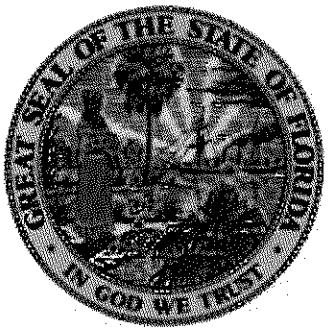

THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

Humana Medical Plan, Inc.

AS OF

November 2, 2012

NAIC COMPANY CODE: 95270
NAIC GROUP CODE: 0119

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EXECUTIVE SUMMARY

A sample of 368 claims, and policies and procedures as they apply to the adjudication of out of network medical provider claims were reviewed. The following table represents general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS			
Statute/Rule	**Description**	**Files Reviewed**	**Number of Violations**
641.3155 (3)(a) and (4)(a)	The Company did not provide timely acknowledgement of the receipt of out of network claims.	368	17
641.3155 (3)(b) & (4)(b)	The Company did not pay, deny, or contest out of network claims within the required timeframe.	368	42
641.3155(6)	The Company did not pay interest on overdue out of network claims.	368	6
641.3903(5)(b)	The Company paid out of network claims on less favorable terms than those provided in the subscriber's Schedule of Benefits.	368	4
641.3156 (2)	The Company improperly denied claims due to internal coding errors.	184	26

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of Humana Medical Plan, Inc. (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of this examination was January 1, 2009, through December 31, 2011. The onsite examination began September 16, 2012, and concluded November 2, 2012.

The purpose of the examination was to review the Company's policies and procedures as they apply to the adjudication of out of network medical provider claims and to determine the Company's compliance with Florida Statutes and the Florida Administrative Code.

The examination included the following procedures:

- Review of the Company's claims handling procedures to ensure adoption and implementation of standards for proper investigation and settlement of claims.
- Review of the Company's internal policies and procedures to determine the methodology for payment of out of network claims.
- Determine how the Company defines usual and customary for out of network claims.
- Review sample of paid and denied out of network claims to determine timely acknowledgements, reasonable and proper investigation, resolution, timely payment and review for consistency with internal policies and procedures and Florida Statutes.

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

Humana Medical Plan, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on June 1, 1987. The Company provides Group Health coverage in the State of Florida.

Total Direct Premiums Written in Florida for Accident and Health for were as follows:

Year	Total Written Premium In Florida (Per Schedule T of Annual Statement)
2009	4,569,476,177
2010	4,834,356,722
2011	4,862,720,296

OUT OF NETWORK CLAIMS HANDLING

I. COMPANY POLICIES AND PROCEDURES REVIEW

The Company defines the usual and customary reimbursement rates for out of network claims as a percentage of Medicare based on the Company's participating contracted rates by county. In January 2009, the Company implemented a system allowing both physician and facility claims to be paid at its usual and customary rates for emergency room services for all health plans. The Company applied a standard percentage of the Medicare allowable amount as the usual and customary fee (for non-participating emergency services) on a statewide basis. Based on an annual review of this process, a decision was made to migrate to a usual and customary reimbursement that varies by geography (Florida community). The usual and customary reimbursement varies dependent upon the community in which the provider is located.

The following percentages were established:

- North Florida - 240% of the Medicare Allowable
- Daytona - 295% of the Medicare Allowable
- Orlando - 181% of the Medicare Allowable
- South Florida - 156% of the Medicare Allowable
- Southwest - 156% of the Medicare Allowable
- Tampa - 286% of the Medicare Allowable
- Florida Panhandle - 240% of the Medicare Allowable

The updated procedure was implemented for facility claims on September 1, 2010, and for physician claims on September 15, 2010; and also applies to Humana One (Individual Plans) claims.

II. CLAIMS REVIEW

The Company was requested to provide a list of all out of network claims paid or denied during the scope period. The Company identified a universe of 560,796 paid or denied out of network claims. A random sample of 184 paid out of network claim files and a random sample of 184 denied out of network claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) **In 17 instances, the Company did not provide timely acknowledgement of the receipt of out of network claims, in violation of Sections 641.3155(3)(a), and (4)(a), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure timely acknowledgement of the receipt of out of network claims.

1b.) **COMPANY RESPONSE:** The Company agreed with this violation.

2) **In 42 instances, the Company did not pay, deny, or contest out of network claims within the required timeframe, in violation of Sections 641.3155(3)(b), and (4)(b), Florida Statutes.**

2a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure that out of network claims are paid, denied, or contested within the required timeframe.

2b.) **COMPANY RESPONSE:** The Company agreed with this violation.

3) **In six (6) instances, the Company did not pay interest on overdue out of network claims, in violation of Section 641.3155(6), Florida Statutes.**

3a.) **CORRECTIVE ACTION:** The Company should establish procedures to ensure that overdue payments of out of network claims include the required 12% interest, pay the interest due on the identified claims, and provide proof of payment.

3b.) **COMPANY RESPONSE:** The Company agreed with this violation.

4) **In four (4) instances, the Company paid out of network claims on less favorable terms than those provided in the subscriber's Schedule of Benefits, in violation of Section 641.3903(5)(b).**

4a.) **CORRECTIVE ACTION:** The Company should implement procedures that ensure claims are properly investigated, verify that out of network claims are paid in accordance with a subscriber's Schedule of Benefits, and issue the appropriate refund, with interest, to the subscriber.

4b.) **COMPANY RESPONSE:** The Company agreed with this violation.

5) **In 26 instances, the Company improperly denied claims due to internal coding errors, in violation of Section 641.3156(2), Florida Statutes.**

5a.) **CORRECTIVE ACTION:** The Company should establish procedures to prevent internal coding errors, and issue the appropriate claim payments, with interest.

5b.) **COMPANY RESPONSE:** The Company agreed with this violation.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.