STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MARKET CONDUCT EXAMINATION

NUMBER 2014C-0064

January 5, 2015

LIMITED MARKET CONDUCT EXAMINATION REPORT

OF

HUMANA INSURANCE COMPANY

LOUISVILLE, KY

NAIC COMPANY CODE 73288

For the Period January 1, 2012 through December 31, 2013

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I. EXECUTIVE SUMMARY

Humana Insurance Company (the Company) is an authorized Wisconsin domiciled company. This examination was conducted by the Department of Insurance and Financial Services (DIFS) in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2013) (*Handbook*) and the Michigan Insurance Code, MCL 500.100 et seq. (the Code). The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations. The scope of market conduct examination includes the Company's activities related to the handling of: (1) Complaint Handling and (2) Claims. The examination covers the period January 1, 2012 through December 31, 2013.

This summary of this limited market conduct examination of the Company is intended to provide an overview of the examination results. The body of the report provides details of the scope of the examination, findings, DIFS recommendations, and Company responses.

DIFS considers a substantive issue one in which a "finding" or violation of Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable.

II. OBJECTIVES, SCOPE AND METHODOLOGY

This report is based on a limited market conduct examination of Humana Insurance Company. The examination was conducted at the Department of Insurance and Financial Services. The contact for this exam was Heather Quinn, Regulatory Compliance Director. DIFS conducted this examination in accordance with statutory authority of MCL 500.222 et seq. All Michigan laws, regulations and bulletins cited in this report may be viewed on the DIFS website at www.michigan.gov/difs.

This examination was conducted under the supervision of Sherry J. Bass-Pohl, Manager of the Market Conduct Company Examination Unit. The examination team consisted of Lynell A. Cauther, Examiner-in-Charge, and was assisted by Market Conduct Examiners Sherry Barrett and Michael Draminski.

The examination was called due to changes in the complaint index and the absence of a prior market conduct examination.

The examination team sampled Company records in the areas of Claims and Complaint Handling. The analysis and examination of these areas were conducted and measured according to the Standards and practices in the NAIC *Handbook*, the applicable statutes in the Code, and the Company's internal guidelines and procedures.

Three types of review may have been utilized for the above standards. Certain standards were examined with a single review, and others were examined using one or more type of review. The NAIC *Handbook* calls for a random sample of 100 files when the examination population is greater than 5,000. This statistical sample applies to the Company as follows:

A. Generic Review: A standard test was applied using analysis of all files written by agents at the specific branch office for the time frame of the examination. The Company provided the general file information as a response to examiner questions.

B. Sample Review: A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC *Handbook*, Chapter 14. The samples included all files within a specific subgroup. The sampling techniques used are based on a 95 percent (95%) confidence level, meaning there is 95 percent (95%) confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. An error rate in excess of the tolerance level in these sections of the report is indicative of a general business practice of engaging in that type of conduct. Note that the statistical error tolerance is not indicative of the actual tolerance of DIFS for deliberate or systematic error.

C. Census Review: Complaint files were not subject to the sampling procedure, as the number of relevant files did not warrant taking a sample. Therefore, every relevant complaint file for the examination period was reviewed by the examination team for compliance with applicable statutes, regulations and internal company guidelines.

This examination report is a report by test. The report contains a summary of pertinent information about the lines of business examined. This includes each NAIC *Handbook* source and Standard, Code citation, any examination findings detailing the non-compliant or problematic activities that were discovered during the course of the exam, the Company response proposing methods for correcting the deficiencies, and recommendation for any further action by DIFS.

III. COMPANY OPERATIONS AND PROFILE

Humana Insurance Company, a wholly owned subsidiary of CareNetwork Inc. which in turn, is a wholly owned subsidiary of Humana Inc., began operations in 1968 as a Wisconsin-domiciled company. It is a mutual company. It is currently licensed to market its products in 49 states and the District of Columbia.

The Company markets and sells its products through independent agents. Approximately 14,377 producers are appointed in Michigan. The Company's top lines of business are group health, group life, dental and disability income and Medicare Services. Its size category is XV ($2 Billion or greater), and the Company is rated A- (Excellent) by the AM Best Company. Its outlook is stable due to the Company experiencing stable financial and market trends, and that there is a low likelihood the Company's rating will change over an intermediate period.

IV. EXAMINATION FINDINGS AND RECOMMENDATIONS

A. CLAIMS

Standard 1: The initial contact by the regulated entity with the claimant is within the required time frame. NAIC *Handbook*, Chapter 16.

Standard 2: Timely investigations are conducted. NAIC *Handbook*, Chapter 16.

Standard 3: Claims are resolved in a timely manner. NAIC *Handbook*, Chapter 16.

***Standard 4*:** The regulated entity responds to claims in a timely manner. NAIC *Handbook*, Chapter 16.

Standard 5: Claim files are adequately documented. NAIC *Handbook*, Chapter 16.

Standard 6: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. NAIC *Handbook*, Chapter 16.

Standard 9: Denied and closed without payment claims are handled in accordance with policy provisions and state law. NAIC *Handbook*, Chapter 16.

MCL 500.2006:

> (1) A person must pay on a timely basis to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.
>
> (2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, individual or entity directly entitled to benefits under its insured's contract of insurance, or third party tort claimant interest as provided in subsection (4).
>
> (3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss shall be considered

paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim shall be considered paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim shall not be untimely during any period in which the insurer is unable to pay the claim when there is no recipient who is legally able to give a valid release for the payment, or where the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim upon determination of who is entitled to receive the payment.

(4) If benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. If the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law. The interest shall be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest shall be payable based upon the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid pursuant to this section shall be offset by any award of interest that is payable by the insurer pursuant to the award.

(5) If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits is liable for interest due to an insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant under this section where a reinsurer fails to pay benefits on a timely basis.

(6) If there is any specific inconsistency between this section and sections 3101 to 3177 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, the provisions of this section do not apply. Subsections (7) to (14) do not apply to an entity regulated under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. Subsections (7) to (14) do not apply to the processing and paying of medicaid claims that are covered under section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

(7) Subsections (1) to (6) do not apply and subsections (8) to (14) do apply to health plans when paying claims to health professionals, health facilities, home health care providers, and durable medical equipment providers, that are not pharmacies and that do not involve claims arising out of sections 3101 to 3177 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a health plan's ability to prescribe the terms and conditions of its contracts, other than as provided in this section for timely payment.

(8) Each health professional, health facility, home health care provider, and durable medical equipment provider in billing for services rendered and each health plan in processing and paying claims for services rendered shall use the following timely processing and payment procedures:

(a) A clean claim shall be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.
(b) A health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider within 30 days after receipt of the claim by the health plan of all known reasons that prevent the claim from being a clean claim.
(c) A health professional, health facility, home health care provider, and durable medical equipment provider have 45 days, and any additional time the health plan permits, after receipt of a notice under subdivision (b) to correct all known defects. The 45-day time period in subdivision (a) is tolled from the date of receipt of a notice to a health professional, health facility, home health care provider, or durable medical equipment provider under subdivision (b) to the date of the health plan's receipt of a response from the health professional, health facility, home health care provider, or durable medical equipment provider.
(d) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) makes the claim a clean claim, the health plan shall pay the health professional, health facility, home health care provider, or durable medical equipment provider within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).
(e) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) does not make the claim a clean claim, the health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider of an adverse claim determination and of the reasons for the adverse claim determination within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(f) A health professional, health facility, home health care provider, or durable equipment provider shall bill a health plan within 1 year after the date of service or the date of discharge from the health facility in order for a claim to be a clean claim.

(g) A health professional, health facility, home health care provider, or medical equipment provider shall not resubmit the same claim to the health plan unless the time frame in subdivision (a) has passed or as provided in subdivision (c).

(9) Notices required under subsection (8) shall be made in writing or electronically.

(10) If a health plan determines that 1 or more services listed on a claim are payable, the health plan shall pay for those services and shall not deny the entire claim because 1 or more other services listed on the claim are defective. This subsection does not apply if a health plan and health professional, health facility, home health care provider, or durable medical equipment provider have an overriding contractual reimbursement arrangement.

(11) A health plan shall not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or durable medical equipment provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or durable medical equipment provider because the health professional, health facility, home health care provider, or durable medical equipment provider claims that a health plan has violated subsections (7) to (10).

(12) A health professional, health facility, home health care provider, durable medical equipment provider, or health plan alleging that a timely processing or payment procedure under subsections (7) to (11) has been violated may file a complaint with the commissioner on a form approved by the commissioner and has a right to a determination of the matter by the commissioner or his or her designee. This subsection does not prohibit a health professional, health facility, home health care provider, durable medical equipment provider, or health plan from seeking court action. A health plan described in subsection (14)(c)(iv) is subject only to the procedures and penalties provided for in subsection (13) and section 402 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402, for a violation of a timely processing or payment procedure under subsections (7) to (11).

(13) In addition to any other penalty provided for by law, the commissioner may impose a civil fine of not more than $1,000.00 for each violation of subsections (7) to (11) not to exceed $10,000.00 in the aggregate for multiple violations.

(14) As used in subsections (7) to (13):

(a) "Clean claim" means a claim that does all of the following:

(i) Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
(ii) Sufficiently identifies the patient and health plan subscriber.
(iii) Lists the date and place of service.
(iv) Is a claim for covered services for an eligible individual.
(v) If necessary, substantiates the medical necessity and appropriateness of the service provided.
(vi) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
(vii) Identifies the service rendered using a generally accepted system of procedure or service coding.
(viii) Includes additional documentation based upon services rendered as reasonably required by the health plan.

(b) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(c) "Health plan" means all of the following:

(i) An insurer providing benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate, including any policy or certificate that provides coverage for specific diseases or accidents only, or any hospital indemnity, medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.
(ii) A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.
(iii) A health maintenance organization licensed or issued a certificate of authority in this state.
(iv) A health care corporation for benefits provided under a certificate issued under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, but not to payments made pursuant to an administrative services only or cost-plus arrangement.

(d) "Health professional" means a health professional licensed or registered under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

MCL 500.2026:

> (1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:
>
> > (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.
> > (b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to claims arising under insurance policies.
> > (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
> > (d) Refusing to pay claims without conducting a reasonable investigation based upon the available information.
> > (e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.
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> > * * *
> >
> > (h) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.
> >
> > * * *
> >
> > (m) Failing to promptly settle claims where liability has become reasonably clear under 1 portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy.
> > (n) Failing to promptly provide a reasonable explanation of the basis in the policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

1. Claims Paid – Individual Accident & Health

The examiners requested the population of Michigan Claims Closed With Payment – Individual

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed With Payment – Individual Accident & Health	185,005	2.30%	88	5/28/2014	0

Findings:
All claims were "clean claims" paid within 45 days after receipt. Six (6) of the 88 claims sampled had paid amount as "$0" which the Company noted, "For all these claims the allowed amount has been attributed to the member's deductible as the member has responsibility for paying the provider for the claims."

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

2. Claims Paid – Group Accident & Health

The examiners requested the population of Michigan Claims Closed With Payment – Group

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed With Payment – Group Accident & Health	142,012	2.30%	88	5/28/2014	0

Findings:
All claims were "clean claims" paid within 45 days after receipt. Fifteen of the 88 claims sampled had paid amount as "$0" which the Company noted, "For all these claims the allowed amount has been attributed to the member's deductible as the member has responsibility for paying the provider for the claims."

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

3. Claims Closed Without Payment – Accident & Health Individual

The examiners requested the population of Michigan Claims Closed Without Payment – Individual

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed Without Payment – Individual	44,252	2.30%	88	5/28/2014	0

Findings:
All claims were denied and closed in accordance with Company guidelines. Twenty-eight of the 88 claims sampled were denied as "duplicate claims".

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

4. Claims Closed Without Payment – Accident & Health Group

The examiners requested the population of Michigan Claims Closed Without Payment – Group

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed Without Payment - Group	17,438	2.30%	88	5/28/2014	0

Findings:
All claims were denied and closed in accordance with Company guidelines. Forty-one of the 88 claims sampled were denied as "duplicate claims".

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

B. COMPLAINT HANDLING

Standard 1: All complaints are recorded in the required format on the regulated entity's complaint register. NAIC *Handbook*, Chapter 16.

Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. NAIC *Handbook*, Chapter 16.

Standard 3: The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. NAIC *Handbook*, Chapter 16.

Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. NAIC *Handbook*, Chapter 16.

MCL 500.2213:

(1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, or 36 that provides for all of the following:

(a) A designated person responsible for administering the grievance system.
(b) A designated person or telephone number for receiving grievances.
(c) A method that ensures full investigation of a grievance.

(d) (Timely notification in plain English to the insured or enrollee as to the progress of an investigation of a grievance.
(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.
(f) Notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation of the grievance and of the right to have the grievance reviewed by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.
(g) A method for providing summary data on the number and types of complaints and grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the commissioner on forms provided by the commissioner.
(h) Periodic management and governing body review of the data to assure that appropriate actions have been taken.
(i) That copies of all complaints and responses are available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the grievance was filed.
(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.
(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.
(l) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may

request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(ii) Benefits or claims payment, handling, or reimbursement for health care services.

(iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

MCL 500.2026:

> (2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

Findings:
There are a total of 257 complaints on the Company Register for the period under review. This included the following: Grievance and Appeals – Commercial grievance and appeal data; Medical Service Operations – Medicare Supplement grievance, appeal, and escalated complaint data and Critical Inquiry Unit – Commercial escalated complaint data. The Company's definition of a grievance is as follows: "A complaint regarding the availability, delivery or quality of services including: an adverse determination; benefits, claims payment, handling or reimbursement; contractual matters between the member and the carrier and complaints that are submitted to DIFS." Complaints are those that do not meet the above definition and are handled by "Customer Service" or "Provider Service". Ten percent of complaints were reported to the Company through DIFS. All complaints were responded to within five (5) days of receipt. Fifteen percent of the complaints that were appealed regarding usage of emergency services were approved with the explanation "this visit was considered an emergency according to the 'prudent layperson' definition of 'Emergency Services', as outlined in the Benefit Plan Document."

Recommendations:
Fifteen percent of the sampled complaints that were appealed showed they were paid, but had notations that future "inappropriate use of the emergency room (ER)" would not be paid. DIFS recommends that the Company provide more information to the policyholders on what is considered an emergency room visit when the policy is written. DIFS would also recommend that the Company mandate their "Customer Service" or "Provider Service" staff apply the "prudent layperson" definition of "Emergency Services" as outlined in the Benefit Plan Document to these claims. This would avoid forcing the policyholder to appeal, only to be subsequently upheld.

Company Response:
No Company response was received.

V. ACKNOWLEDGEMENT

This examination report of Humana Insurance Company is respectfully submitted to the Director of the Department of Insurance and Financial Services, State of Michigan.

The courteous cooperation and assistance of the officers and employees of the Company extended to the examiners during the course of the examination is hereby acknowledged.

In addition to the undersigned, Sherry Barrett, Market Conduct Examiner, and Michael Draminski, Market Conduct Examiner, participated in the examination.

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Lynell A. Cauther, AMCM
Examiner-in-Charge
Department of Insurance and Financial Services
Market Conduct Section