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BEFORE THE UTAH INSURANCE COMMISSIONER

UTAH INSURANCE DEPARTMENT, Complainant, vs. HUMANA INSURANCE COMPANY, Respondent.	FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER Docket No. 2020-4261

Complainant, Utah Insurance Department ("Department") and Respondent, Humana Insurance Company. ("Respondent"), have stipulated to entry of the following Findings of Fact, Conclusions of Law, and Order. Based upon that stipulation, and good cause appearing, the following are made and entered:

FINDINGS OF FACT

1. Respondent is a life, health, and accident insurance company domiciled in the State of Wisconsin and authorized to do the business of insurance in the State of Utah under License No. 1166.

2. Respondent's mailing address is P.O. Box 740036, Louisville, KY 40201-7436.

3. The Department conducted a Market Conduct Examination ("Examination"), through INS Regulatory Services, Inc., on Respondent for the period January 1, 2015 to December 31, 2017.

4. Based upon that Examination, the Department has made preliminary findings that multiple violations of the Utah Insurance Code or Department Rules have occurred.

5. The purpose of the Examination was to determine Respondent's compliance in claims and mental health parity. The scope of the Examination included a review of Company Operations and Management, Claims, Utilization Reviews, Provider Relations, Marketing and Sales, Pharmacy Review, and Mental Health Parity.

6. A total of 17 findings were contained in the report. The Examination findings are:

a. Finding 1: Respondent failed to comply with reasonable requests by the examiners causing the untimely responses to delay the Examination.

b. Finding 2: The Examination revealed various IT glitches or coding errors resulting in a showing of systemic failure in the management of the Company IT systems. These acts were committed or performed with such frequency as to be a general business practice by Respondent in failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.

c. Finding 3: Respondent failed to send an explanation of benefits in four (4) instances out of 109 paid claims reviewed.

d. Finding 4: In one (1) instance out of 109 mental health and substance use disorder paid claims reviewed, Respondent failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits by terms of its policy contrary to the

mental health parity laws. Respondent does not enforce these provisions, so the forms are not proper and are misleading, which is a violation of § 31A-21-201(2) and (3).

e. Finding 5: In one (1) instance out of twelve (12) claims labeled as urgent care claims within the medical and surgical and mental health and substance use disorder denied claims, the claim was a post-service claim where Respondent failed to pay or deny the claim within 30 days.

f. Finding 6: In one (1) instance out of 109 denied claim files reviewed, it failed to adopt and implement reasonable standards for the prompt investigation and processing of a claim by sending numerous medical record requests for records that had previously been obtained.

g. Finding 7: In one (1) instance out of 109 mental health and substance use disorder pharmacy denied claims files reviewed, Respondent failed to adopt and implement reasonable standards for the prompt investigation and processing of claims causing it to improperly deny this claim and provide an unreasonable explanation.

h. Finding 8: In one (1) instance out of 109 paid claim files reviewed, it failed to provide notification within 12 months to recover amounts paid to a provider in error.

i. Finding 9: In 42 instances out of 116 utilization review files reviewed, Respondent failed to provide notice to the claimant of the insurer's benefit decision. In addition, these acts were committed or performed with such frequency as to indicate a general business practice by the insurer in failing to acknowledge and act promptly upon communications about claims and failing to adopt and implement reasonable standards for the prompt investigation and processing of claims, which is a violation of Utah Code § 31A-26-303(3)(a) and (b).

j. Finding 10: In one (1) instance out of 116 utilization review files reviewed it failed to send a resolution letter notifying the patient that treatment was authorized.

k. Finding 11: Respondent was requested to provide advertising, marketing and sales material including the summary of benefits and coverage for the 17 products sold during the examination period. The examiners requested samples of five (5) of those policies. In three (3) instances out of 17 different policies sold during the examination period, Respondent's policies did not impose parity between mental health and substance use disorder benefits and medical and surgical benefits relative to nonquantitative treatment limits contrary to the mental health parity laws. Respondent does not enforce these provisions, so the forms are not proper and are misleading, which is a violation of Utah Code § 31A-21-201(2) and (3).

l. Finding 12: Respondent provided notice in 2017 to the Department that transitional coverage would be discontinued for the renewal year 2018 for five (5) small employer groups with 42 employees. The groups were also notified of the discontinuance of this coverage. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the groups had an option of continuing their transitional coverage. Similarly, the groups were also notified of the discontinuance of this coverage for the 2019 renewal year. The groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the group had an option of continuing the transitional coverage in the renewal year 2019. As of the February 1, 2019 Respondent membership report, a total of 11 enrollees with two small groups remained active on transitional coverage. As a result, Respondent made communications that contained false or misleading insurance-related information to consumers and provided information to the Department that was inaccurate.

m. Finding 13: Respondent provided notice in December 2018 to the Department that it

identified premium billing discrepancies that occurred when changes were made to employer group dependent or spousal coverage under group medical, dental and vision plans. This change in coverage tier resulted in an overcharge and overpayment of premium. This error impacted 65 groups during the timeframe of January 1, 2006 through April 30, 2018, including the examination period. The billing error was discovered in March 2018 during the review of a customer inquiry. Respondent identified $41,152.23 of overpayment of premium and $22,303.06 in interest to the 65 groups. Respondent provided letters to the members and groups notifying them of this billing error and provided refunds to all terminated groups and credited the account of active groups.

n. Finding 14: Respondent imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on attention-deficit/hyperactivity disorder (ADHD) medications than are imposed on the medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws.

o. Finding 15: Respondent imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on substance abuse medication (buprenorphine containing products) than are imposed on the medical and surgical opioid pain medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws.

p. Finding 16: Respondent imposed greater benefit limitations on mental health and substance use disorder patients by involving more restrictions on the brand name category of atypical antipsychotics than are imposed on the brand name category of medical and surgical

medications relating to formulary and non-formulary design, tier and cost placement and prior authorization and required prior drug therapy plans. This violates the mental health parity laws.

q. Finding 17: In three (3) instances out of 10 utilization review files, it failed to provide resolution letters referencing the correct number of days that treatment was authorized.

7. A total forfeiture of $34,321,000 was calculated for 34,321 violations of the Utah Insurance Code. $32,821,000 of the forfeiture was stayed, for a total due of $1,500,000, plus 24 months' probation.

8. Respondent agrees to these Findings of Fact, Conclusions of Law and Order ("Order") for purposes of settlement with the express reservation that it does not admit to a violation of federal or state laws, regulations, or rules and that the existence of a violation is in dispute. Neither this Order nor any of the communications or negotiations leading up to this Order is now or may be deemed in the future to be an admission or evidence of any liability or wrongdoing by Respondent with respect to the subject matter of this Order.

9. The Department and Respondent have agreed to an administrative forfeiture of $1,500,000.00.

CONCLUSIONS OF LAW

1. The Utah Insurance Commissioner ("Commissioner") has jurisdiction over the parties and this informal adjudicative proceeding pursuant to Utah Code §§ 31A-1-105 and 31A-2-201.

2. The Commissioner has legal authority to impose penalties on the Department's licensees who violate the Utah Insurance Code. Utah Code § 31A-2-308.

3. Respondent violated Utah Code § 31A-2-204(5)(a) and (b) and Utah Administrative Code, R590-192-11(1) when it failed to comply with reasonable requests by the examiners

causing the untimely responses to delay the Examination.

4. Respondent violated Utah Code §§ 31A-26-301.6(10)(d) and 31A-26-303(3)(b) when the Examination revealed various IT glitches or coding errors resulting in a showing of systemic failure in the management of the Company IT systems. These acts were committed or performed with such frequency as to be a general business practice by Respondent in failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.

5. Respondent violated R590-192-8(1) when it failed to send an explanation of benefits in four (4) instances out of 109 paid claims reviewed.

6. Respondent violated Utah Code § 31A-22-625(3)(a) and (b), 42 U.S.C. § 300gg-26(3)(A) and 45 C.F.R. 146.136(c)(2)(i) when in one (1) instance out of 109 mental health and substance use disorder paid claims reviewed, it failed to impose parity between mental health and substance use disorder benefits and medical and surgical benefits by terms of its policy contrary to the mental health parity laws. Respondent does not enforce these provisions, so the forms are not proper and are misleading, which is a violation of § 31A-21-201(2) and (3).

7. Respondent violated Utah Code § 31A-26-301.6(3)(a) when in one (1) instance out of twelve (12) claims labeled as urgent care claims within the medical and surgical and mental health and substance use disorder denied claims, the claim was a post-service claim where Respondent failed to pay or deny the claim within 30 days.

8. Respondent violated Utah Code § 31A-26-303(3)(b) when in one (1) instance out of 109 denied claim files reviewed, it failed to adopt and implement reasonable standards for the prompt investigation and processing of a claim by sending numerous medical record requests for records that had previously been obtained.

9. Respondent violated Utah Code §§ 31A-26-301.6(6) and (10)(d) and 31A-26-303(1), (3)(b) and (3)(e) when in one (1) instance out of 109 mental health and substance use disorder pharmacy denied claims files reviewed, Respondent failed to adopt and implement reasonable standards for the prompt investigation and processing of claims causing it to improperly deny this claim and provide an unreasonable explanation.

10. Respondent violated Utah Code § 31A-26-301.6(14)(a)(iii) when in one (1) instance out of 109 paid claim files reviewed, it failed to provide notification within 12 months to recover amounts paid to a provider in error.

11. Respondent violated R590-192-9(4)(a) and Utah Code § 31A-26-301.6(7)(a) when in 42 instances out of 116 utilization review files reviewed, Respondent failed to provide notice to the claimant of the insurer's benefit decision. In addition, these acts were committed or performed with such frequency as to indicate a general business practice by the insurer in failing to acknowledge and act promptly upon communications about claims and failing to adopt and implement reasonable standards for the prompt investigation and processing of claims, which is a violation of Utah Code § 31A-26-303(3)(a) and (b).

12. Respondent violated R590-192-6(1) when in one (1) instance out of 116 utilization review files reviewed it failed to send a resolution letter notifying the patient that treatment was authorized.

13. Respondent violated Utah Code § 31A-22-625(3)(a) and (b), 42 U.S.C. § 300gg-26(3)(A) and 45 C.F.R. 146.136(c)(2)(i). Respondent was requested to provide advertising, marketing and sales material including the summary of benefits and coverage for the 17 products sold during the examination period. The examiners requested samples of five (5) of those

policies. In three (3) instances out of 17 different policies sold during the examination period, Respondent's policies did not impose parity between mental health and substance use disorder benefits and medical and surgical benefits relative to nonquantitative treatment limits contrary to the mental health parity laws. Respondent does not enforce these provisions, so the forms are not proper and are misleading, which is a violation of Utah Code § 31A-21-201(2) and (3).

14. Respondent violated Utah Code §§ 31A-23a-402(1)(a)(i) and 31A-2-202(6). Respondent provided notice in 2017 to the Department that transitional coverage would be discontinued for the renewal year 2018 for five (5) small employer groups with 42 employees. The groups were also notified of the discontinuance of this coverage. However, the groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the groups had an option of continuing their transitional coverage. Similarly, the groups were also notified of the discontinuance of this coverage for the 2019 renewal year. The groups were subsequently and erroneously sent both a renewal letter offering an Affordable Care Act (ACA) -compliant plan and a letter indicating the group had an option of continuing the transitional coverage in the renewal year 2019. As of the February 1, 2019 Respondent membership report, a total of 11 enrollees with two small groups remained active on transitional coverage. As a result, Respondent made communications that contained false or misleading insurance-related information to consumers and provided information to the Department that was inaccurate.

15. Respondent violated Utah Code § 31A-23a-402(1)(a)(i) when it provided notice in December 2018 to the Department that it identified premium billing discrepancies that occurred when changes were made to employer group dependent or spousal coverage under group

medical, dental and vision plans. This change in coverage tier resulted in an overcharge and overpayment of premium. This error impacted 65 groups during the timeframe of January 1, 2006 through April 30, 2018, including the examination period. The billing error was discovered in March 2018 during the review of a customer inquiry. Respondent identified $41,152.23 of overpayment of premium and $22,303.06 in interest to the 65 groups. Respondent provided letters to the members and groups notifying them of this billing error and provided refunds to all terminated groups and credited the account of active groups.

16. Respondent violated Utah Code § 31A-22-625(3)(a) and (b), 42 U.S.C. § 300gg-26(3)(A) and 45 C.F.R. 146.136(c)(2)(i) when it imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on attention-deficit/hyperactivity disorder (ADHD) medications than are imposed on the medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws.

17. Respondent violated Utah Code § 31A-22-625(3)(a) and (b), 42 U.S.C. § 300gg-26(3)(A) and 45 C.F.R. 146.136(c)(2)(i) when it imposed greater benefit limitations on mental health and substance use disorder patients by placing more restrictions on substance abuse medication (buprenorphine containing products) than are imposed on the medical and surgical opioid pain medications relating to formulary and non-formulary design, tier and cost placement and prior authorization/required prior drug therapy plans. This violates the mental health parity laws.

18. Respondent violated Utah Code § 31A-22-625(3)(a) and (b), 42 U.S.C. § 300gg-26(3)(A) and 45 C.F.R. 146.136(c)(2)(i) when it imposed greater benefit limitations on mental

health and substance use disorder patients by involving more restrictions on the brand name category of atypical antipsychotics than are imposed on the brand name category of medical and surgical medications relating to formulary and non-formulary design, tier and cost placement and prior authorization and required prior drug therapy plans. This violates the mental health parity laws.

19. Respondent violated R590-192-6(1) when in three (3) instances out of 10 utilization review files, it failed to provide resolution letters referencing the correct number of days that treatment was authorized.

20. As penalties for the violations in this case, Respondent should be ordered to pay a forfeiture of $1,500,000.00.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby Ordered that:

1. Respondent shall pay a forfeiture of $1,500,000.00 for the violations described in the Conclusions of Law. The forfeiture shall be paid within 30 days from the date of this Order.

2. Respondent shall be placed on probation for a period of 24 months from the date of this Order. During the probationary period Respondent shall have no further violations of Utah insurance laws. The Department will conduct random audits during the probationary period.

3. Respondent is ordered not to commit the violations described in the Conclusions of Law in the future.

DATED this 29th day of September, 2020.

TODD E. KISER
Utah Insurance Commissioner

NOTICE TO RESPONDENT

Failure to obey this Order may subject you to further penalties that include a forfeiture of up to $2,500 per violation, with each day of the violation constituting a separate violation. Other penalties for failing to obey this Order may include license suspension, probation, refusal to renew, or revocation. Failure to obey this Order may also result in an action taken against you in a court of competent jurisdiction where forfeitures of up to $10,000 for each day the failure to comply continues until judgment is rendered. If you are licensed in other jurisdictions, you may be required to report this proceeding to those jurisdictions.