Report on

Market Conduct Examination

of

Humana Insurance Company

Louisville, Kentucky

by Representatives of the

North Carolina Department of Insurance

as of

October 5, 2020

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Raleigh, North Carolina
October 5, 2020

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Honorable Commissioners:

In accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of the following entity

**Humana Insurance Company**
**(NAIC #73288)**
NAIC Exam Tracking System Exam Number: NC-NC094-07
Louisville, Kentucky
(hereinafter generally referred to as the Company)

The examination was conducted at the Company's home office located at 500 W. Main Street, Louisville, Kentucky and at the North Carolina Department of Insurance (Department) office located at 325 N. Salisbury Street, Raleigh, North Carolina. A report thereon is respectfully submitted.

## SCOPE OF EXAMINATION

This examination commenced on May 20, 2018 and covered the period of July 1, 2016 through June 30, 2017, with analyses of certain operations of the Company being concluded through June 30, 2020. This action was taken due to market analysis of the “and previous annual filing submissions. All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive and consisted of an examination of the Company’s practices and procedures in utilization management, policyholder treatment and claims practices. The findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department’s practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 0 percent tolerance level for timeliness of utilization review, and member appeal/grievance acknowledgement and determination letters. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals and grievances, and claims processing. Sample sizes were generated using Audit Command Language software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

## EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with Company procedures and practices in the following areas:

*Utilization Management*

- Failure to maintain adequate determination notification details;
- Failure to provide determination notifications to providers within three business days;
- Failure to maintain adequate documentation to complete retrospective reviews; failure to utilize N.C. licensed medical doctors in the appeals process.

*Policyholder Treatment*

- Failure to acknowledge grievances in three business days or at all after receipt;
- Failure to communicate grievance review decisions to members within 30 days after receipt;
- Penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay;
- Imposing cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer;
- Failure to pay applicable interest on a claim for retroactive anesthesia services.

*Claims Practices*

- Imposing cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer;
- Failure to pay for emergency services that a prudent layperson acting reasonably would believe that a delay would worsen if care was not rendered;
- Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear;
- Attempting to settle a claim for less than the amount to which a reasonable person would have believed they were entitled;
- Failure to provide statutorily compliant appeal decision timelines on the Explanation of Benefits.;
- Penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay;
- Failure to pay applicable interest; failing to pay claims within the grace period.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com.

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate

its ability and intention to conduct business in North Carolina according to its insurance laws and regulations.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

## PPO LINES OF BUSINESS

## UTILIZATION MANAGEMENT

Policies and Procedure

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, the Company has established a formal structure to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Program, which is integrated with other operational areas of the Company. The Company's policies and procedures were found to follow appropriate North Carolina statutes.

Medical Necessity Reviews

The scope of utilization management services includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning.

Prospective Reviews

The Company provided a listing of 585 prospective review files. One hundred thirty-one files were randomly selected for review to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Fifteen prospective review files (11.5 percent error ratio) did not contain enough determination notification details. Eight prospective files (6.1 percent error ratio) revealed that the determination notification was not communicated to the provider within three business days. The Company was deemed to be in violation of the provisions of NCGS 58-50-61(f).

Concurrent Reviews

The Company provided a listing of 115 concurrent review files. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Sixteen concurrent review files (14.0 percent error ratio) did not contain enough determination notification details. The Company was deemed to be in violation of the provisions of NCGS 58-50-61(f).

Retrospective Reviews

The Company provided a listing of 34 retrospective review files. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Six retrospective review files (17.6 percent error ratio) did not contain enough documentation to complete the file review. The Company was deemed to be in violation of the provisions of NCGS 58-50-61(g).

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of the appeal if a delay in the rendering of health care would be detrimental to the member's health.

Standard Non-certification Appeals

The Company provided a listing of five standard non-certification appeal files. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

One standard appeal file (20.0 percent error ratio) contained evidence that the decision to uphold the denial was not issued by a medical doctor licensed to practice medicine in North Carolina. The Company was deemed to be in violation of the provisions of NCGS 58-50-61 (j).

The average service time to process a standard non-certification appeal was 21 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 1 | 20.0 |
| 8 - 14 | 1 | 20.0 |
| 22 - 30 | 3 | 60.0 |
| **Total** | **5** | **100.0** |

Expedited Non-certification Appeals

The Company provided a listing of two expedited non-certification appeal files. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process an expedited non-certification appeal was 2 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 2 | 100.0 |
| **Total** | **2** | **100.0** |

## POLICYHOLDER TREATMENT

Member Grievances

The Company provided a listing of 56 grievance files. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Three grievance files (5.4 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for emergency services provided by a health care provider not under contract with the insurer. The member, a prudent layperson acting reasonably, believed that a delay would worsen the emergency if care was not rendered. Because of circumstances beyond the member's control, emergency services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was deemed to be in violation of the provisions of NCGS 58-3-190(b)(1)(2) and (d).

Ten grievance files (17.9 percent error ratio) contained evidenced that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d).

One grievance file (1.8 percent error ratio) revealed that interest was not paid on a claim for retroactive anesthesia services. The Company was deemed to be in violation of the provisions of NCGS 58-3-225(e).

At the request of the examiners, recoveries totaling $86,475.74 were issued by the Company to the designated claimants.

The Company was deemed to be in violation of the provisions of NCGS 58-50-62 as 12 files (21.4 percent error ratio) revealed the following:

- An acknowledgement letter was not sent to the member in three business days after receiving the grievance in eight files,
- No acknowledgement letter was sent to the member at all in three files,
- The review decision was not communicated to the member within 30 days after receiving the grievance in one file.

The average service time to process a member grievance was 25 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 3 | 5.3 |
| 8 - 14 | 2 | 3.6 |
| 15 - 21 | 5 | 8.9 |
| 22 - 30 | 45 | 80.4 |
| 31 - 60 | 1 | 1.8 |
| **Total** | **56** | **100.0** |

Quality of Care – Grievance

The Company provided a listing of one quality of care grievance file. The only listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

## CLAIMS PRACTICES

Group Ambulance Claims Paid

The Company provided a listing of 173 ambulance paid claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Thirty-one claim files (23.7 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for emergency services provided by a health care provider not under contract with the insurer. The member, a prudent layperson acting reasonably, believed that a delay would worsen the emergency if care was not rendered. Because of circumstances beyond the member's control, emergency services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was deemed to be in violation of the provisions of NCGS 58-3-190(b)(1)(2) and (d).

Thirty-eight claim files (29.0 percent error ratio) contained evidence that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d).

At the request of the examiners, recoveries totaling $10,474.61 were issued by the Company to thirty-one designated claimants. Twenty-four claims (18.3 percent error ratio) were paid with interest and the Company was deemed to be in violation of the provisions of NCGS 58-3-225(e). For seven (7) claims, the additional allowed amount was applied in total to the member's in-network deductible.

Thirty-eight claim files (29.0 percent error ratio) revealed that the insurer did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The insurer attempted to settle a claim for less than the amount to which a reasonable person would have believed they were entitled. The Company was deemed to be in violation of the provisions of 58-63-15(11)(f) and (h).

One hundred thirty-one claim files (100 percent error ratio) referenced non-compliant appeal (grievance) decision timelines on the Explanation of Benefits (EOB). The EOB

contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2)

The average service time to process a claim payment was 8 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 1 - 7 | 77 | 58.7 |
| 8 - 14 | 38 | 29.1 |
| 15 - 21 | 8 | 6.1 |
| 22 - 30 | 8 | 6.1 |
| **Total** | **131** | **100.0** |

Group Ambulance Claims Denied

The Company provided a listing of 14 group ambulance denied claims. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Fourteen claim files (100 percent error ratio) referenced non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to ‘see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2)

The average service time to process and deny a claim was 11 calendar days. A chart of the average service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 1 - 7 | 6 | 42.8 |
| 8 - 14 | 4 | 28.6 |
| 15 - 21 | 2 | 14.3 |
| 22 - 30 | 2 | 14.3 |
| **Total** | **14** | **100.0** |

Group Anesthesia "All Other" Claims Paid

The Company provided a listing of three group anesthesia “all other” paid claims. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Two claim files (66.7 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for anesthesia services provided by a health care provider not under contract with the insurer. Because of circumstances beyond the member’s control, anesthesia services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was deemed to be in violation of the provisions of NCGS 58-3-190(d).

Three claim files (100 percent error ratio) contained evidence that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d).

At the request of the examiners, recoveries totaling $1813.25 were issued by the Company to the designated claimants.

Two claim files (66.7 percent error ratio) revealed that the insurer did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The insurer attempted to settle a claim for less than the amount to which a

reasonable person would have believed they were entitled. The Company was deemed to be in violation of the provisions of 58-63-15(11)(f) and (h).

Three claim files (100 percent error ratio) referenced non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to 'see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process a claim payment was 13 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 1 – 7 | 1 | 33.4 |
| 8 – 14 | 1 | 33.3 |
| 22 - 30 | 1 | 33.3 |
| **Total** | **3** | **100.0** |

Group Anesthesia "All Other" Claims Denied

The Company provided a listing of three group anesthesia "all other" denied claims. The entire listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Three claim files (100 percent error ratio) referenced non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to 'see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company

was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process and deny a claim was 13 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 3 | 100.0 |
| **Total** | **3** | **100.0** |

Group Anesthesia "Surgery Related" Claims Paid

The Company provided a listing of 566 ambulance paid claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

One claim file (0.8 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for emergency anesthesia services provided by a health care provider not under contract with the insurer. The member, a prudent layperson acting reasonably, believed that a delay would worsen the emergency if care was not rendered. Because of circumstances beyond the member's control, emergency anesthesia services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was reminded of the provisions of NCGS 58-3-190(b)(1)(2) and (d).

Forty-two claim files (32.1 percent error ratio) contained evidence that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d).

At the request of the examiners, recoveries totaling $49,965.24 were issued by the Company to twenty-one designated claimants. Eighteen claims (13.7 percent error ratio) were paid with interest and the Company was deemed to be in violation of the provisions of NCGS 58-3-225(e). For three (3) claims, the additional allowed amount was applied in total to the member's in-network deductible.

Forty-two claim files (32.1 percent error ratio) revealed that the insurer did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The insurer attempted to settle a claim for less than the amount to which a reasonable person would have believed they were entitled. The Company was deemed to be in violation of the provisions of 58-63-15(11)(f) and (h).

One hundred thirty-one claim files (100 percent error ratio) contained non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to 'see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process a claim payment was 11 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 56 | 42.7 |
| 8 - 14 | 47 | 35.9 |
| 15 - 21 | 19 | 14.5 |
| 22 - 30 | 6 | 4.6 |
| 31 - 60 | 3 | 2.3 |
| **Total** | **131** | **100.0** |

Group Anesthesia "Surgery Related" Claims Denied

The Company provided a listing of 143 anesthesia “surgery related” denied claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Three claim files (2.3 percent error ratio) contained evidence that the insurer did not provide benefits for anesthesia services related to maternity coverage. The Company was reminded of the provisions of NCGS 58-3-170(a). The Affordable Care Act also requires coverage for maternity care and treatment beginning January 1, 2014.

At the request of the examiners, recoveries totaling $43,975.16 were issued by the Company to the designated claimants.

Three claim files (2.3 percent error ratio) revealed that the insurer did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The insurer attempted to settle a claim for less than the amount to which a reasonable person would have believed they were entitled. The Company was reminded of the provisions of 58-63-15(11)(f) and (h).

One hundred thirty-one claim files (100 percent error ratio) contained non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to ‘see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process and deny a claim was 11 calendar days. A chart of the average service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 81 | 61.8 |
| 8 - 14 | 38 | 29.0 |
| 15 - 21 | 5 | 3.8 |
| 22 - 30 | 1 | 0.8 |
| 31 - 60 | 5 | 3.8 |
| Over 60 | 1 | 0.8 |
| **Total** | **131** | **100.0** |

Group Emergency Services Claims Paid

The Company provided a listing of 7,558 emergency services paid claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

Seven claim files (5.3 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for emergency services provided by a health care provider not under contract with the insurer. The member, a prudent layperson acting reasonably, believed that a delay would worsen the emergency if care was not rendered. Because of circumstances beyond the member's control, emergency services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was deemed to be in violation of the provisions of NCGS 58-3-190(b)(1)(2) and (d).

Seven claim files (5.3 percent error ratio) contained evidence that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was deemed to be in violation of the provisions of NCGS 58-3-200(d).

At the request of the examiners, recoveries totaling $18,448.48 were issued by the Company to seven designated claimants. Seven claims (5.3 percent error ratio) were paid with

interest and the Company was deemed to be in violation of the provisions of NCGS 58-3-225 (e).

Seven claim files (5.3 percent error ratio) revealed that the insurer did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The insurer attempted to settle a claim for less than the amount to which a reasonable person would have believed they were entitled. The Company was deemed to be in violation of the provisions of 58-63-15(11)(f) and (h).

One claim file (0.8 percent error ratio) was incomplete as no EOB was evidenced and the service time to process the claim could not be calculated. The Company was reminded of the provisions of 11 NCAC 19.0102 and 19.0105. The survey was based on the remaining one hundred and thirty claims.

One hundred thirty claim files (97.0 percent error ratio) contained non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to 'see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process a claim payment was 11 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 85 | 65.3 |
| 8 - 14 | 15 | 11.4 |
| 15 - 21 | 17 | 13.1 |
| 22 - 30 | 4 | 3.2 |
| 31 - 60 | 4 | 3.2 |
| Over 60 | 5 | 3.8 |
| **Total** | **130** | **100.0** |

Group Emergency Services Claims Denied

The Company provided a listing of 1,503 emergency services denied claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

One claim file (0.8 percent error ratio) contained evidence that the insurer did not provide benefits for emergency services related to maternity coverage. The Company was reminded of the provisions of NCGS 58-3-170(a). The Affordable Care Act also requires coverage for maternity care and treatment beginning January 1, 2014.

Four claim files (3.1 percent error ratio) revealed that the member was subjected to cost-sharing (balance billing) for emergency services provided by a health care provider not under contract with the insurer. The member, a prudent layperson acting reasonably, believed that a delay would worsen the emergency if care was not rendered. Because of circumstances beyond the member's control, emergency services could not be sought from a provider under contract with the insurer. Insurers shall not impose cost-sharing for emergency services that differ from the cost-sharing that would have been imposed if the provider was under contract with the insurer. The Company was deemed to be in violation of the provisions of NCGS 58-3-190(b)(1)(2) and (d).

One claim file (0.8 percent error ratio) contained evidence that the insurer penalized or subjected the member to out-of-network benefits although contracting health care providers were not reasonably available to meet health needs of the insured without unreasonable delay. The Company was reminded of the provisions of NCGS 58-3-200(d).

At the request of the examiners, recoveries totaling $16,042.97 were issued by the Company to the designated claimant.

Two claim files (1.5 percent error ratio) revealed that a claim status report was not provided to the insured within 60 days from receipt of the claim. The Company was reminded of the provisions of NCGS 58-3-225(g).

One hundred thirty claim files (97.0 percent error ratio) contained non-compliant appeal (grievance) decision timelines on the EOB. The EOB contained a statement that the grievance decision would be issued by the Company within 60 days of receiving the grievance and referenced a footnote instructing the member to 'see their Benefit Plan Document for state specific requirements which placed an extraneous burden on the member. The North Carolina 30-day statutory response time requirement should have been reflected on the EOB. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(e)(2).

The average service time to process and deny a claim was 22 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 70 | 53.4 |
| 8 - 14 | 9 | 6.9 |
| 15 - 21 | 5 | 3.8 |
| 22 - 30 | 7 | 5.3 |
| 31 - 60 | 24 | 18.3 |
| Over 60 | 16 | 12.3 |
| **Total** | **131** | **100.0** |

## INDEMNITY LINES OF BUSINESS

## CLAIMS PRACTICES

Individual Medicare Supplement Claims Paid

The Company provided a listing of 37,479 individual Medicare supplement paid claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process a claim payment was 3 calendar days. A chart of the service time follows:

| rice Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 123 | 93.9 |
| 8 - 14 | 8 | 6.1 |
| **Total** | **131** | **100.0** |

Individual Medicare Supplement Claims Denied

The Company provided a listing of 7,887 individual Medicare supplement denied claims. One hundred thirty-one files were randomly selected and reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process and deny a claim was 22 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 118 | 90.1 |
| 8 - 14 | 9 | 6.8 |
| 15 - 21 | 3 | 2.3 |
| 22 - 30 | 1 | 0.8 |
| **Total** | **131** | **100.0** |

Individual Medicare Supplement Claims Denied within Grace Period

The Company provided a listing of one individual Medicare Supplement claims denied within the grace period. The only listing was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

One claim file (100 percent error ratio) revealed that dates of service during the grace period of the policy were denied. The last premium eligibility date began 10/1/2015 and ended

10/31/2015 and the claim should have been paid through the grace period. The Company was deemed to be in violation of the provisions of NCGS 58-51-15(a)(3).

At the request of the examiners, recoveries totaling $10.49 were issued by the Company to the designated claimant.

The average service time to process and deny a claim was 2 calendar days. A chart of the service time follows:

| Service Days | Number of Files | Percentage of Total |
|---|---|---|
| 0 - 7 | 1 | 100.0 |
| **Total** | **1** | **100.0** |

## COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must complete and implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to compliance with statutory requirements regarding: maintenance of adequate documentation, timely determination notices to providers, utilizing N.C. licensed doctors in the appeals process, timely acknowledgement of grievances and communication of grievance decisions, subjecting members to out-of-network benefits when contracting providers were not available to meet their health needs without unreasonable delay; imposing cost-sharing for emergency, anesthesia and ambulance services provided by out-of-network providers within in-network and/or emergency settings, paying for emergency services that a layperson would believe would worsen if care was not rendered, providing benefits for maternity related services, paying claims within the grace period or with applicable interest, adhering to the Unfair Claims Settlement Practices provisions, and providing statutorily compliant appeal decision timelines on the EOB.

Upon acceptance of the Report the Company shall provide the Department with a statement of corrective action plan to address the violations identified during the examination.

The Department will conduct a future investigation if warranted to determine if the Company successfully implemented its statement of corrective action.

## CONCLUSION

A target examination has been conducted on the market conduct affairs of Humana Life Insurance Company for the period January 1, 2016, through June 30, 2017, with analyses of certain operations of the Company being conducted through June 30, 2020.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of utilization management, policyholder treatment and claims practices.

In addition to the undersigned, Scott Grindstaff, HIS, MHP, MCM, Examiner -In-Charge, Shane Jordan, MHS, MCM and Darla Wright, MCM, North Carolina Market Conduct Senior Examiners and Tanyelle Byrd, MCM, MBA, HIA, Senior Market Analyst and Cheryl Allen-Bivens, Market Analyst participated in this examination.

Respectfully submitted,

Vicki S. Royal

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Examiner-In-Charge
Market Regulation Division
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I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Teresa Knowles

Teresa Knowles, ACS
Deputy Commissioner
Market Regulation Division
State of North Carolina