 (2) (c) (2), Wis. Adm. Code, which requires a defined network plan to include a provision that requires the contracting entity to promptly

respond to complaints and grievances filed with the insurer to facilitate resolution. The company agreed that neither the HealthEOS nor the PreferredOne network agreement was compliant, but indicated that the HealthEOS agreement would be terminating and PreferredOne would be compliant going forward.

13. **Recommendation:** It is again recommended that the company revise all of its provider contracts to require that providers identify complaints and grievances, and to require that providers forward complaints and grievances to the company, in a timely manner, for recording and resolution to ensure compliance with s. Ins. 18.03 (2) (c) (2), Wis. Adm. Code.

14. **Recommendation:** It is recommended that the company file with the OCI a report when the process of revising its provider and network agreements is completed, but no later than one year after the adoption of the examination report, in order to document compliance with s. Ins 18.03 (2) (c) (2), Wis. Adm. Code.

The examiners reviewed the company's response to the 2001 Market Conduct Examination regarding implementation of a compliance program to ensure the company complied with all applicable provisions of ch. 609, Wis. Stat., regarding preferred provider plans. The examiners found that the company did not comply with all of the required provisions. The examiners found that the company's compliance plan did not specifically include regular audits as required under s. Ins 9.42 (3), (4) and (5), Wis. Adm. Code, which states that the insurers compliance plan shall include regular internal audits, including regular audits of any contractors or subcontractor who perform functions relating to compliance of ch. 609, Wis. Stat.; maintain management reports and records reasonably necessary to monitor, supervise and audit any party that an insurer materially relies on to perform the function relating to compliance with ch. 609, Wis. Stat. and the insurer shall maintain any audits, and associated work papers of audits conducted relating to the business and service operation of the insurer.

15. **Recommendation:** It is recommended that the company develop and implement an audit component to its compliance program to ensure that it complies with all applicable provisions of ch. 609, 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, its complaint log and OCI complaints.

The examiners reviewed a random sample of 50 complaints from the company's internal complaint log. The examiners verified that the company notified the complainants of the right to file a grievance under s. Ins 18.03, Wis. Adm. Code, when it was not able to resolve the complaint. Prior to the examination, the examiners completed a complaint analysis of the complaints received by OCI involving the company for the period of review. The examiners found that the issues identified in the company's complaint log sample were similar to those found in the OCI complaint analysis. No exceptions were noted regarding the complaint review.

ELECTRONIC COMMERCE

The examiners reviewed the company's response to OCI's electronic commerce interrogatory, its website, security process and online provider directories.

The examiners found that the company website (www.humana.com) offered information about individual and group health products, Medicare Advantage plans and Humana Dental. The website contained a privacy statement.

Visitors to the website could obtain quotes by entering a zip code, and could enroll on-line for PPFS, PPO, PDP products. The website included formulary information and confidential member claim information. The company's Internet infrastructure had multi-layered firewall systems that offered protection against unauthorized attempts to gain access to the information systems. The company also had multi-layered security to ensure that authorized uses were controlled. The examiners did note that insured individuals who wanted to find a provider had to first know and identify the name of their network before they were able to find provider information.

The examiners requested that the company provide documentation that it had developed written procedures regarding the inclusion of company information on agent personal websites, including advertising, and its inclusion of these requirements in its agents contract to show compliance with a recommendation from the 2001 Market Conduct examination. The company provided a copy of its producing agent and agency contract and stated that agents must follow its agent advertising guidelines found on the HumanaOne agent website. Agents marketing the HumanaOne product are allowed to produce their own advertisements but must submit them for review to the company. Agents selling group insurance products use predefined broker advertising designed by the company. The company indicated that it had not maintained during the period of review a list of agents who had websites that included company information.

The examiners documented that the company implemented a new system called the agent relationship management software (ARMS) system for the company's telesales and field representatives starting in October 2006. In December of 2006, the company added a field that captured agent websites, and effective August 2007, it established a requirement to ensure this field was completed. The examiners found that the company's corrective action was implemented after the period of review. 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.

16. **Recommendation:** It is again recommended that the company develop written procedures and implement a process regarding the use of personal website by agents for insurance related business, including advertising, to ensure compliance with s. Ins 3.27 (27), Wis. Adm. Code.

17. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to document the creation and use by its agents of personal websites that include company information and to document compliance with s. Ins 3.27 (27), Wis. Adm. Code.

SMALL EMPLOYER

The examiners reviewed the company's response to OCI's small employer interrogatory, field underwriting guide, and underwriting manuals, rating methodology, new business rates, renewal system, actuarial certifications and waiver and disclosure forms.

The company indicated in its interrogatory response that it used geographic location, number of employees, age of employees, and gender of employees as case characteristics for rating. The company's renewal manual stated that the company's demographics or case characteristics included area, age, gender, family status, case size, benefit plan design and **industry** [emphasis added]. The manual also stated, "Industry - To a certain extent, claims cost, is affected by or varies with industry or occupation. " The examiners found that the company case characteristics used for rating its small employer business included industry as a case characteristic based on their review of the company renewal manual and the file history rating factor spreadsheet. Section 635.02 (2), Wis. Stat., provides that the term "case characteristic" does not include loss or claim history, health status, occupation, duration of coverage, or other factors related to claim experience.

18. **Recommendation:** It is recommended that the company revise its internal policies, procedures and manuals to provide that industry or occupation is not included in the definition of "case characteristic", to ensure compliance with s. 635.02 (2), Wis. Stat.

The examiners reviewed the company's small business case review manual to document compliance with s. Ins 8.48 (1), Wis. Adm. Code, which requires that before completing an application for a policy, an agent shall provide to the small employer rating and renewability information as a separate written notice. The examiners found that page 23 of the manual contained information on the Wisconsin rating and renewability form, including the statement that "If the group is located in the state of Wisconsin, the file must include a Rating and Renewability Form that is signed and dated. If this form is not in the file, the Sales

Coordinator must ask for it. New cases will not be issued without the Rating and Renewability Form."

The examiners reviewed a random sample of 46 small employer group policies issued during the period of review. The examiners found two of the company small employer group files included rating and renewability forms that were signed after the application; one company filed included a form that was signed but not dated; and two company files where the form was not provided for review. The company indicated that it was implementing a new procedure that a new case could not be worked unless the rating and renewability form was included in the submission. The new procedures state that the signed and dated form must be received and the employer group application must be resigned after the signature date on the rating and renewability form. Section Ins 8.48 (1), Wis. Adm. Code, a small group insurer must provide rating and renewability information as a separate written notice to the small employer group before an application for coverage is taken.

19. **Recommendation:** It is again recommended that the company provide rating and renewability information as a separate written notice, to the small employer group before an application for coverage is taken, as required by s. Ins 8.48 (1), Wis. Adm. Code.

20. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to document that it provides rating and renewability information as a separate written notice to the small employer group before an application for coverage is taken and to document compliance with s. Ins 8.48 (1), Wis. Adm. Code.

The examiners requested a random sample of 50 small employer group issued files. The company did not provide four small employer group files. The examiners found that nine of the 46 small group files reviewed were not complete. The company obtained the missing information for seven of the small group files via phone and documented in case log notes. However, the company was not able to retrieve the missing information for the remaining six files. The company indicated that its record retention system, as it related to underwriting, would be updated in 2008 so that all documents would be scanned up front, and

it provided a copy of its new case processing guidelines. The examiners found that the company did not demonstrate compliance with s. Ins 6.80 (4) (b), Wis. Adm. Code, which requires 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.

21. **Recommendation:** It is recommended that the company develop and implement a process, including written procedures, to ensure and document that records are maintained as required by s. Ins. 6.80 (4) (b), Wis. Adm. Code.

The examiners found that 17 of the 46 small employer group files reviewed included applications that were not complete, including information regarding the number of employees listed on the group application that did not match the wage and tax statement, the actual application count and/or waiver count. The company stated that the numbers of employees for these small employer groups did not match the supporting documentation because the group had at least one employee in the waiting period. It also indicated that applications or waivers from employees in the waiting period were not required. The examiners were not able to document the company's statement.

The examiners requested a random sample of 25 small employer quotes issued during the period of review. The company failed to provide three of the requested files indicating that although the records of quote creations were maintained for 36 months, the quote documents were purged five months after the requested effective date of the quote. The examiners found that none of the 22 quote files reviewed included the date the quote was received by the company. Section Ins 6.80 (4), 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.

22. **Recommendation:** It is recommended that the company maintain records of all quotes, including the date received, and all documents associated with the quotes in a form capable of being converted to readable documents in order to comply with s. Ins 6.80 (4), Wis. Adm. Code.

The company provided a copy of the written procedures it used when a small employer group was submitted for underwriting approval. Although the company's written procedures require that its processing unit obtain any missing information from the writing agent before the unit processed a group application, the examiners found that the files reviewed indicated that the process was not consistently followed to ensure compliance. Section Ins. 8.65 (1) and (2), Wis. Adm. Code, provides that the insurer shall require the employer to provide a complete list of eligible employees and dependents, and secure a waiver signed by the eligible employee as part of the application process.

23. **Recommendation:** It is recommended that the company develop a process, including period scheduled reviews, to ensure its written procedures are followed in order to document compliance with s. Ins 8.65, Wis. Adm. Code.

The examiners reviewed the company's small group underwriting field sales guide. The examiners found that the company's internal policies and procedures provided that employers with 51 or more eligible employees may exclude from coverage certain classes of employees including union, non-union, hourly, salary, management and non-management. Section 632.746 (10), Wis. Stat., if an insurer offers a group health benefit plan to an employer, the insurer shall offer coverage to all of the eligible employees of the employer and their dependents.

24. **Recommendation:** It is recommended that the company revise its internal policies and procedures to provide that if the company offers a group health benefit plan to an employer it must offer coverage to all of the eligible employees of the employer and their dependents, as required by s. 632.746 (10), Wis. Stat.

The examiners found that the company's small group underwriting field sales guide stated that "when a husband/wife are both employed by the same employer and choose employee/spouse or family coverage, the employee covered as the dependent is not required to fill out a waiver form." The company indicated that it did not require a signed waiver because it did not view employees choosing to be covered as a dependent under their spouse's plan to be waiving coverage. Section Ins 8.65, Wis. Adm. Code, provides that a small employer insurer

shall require each small employer that applies for a policy to provide a complete list of eligible employees and dependents of eligible employees of the small employer. A small employer insurer must obtain a signed waiver from all eligible employees or the dependents of the employee declining coverage.

25. **Recommendation:** It is recommended that the company revise its internal polices and procedures to provide that it obtain a signed waiver form from all eligible employees declining coverage as required by s. Ins 8.65, Wis. Adm. Code.

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 reviewed the company's short-range and long-range marketing goals for group, individual, telemarketing process and procedures, and agent compensation schedules. The examiners also reviewed the company's Medicare Advantage and Medicare Part D prescription drug plan (PDP) agent sales and marketing activities, including interviewing company management responsible for these activities.

The company indicated that most of its sales involved Medicare Advantage and Medicare PDP plans and HumanaOne sales. The company was the largest Wisconsin writer of Medicare Advantage plans through July 2007 and the 2nd largest for the rest of 2007, and the largest Wisconsin writer of Medicare PDP plans during the period of review. The company indicated that approximately 95% of its Wisconsin Medicare Advantage business was sold by career agents and 5% by delegated agent. Its delegated agents sold approximately 77% of its Wisconsin Medicare PDP plans, and its career agents sold 23%.

The company utilized several marketing arrangements to market its commercial business, such as its HumanaOne individual product, and its Medicare plans. These arrangements included company agent employees, who took applications by telephone as a result of incoming calls to its call centers; and resident Humana MarketPOINT agents, both of which were captive agents, defined as Humana employees. MarketPOINT is a subsidiary of Humana, Inc. The company also contracted with managing general agents (MGAs) and general agents (GAs), who recruited independent agents to write Humana business. It identified independent agents as delegated agents.

The company's field and telesales agents oversaw the delegated agents training including product knowledge, education and certification. Company agency management supervised agent contracts and commissions.

The examiners reviewed a random sample of 50 company advertisements. The examiners found four series of advertisements did not clearly identify the policies or the benefit amounts referred to in the advertisement. The company indicated it would refer to optional benefits in the marketing points on a "go forward". Section Ins. 3.27 (19), Wis. Adm. Code, provides that when an advertisement refers to a choice regarding benefit amounts, it shall disclose that the benefit amounts provided will depend upon the plan selected and that the premium will vary with the amount of the benefits.

26. **Recommendation:** It is recommended that the company develop written procedures and implement measures to ensure that all advertisements clearly and conspicuously disclose the information required by s. Ins. 3.27 (19), Wis. Adm. Code.

27. **Recommendation:** It is recommended that the company implement procedures to ensure that records are maintained as required by s. Ins. 6.80 (4), Wis. Adm. Code, and can be made available upon request in accordance with the provisions of s. 601.42, Wis. Stat.

Medicare Advantage and Medicare Prescription Drug Plan Marketing

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) created Medicare Part D prescription drug plans (PDPs), which provided access for Medicare beneficiaries to obtain Medicare prescription drug plan coverage, and changed the name of Medicare+Choice plans to Medicare Advantage plans. Medicare PDPs became available beginning January 1, 2006, with an open enrollment period beginning October 15, 2005.

Federal law preempted states from regulating Medicare Advantage and Medicare PDP plans. However, agents marketing these plans were required to be licensed insurance intermediaries, and state insurance departments were responsible for regulating the marketing activities of agents in reference to Medicare Advantage and PDP plans.

During the period of review, the company contracted with CMS to two Medicare Advantage PFFS plans with prescription drug coverage; two preferred provider organization (PPO) plans, one with prescription drug coverage, and three stand-alone PDP plans.

The company utilized captive and independent agents to solicit Medicare Advantage and PDP business through pre-arranged home visits and electronically by telephone or by using the Internet. The company maintained a website that allowed Medicare beneficiaries to enroll in Medicare plans over the Internet with or without agent involvement.

The company contracted with MGAs and GAs to recruit independent agents to market its Medicare Advantage and PDP plans. MarketPOINT agents, who sold predominantly Medicare Advantage and prescription drug plans, were Humana employees. The company had a nationwide marketing agreement with Wal-Mart that allowed its agents to staff informational booths and to enroll Medicare beneficiaries at these booths. The company also had marketing agreements for resident agents of the State Farm Mutual Automobile Insurance Company and resident agents of the USAA Life General Agency. These marketing agreements required that State Farm Mutual and USAA Life were responsible for providing licensing information regarding their agent to Humana and that Humana would complete the appointment process.

The examiners reviewed the company's agent training materials, including the annual certification training materials used during the 2006 and 2007 enrollment period. The certification training, which included a test, was required for an agent to continue to sell Medicare Advantage plans and PDP plans.

The company compensated delegated agents based on a flat fee per Medicare plan enrollment. The flat fee for Medicare Advantage PFFS enrollment during 2006 was $300 and the fee paid for Medicare PDP enrollment was $50. The company's captive agents were paid on a salary basis.

The company indicated that on May 25, 2007, CMS issued guidance for companies marketing Medicare Advantage PFFS and PDP plans regarding agent complaints. The company stated it had reported to CMS on a biweekly basis the results of its investigations of these complaints regarding allegations against sales agents. The examiners reviewed the complaints reported to CMS and found that the criteria used by CMS to identify and report agent

complaints differed significantly from that of the OCI. The examiners found that 65 complaints had been reported to CMS and six of the agents had three or more reported complaints.

PRODUCER LICENSING

The examiners reviewed the company's response to OCI's producer licensing interrogatory, agency agreements, producer listing and termination procedures for agents writing commercial business, Medicare plan business and for its telemarketers.

The company's agency management section was responsible for processing agent contracts and tracking agent and call center associate insurance licenses and appointments with the various state insurance departments. The agency management section was also responsible for assuring compliance with all state insurance laws regarding agent licenses, appointments and terminations. The company utilized the services of NIPR (National Insurance Producer Registry) to file all state appointments.

The examiners requested that the company provide a copy of its procedures for terminating agents. The company's procedures indicated that it terminated non-resident agents 30 days after the OCI sent notice of an expired agent license and that it terminated resident agents 90 days after it received the notice. Section 628.10 (2) (am), Wis. Stat., a license is suspended on the date a fee is due, and if payment is not made within 60 days, the license is revoked effective the date the fee was due.

28. **Recommendation:** It is recommended that the company implement a termination process to terminate agents with expired licenses effective the date of license revocation, and that it provide to the OCI within 90 days of adoption of the examination report documentation that it has implemented the process in accordance with s. 628.10 (2) (am), Wis. Stat.

The examiners requested from the company a listing of all Wisconsin agents who represented the company as of the end of the examination period. The examiners compared these records with the agent database maintained by the OCI.

The examiners found the following discrepancies between the company's data and that in the OCI data files:

- 4 agents listed as active in company data but that OCI data listed as terminated,
- Two agents listed as active in company data but that OCI data indicated had not been active for over five years,

- Five agents shown as active in company data but that OCI data indicated were not licensed during the period of review.

Section Ins 6.57 (2), Wis. Adm. Code, provides that notice of termination of appointment of individual intermediary shall be filed prior to or within 30 calendar days of the termination date with the office of the commissioner of insurance.

29. **Recommendation:** It is again recommended that the company promptly terminate agents pursuant to s. Ins 6.57 (2), Wis. Adm. Code.

30. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to document the timely termination of agents to show compliance with s. Ins 3.27 (27), Wis. Adm. Code.

The examiners found that the OCI's data included 43 agents as listed with the company but that the company data did not include as agents representing the company. The company indicated that it terminated 31 of these agents but due to constraints in its vendor's system that transactions were not accepted after 8:00 p.m. or on Sundays, the transactions were not processed. Section Ins 6.57 (3), Wis. Adm. Code, provides that each insurer shall pay once a year, the annual appointment fee within 30 days after the mailing of a payment notice to such insurer showing the amount due for all individuals serving as agents for the insurer.

31. **Recommendation:** It is again recommended that the company carefully review and compare the annual renewal billing sent by OCI to the company's records, promptly initiate an investigation into the reason(s) an agent does not appear on the annual renewal billing when the company's records show the person is an active agent appointed to represent the company and take the appropriate action to rectify the situation.

32. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to compare its Wisconsin monthly agent noncompliance listing with its listing of appointed agents and to document the timely termination of agents to show compliance with s. Ins 6.57 (3), Wis. Adm. Code.

The examiners reviewed a random sample of 50 company active agent files. The examiners found that the company failed to submit for 33 agents appointment applications to OCI within 15 days after the earlier of the date the agent contract is executed or the first insurance application is submitted to ensure compliance with s. Ins 6.57 (1), Wis. Adm. Code.

The company stated that the 33 agents were non-resident agents and that in the past when it received a contract from a non-resident agent, it only appointed agents who noted that they had a non-resident Wisconsin license. The company indicated that it would verify by means of the state website those agents with a Wisconsin license and would appoint these agents.

33. **Recommendation:** It is recommended that the company develop a process to follow its written procedures for the appointment of new agents to ensure compliance with s. Ins. 6.57 (1), Wis. Adm. Code.

The examiners reviewed a random sample of 50 company terminated agent files, including the termination letters sent to the agents. The company was not able to reproduce the termination letters for 28 agent files in the sample. The company could not provide the termination date for five agent files in the sample. The examiners found that two of 50 terminated agent files indicated the company reported to the OCI that agent termination was due to voluntary surrender. However, the OCI data indicated that one agent license was revoked and the other the agent license expired in another state. The examiners found that four of 50 terminated agent files indicated that the company filed notice of termination of appointment of the agent with the OCI beyond the 30-day deadline. Section Ins 6.57 (2), Wis. Adm. Code, provides that within 15 days of the notice of termination of appointment being sent to the OCI, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative of the company and that he or she may not act as its representative. The notice shall also include a formal demand for the return of all indicia of agency. Section Ins 6.57 (2), Wis. Adm. Code, also provides that notice of termination of appointment of be filed prior to or within 30 days of the termination date.

The examiners conducted a data match of company commissions paid and company applications taken for its HumanaOne business during the period of review with the OCI agent database to document that company telemarketers/captive and delegated agents were licensed and appointed with the company at the time the company accepted the applications and paid commissions. The examiners found that the company accepted applications submitted by 21

agents who were not licensed or appointed with the company. The examiners also found that the company accepted 19 applications that did not identify the writing agent but only identified an agency name and internal agency number. The company was not able to provide the name of the writing agent for the 19 applications. The examiners also found that the company accepted one application where the writing agent was appointed more than 15 days after the application was submitted.

The examiners found that the company utilized a dummy social security number for electronic applications taken by call center associates. The examiners requested that the company provide documentation regarding the name and licensing and appointment status of the agents taking these applications. The examiners found that the company accepted seven electronic applications taken by one call center associate who was not licensed or listed at the time the applications were submitted. The examiners also found that the company accepted 72 applications submitted by 13 call center associates who were not listed within 15 days of submission of the applications.

The company used a generic social security number for applications submitted by its MarketPOINT agents. The examiners requested that the company provide documentation regarding the name and licensing and appointment status for agents taking these applications. The examiners found the company accepted an application from one MarketPOINT agent who was appointed with the company more than 15 days after the application was submitted.

34. **Recommendation**: It is recommended that the company accept business only from intermediaries that are licensed agents listed with the company in order to comply with s. 628.03 (1), Wis. Stat. and s. Ins 6.57 (5), Wis. Adm. Code.

35. **Recommendation:** It is again recommended that the company develop a process to ensure its written procedures are followed to show compliance with s. Ins 6.57 (2), Wis. Adm. Code .

36. **Recommendation:** It is recommended that the company conduct periodic scheduled reviews to ensure that the reason for agent termination reported to the OCI is accurate and that notification of agent termination is filed with the OCI within 30 days of the termination date in order to document compliance with s. Ins 6.57 (2) and s. 628.11, Wis. Stat.

Medicare Advantage Agent Licensing

The examiners requested from the company data regarding enrollment applications taken for its Medicare plans during the period of review in order to conduct a data match with the OCI agent database to document that all agents had valid Wisconsin accident and health licenses at the time the Medicare Advantage or Medicare PDP enrollment applications were taken. The examiners were not able to document that all agents taking electronic applications from Wisconsin Medicare beneficiaries were licensed at the time enrollment applications were taken. The company stated that when its enrollment staff was entering the vast amounts of enrollment applications, its quality control on the agent data field was minimal. The data also included members who somewhere in their history had a Wisconsin address tied to their membership, plan changes when no agent was involved, and duplicate listings although the member had been continuously covered.

The examiners requested from the company data regarding commissions paid for Medicare Advantage and Medicare PDP written during the period of the examination in order to conduct a data match with enrollment applications written and with the OCI agent database. The examiners identified 40 agents who were paid commissions for Medicare plans written for Wisconsin Medicare beneficiaries but who were not Wisconsin licensed insurance agents. Section 628.03 (1), Wis. Stat., provides that no person may perform, offer to perform or advertise any service as an intermediary in Wisconsin unless they obtain an insurance license.

37. **Recommendation:** It is recommended that the company develop and implement a process including written criteria and procedures for ensuring that all agents marketing Medicare Advantage and Medicare PDP plans to Wisconsin Medicare beneficiaries have valid insurance licenses, as required by s. 628.03 (1), Wis. Stat.

The company stated that CMS guidance to the company stipulated the acceptance of an enrollment application regardless of the agent of record if the applications was completed and properly executed by an eligible Medicare beneficiary. Humana indicated it understood this to mean that it was required by CMS to accept business from agents, despite the fact that they

were not appropriately licensed in the state of Wisconsin. The company stated it accepted all completed Medicare Advantage and Medicare PDP enrollment applications it received, including enrollment applications taken by agents not licensed in Wisconsin. Section 628.03, Wis. Stat., requires that agents be licensed **before** [emphasis added] performing or offer to perform or advertise any service as an intermediary in this state.

The company indicated it developed new procedures following the July 30, 2007 CMS audit recommendations to prevent agents who were not properly certified (taken and passed a MA training class) and licensed to access its electronic submission system and established new procedures to identify agents who submit paper applications.

NEW BUSINESS, UNDERWRITING AND RATING

The examiners reviewed the company's response to the new business and underwriting interrogatory, field sales underwriting guide, and rating and underwriting procedure manuals. The examiners confirmed that all individual rates used during the period of review were filed with the OCI within 15 days of use.

The examiners reviewed a random sample of 50 issued application files to document that the applications were complete, the agents taking the applications were licensed and listed with the company, and that the company followed and consistently applied its underwriting procedures. The review included enrollment applications for its HumanaOne product taken over the Internet, by telephone and paper applications. The examiners found agent licensing and listing issues that are reported in the Producer Licensing section of this report. No underwriting exceptions were noted regarding the issued file review.

The examiners reviewed a random sample of 50 individual declined application files. The examiners found that 46 of the 50 files included decline letters with an incorrect web address in the Health Insurance Risk-Sharing Plan (HIRSP) notice. HIRSP was amended 2005 Wisconsin Act 74, which became effective July 1, 2006. Section 632.875, Wis. Stat., provides that if an insurer issues a notice of rejection or cancellation of coverage, a notice of reduction or limitation of coverage including restrictive riders or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible under s.149, Wis. Stat., the insurer shall notify all persons affected of the existence of the mandatory health insurance risk-sharing plan.

38. **Recommendation:** It is recommended that the company correct its individual declination letter to provide the correct HIRSP web address in order to comply with s. 632.785, 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 company's vendor and agent agreements were reviewed for privacy provisions. The examiners also interviewed the company's privacy officer.

The examiners found that the company's privacy program was comprehensive and designed to comply with federal HIPAA laws. The company had extensive policies and procedures regarding the internal handling of nonpublic personal health and financial information.

The company stated in response to an interrogatory question, that in 2006, the HIPAA Privacy Compliance Audit Program expanded to include privacy and security audits of external business associates. The main objective of the audit was to determine compliance to privacy and security requirements of the company's business associate agreements and to provide assistance in safeguards to protect company insureds' personal and health information. The examiners found that during the period of the review the company performed an audit of the privacy programs of 63 contracted delegated agencies, 40 of which were found to be out of compliance with the privacy-related provisions of its business associate agreement. As part of the audit process, the company used a HIPAA privacy and security assessment form which encompassed the areas of handling, appropriate uses and disclosure of personally identifiable health and financial information, handling of potential confidentiality breaches and privacy-related complaints, and security of computer systems and networks. The audit also included a review of privacy and security procedures and reports from the agencies and on-site audit reviews when applicable. The company provided the non-compliant agencies with a document titled HIPAA privacy & security guidance tool book. The document provided Internet resources,

general privacy information, an overview of contractual obligations, and suggestions for privacy safeguards and training. The company indicated that it would conduct an annual risk assessment of some of its contracted agencies as part of its privacy auditing process, and the response to the assessment would determine the depth of future audits. However, the company did not provide a written plan for continued monitoring and oversight of the privacy programs of its contracted agencies determined to be noncompliant with the risk assessment to ensure compliance with s. 610.70, Wis. Stat., regarding disclosure of personal medical information and chapter Ins 25, Wis. Adm. Code, regarding the privacy of consumer financial and health information.

39. **Recommendation:** It is recommended that the company develop written policies and processes for follow-up and monitoring of contracted agencies found noncompliant with the annual risk assessment to ensure compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

The examiners found that the company's internal policies and procedures provided that it must act on a request for access to personal health information in its possession within 30 days when information was maintained on-site and within 60 days when information was maintained off-site. Its policies and procedures further provided that a one-time extension of no more than 30 days was allowed if the company notified the individual with a written statement of the reason for the delay and the date by which it would complete the action on the request. Section 610.70 (3) (a), Wis. Stat., provides that the company shall within 30 days after receiving a request for access to recorded medical information in its possession (1) Inform the individual of the nature and substance of the information, (2) Permit the individual to inspect the information, (3) Disclose to the individual the identities of any persons to whom the insurer has disclosed the information within 2 years of the request, and (4) Provide to the individual a summary of the procedures by which the individual may request the correction, amendment or deletion of any medical information in the company's possession. The company indicated that due to its need to comply with the rules and timeframes of all states in which it operated, it did not include state-

specific timeframes in the policies and procedures. The policies and procedures direct the user to refer to the state laws and regulations for state-specific requirements.

40. **Recommendation:** It is recommended that the company revise its written policies and procedures to provide that the company must within 30 days after receiving a request for access to recorded medical information in its possession provide all the information as required by s. 610.70 (3) (a), Wis. Stat.

The company's internal policies and procedures provided that it must process a request to amend medical records in the company's possession within 60 days of receipt. It further provided that if the company was unable to make a decision within 60 days it could extend its decision period for an additional 30 days. Section 610.70 (4) (a), Wis. Stat., provides that within 30 business days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer's possession it shall do either of the following: (1) Comply with the request, (2) Notify the individual of all of the following: a. That the insurer refuses to comply with the request, b. The reasons for the refusal, c. That the individual has a right to file a statement to be furnished to any person to whom the insurer would have been required to furnish a correction, amendment or deletion.

41. **Recommendation:** It is recommended that the company revise its written policies and procedures to provide that the company must within 30 days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in its possession follow the requirements required by s. 610.70 (4) (a), Wis. Stat.

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. No exceptions were noted.

V. CONCLUSION

The examiners found that Humana Insurance Company did not comply with eleven of the twenty-four recommendations from the market conduct examination that was adopted in 2002. The examiners further found that four of these recommendations were non-compliant for the third time. This compliance examination resulted in 30 additional recommendations in the areas of claims, managed care, producer licensing, small employer, grievance and IRO, marketing, sales and advertising, underwriting and rating.

Many of the company's policies and procedures were established by the company's parent company for use by its company's nationwide. The examiners found that the company's procedures were well written but that the company was not able to document that it consistently followed its written procedures due in part that many functions were performed by the company's parent company. The examiners were not able to document that the company consistently complied with the requirements of Wisconsin insurance law specific to its Wisconsin insurance business.

The examiners' review of the company's oversight of Medicare Advantage and Medicare prescription drug plan agent marketing activities indicated that it did not comply with Wisconsin agent licensing requirements. In addition, the company was not able to consistently document the licensing and appointment status of agents taking electronic applications for its HumanaOne individual. During the period of review, the company exercised little oversight of its agent licensing and appointment processes.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 13 1. It is recommended that the company revise its internal policies, procedures and process to provide that it disclose to the insured upon request the specific amount allowable under the company's guidelines as required by s. Ins 3.60 (6) (a) 2, Wis. Adm. Code.

Page 15 2. It is again recommended that the company improve its claim handling process to ensure identification of claims subject to payment of interest and promptly pay interest to ensure compliance with s. 628.46, Wis. Stat.

Page 15 3. It is recommended that within 90 days of adoption of the report, that the company provide written documentation that it has reviewed the claims that were readjusted during the period of review and has paid interest where owed.

Grievance and Independent Review

Page 16 4. It is recommended that the company develop a process to ensure that their written procedures are followed, including periodic scheduled reviews, in order to comply with s. Ins 18.03 (4), Wis. Adm. Code.

Page 17 5. It is again recommended that the company resolve all grievances within 30 days and that the company provide written notice to the grievant, if a grievance will not be resolved within 30 days, to ensure compliance with s. Ins 18.03 (6), Wis. Adm. Code.

Page 17 6. It is recommended that the company conduct periodic scheduled reviews to document that it sends an extension letter to the grievant when a grievance will not be resolved within 30 days and to document compliance with s. Ins 18.03 (6), Wis. Adm. Code

Page 17 7. It is again recommended that the company send the grievant a notice of the time and place of the grievance meeting at least 7 calendar days before the grievance meeting to ensure compliance with s. Ins 18.03 (3) (b), Wis. Adm. Code.

Page 17 8. It is recommended that the company conduct periodic schedule reviews to document that it sends to the grievant a notice of the time and place of the grievance meeting at least 7 calendar days before the grievance meeting and to document compliance with s. Ins 18.03 (3) (b), Wis. Adm. Code

Page 18 9. It is again recommended that the company revise its claim denial letters to disclose that some states, including Wisconsin, may have time frame requirements that differ from the ERISA guidelines to ensure compliance with s. Ins 18.03 (2) (a) and (b), Wis. Adm. Code.

Page 20 10. It is recommended that the company develop and implement a process, including written procedures, ensure compliance with s. 632.835 (3) (b), Wis. Adm. Code.

Managed Care

Page 23 11. It is recommended that the company revise its provider agreements at the time of their next renewal date but no later than one year after the adoption of the examination report to ensure the agreements are compliant with the requirements of s. 609.24, Wis. Stat.

Page 23 12. It is recommended that the company include language in each of its provider agreements at the time of their next renewal date but no later than one year after the adoption of the examination report to ensure the agreements are compliant with the requirements of s. 609.30, Wis. Stat.

Page 24 13. It is again recommended that the company revise all of its provider contracts to require that providers identify complaints and grievances, and to require that providers forward complaints and grievances to the company, in a timely manner, for recording and resolution to ensure compliance with s. Ins. 18.03 (2) (c) (2), Wis. Adm. Code.

Page 24 14. It is recommended that the company file with the OCI a report when the process of revising its provider and network agreements is completed, but no later than one year after the adoption of the examination report, in order to document compliance with s. Ins 18.03 (2) (c) (2), Wis. Adm. Code.

Page 24 15. It is recommended that the company develop and implement an audit component to its compliance program to ensure that it complies with all applicable provisions of ch. 609, Wis. Stat.

Electronic Commerce

Page 27 16. It is again recommended that the company develop written procedures and implement a process regarding the use of personal websites by agents for insurance related business, including advertising, to ensure compliance with s. Ins 3.27 (27), Wis. Adm. Code.

Page 27 17. It is recommended that the company conduct periodic scheduled reviews to document the creation and use by its agents of personal websites that include company information and to document compliance with s. Ins 3.27 (27), Wis. Adm. Code

Small Employer

Page 29 18. It is recommended that the company revise its internal policies, procedures and manuals to provide that industry or occupation is not included in the definition of "case characteristic", to ensure compliance with s. 635.02 (2), Wis. Stat.

Page 29 19. It is again recommended that the company provide rating and renewability information as a separate written notice, to the small employer group before an application for coverage is taken, as required by s. Ins 8.48 (1), Wis. Adm. Code.

Page 29 20. It is recommended that the company conduct periodic scheduled reviews to document that it provides rating and renewability information as a separate written notice to the small employer group before an application for coverage is taken and to document compliance with s. Ins 8.48 (1), Wis. Adm. Code

Page 30 21. It is recommended that the company develop and implement a process, including written procedures, to ensure and document that records are maintained as required by s. Ins. 6.80 (4) (b), Wis. Adm. Code.

Page 30 22. It is recommended that the company maintain records of all quotes, including the date received, and all documents associated with the quotes in a form capable of being converted to readable documents in order to comply with s. Ins 6.80 (4), Wis. Adm. Code.

Page 31 23. It is recommended that the company develop a process, including period scheduled reviews, to ensure its written procedures are followed in order to document compliance with s. Ins 8.65, Wis. Adm. Code.

Page 31 24. It is recommended that the company revise its internal policies and procedures to provide that if the company offers a group health benefit plan to an employer it must offer coverage to all of the eligible employees of the employer and their dependents, as required by s. 632.746 (10), Wis. Stat.

Page 32 25. It is recommended that the company revise its internal polices and procedures to provide that it obtain a signed waiver form from all eligible employees declining coverage as required by s. Ins 8.65, Wis. Adm. Code

Marketing, Sales and Advertising

Page 34 26. It is recommended that the company develop written procedures and implement measures to ensure that all advertisements clearly and conspicuously disclose the information required by s. Ins. 3.27 (19), Wis. Adm. Code.

Page 34 27. It is recommended that the company implement procedures to ensure that records are maintained as required by s. Ins. 6.80 (4), Wis. Adm. Code, and can be made available upon request in accordance with the provisions of s. 601.42, Wis. Stat.

Producer Licensing

Page 37 28. It is recommended that the company implement a termination process to terminate agents with expired licenses effective the date of license revocation, and that it provide to the OCI within 90 days of adoption of the examination report documentation that it has implemented the process in accordance with s. 628.10 (2) (am), Wis. Stat.

Page 38 29. It is again recommended that the company promptly terminate agents pursuant to s. Ins 6.57 (2), Wis. Adm. Code.

Page 38 30. It is recommended that the company conduct periodic scheduled reviews to document the timely termination of agents to show compliance with s. Ins 3.27 (27), Wis. Adm. Code.

Page 38 31. It is again recommended that the company carefully review and compare the annual renewal billing sent by OCI to the company's records, promptly initiate an investigation into the reason(s) an agent does not appear on the annual renewal billing when the company's records show the person is an active agent appointed to represent the company and take the appropriate action to rectify the situation.

Page 38 32. It is recommended that the company conduct periodic scheduled reviews to compare its Wisconsin monthly agent noncompliance listing with its listing of appointed agents and to document the timely termination of agents to show compliance with s. Ins 6.57 (3), Wis. Adm. Code.

Page 39 33. It is recommended that the company develop a process to follow its written procedures for the appointment of new agents to ensure compliance with s. Ins. 6.57 (1), Wis. Adm. Code.

Page 40 34. It is recommended that the company accept business only from intermediaries that are licensed agents listed with the company in order to comply with s. 628.03 (1), Wis. Stat. and s. Ins 6.57 (5), Wis. Adm. Code.

Page 40 35. It is again recommended that the company develop a process to ensure its written procedures are followed to show compliance with s. Ins 6.57 (2), Wis. Adm. Code.

Page 40 36. It is recommended that the company conduct periodic scheduled reviews to ensure that the reason for agent termination reported to the OCI is accurate and that notification of agent termination is filed with the OCI within 30 days of the termination date in order to document compliance with s. Ins 6.57 (2) and s. 628.11, Wis. Stat.

Page 41 37. It is recommended that the company develop and implement a process including written criteria and procedures for ensuring that all agents marketing Medicare Advantage and Medicare PDP plans to Wisconsin Medicare beneficiaries have valid insurance licenses, as required by s. 628.03 (1), Wis. Stat.

Underwriting and Rating

Page 43 38. It is recommended that the company correct its individual declination letter to provide the correct HIRSP web address in order to comply with s. 632.785, Wis. Stat.

Privacy and Confidentiality

Page 45 39. It is recommended that the company develop written policies and procedures for follow-up and monitoring of contracted agencies found noncompliant with the annual risk assessment to ensure compliance with s. 610.70, Wis. Stat. and ch. Ins 25, Wis. Adm. Code.

Page 46 40. It is recommended that the company revise its written policies and procedures to provide that the company must within 30 days after receiving a request for access to recorded medical information in its possession provide all the information as required by s. 610.70 (3) (a), Wis. Stat.

Page 46 41. It is recommended that the company revise its written policies and procedures to provide that the company must within 30 days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in its possession follow the requirements required by s. 610.70 (4) (a), Wis. Stat.

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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Ashley Natysin	Advanced Examiner
Nitza Pfaff	Insurance Examiner
Lynn Pink	Insurance Examiner
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Respectfully submitted,

Linda R. Low

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