STATE OF ARIZONA
FILED

JUN 24 2008

DEPT OF INSURANCE
BY

STATE OF ARIZONA

ARIZONA DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 08A-112-INS
HUMANA HEALTH PLAN, INC. NAIC #95885	**CONSENT ORDER**
Respondent.	

On August 8, 2007 the Arizona Department of Insurance ('Department') called a healthcare insurance compliance examination ('Examination') of Humana Health Plan, Inc. ('Humana' or the 'Company') covering the time period from January 1, 2006 through December 6, 2007 ('Examination Period'). The Examination Period was divided into four six-month periods ('Partial Examination Periods' or 'PEPs') as follows:

PEP 1:	January 1, 2006 – June 30, 2006
PEP 2:	July 1, 2006 – December 31, 2006
PEP 3:	January 1, 2007 – June 30, 2007
PEP 4:	July 1, 2007 – December 6, 2007

The Report of the Health Insurance Compliance Examination of Humana Health Plan, Inc. dated March 3, 2008 ('Report'), which is included herein by reference, alleges that Humana Health Plan, Inc. violated Arizona Revised Statutes (A.R.S.) §§ 20-2533 through 20-2536, A.R.S. § 20-1074 and A.R.S. § 20-1077. Humana Health Plan, Inc. wishes to resolve this matter without formal proceedings. Humana admits the following Findings of Fact are true and consents to the entry of the following Conclusions of Law solely for the purpose of resolving the allegations contained in the Report and consents to the entry of the following Order.

FINDINGS OF FACT

I. Jurisdiction.

Humana Health Plan, Inc. is, and throughout the Examination Period was, authorized to operate as a health care services organization insurer pursuant to a Certificate of Authority issued by the Arizona Insurance Director ('Director').

II. Utilization Review and Health Care Appeals.

A. During the Examination Period, in 36 of 62 (58% of) appeals, Humana Health Plan, Inc. failed to provide a health care appeals information packet to the member within five business days after the date the appeal was initiated.

B. During the Examination Period, in 33 of 62 (53% of) appeals, Humana Health Plan, Inc. failed to notify the member of the right to appeal or failed to issue an explanation of benefits document that provided the member the correct timeframe to file an appeal.

C. During the Examination Period, Humana's initial determination letter appeared to provide the company discretion in deciding if an appeal that was certified by a provider would be heard as an expedited appeal.

D. During PEP 3, in 1 of 1 (100% of) requests for expedited medical review, Humana Health Plan, Inc. failed to inform the member and the member's treating provider of the expedited decision within one business day.

E. During PEP 3, in 1 of 1 (100% of) requests for an expedited medical review where there was an adverse decision, Humana Health Plan, Inc. failed to notify the member or the member's treating provider by telephone and mail

of the adverse decision or of the member's option to immediately proceed to an expedited appeal.

F. During the Examination Period, in 4 of 10 (40% of) requests for informal reconsideration, Humana Health Plan, Inc. failed to mail a written acknowledgment to the member within five business days after receipt of the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receipt of the request or failed to do either.

G. During PEPs 2 and 4, in 2 of 6 (33% of) informal reconsiderations, Humana Health Plan, Inc. failed to mail notice of its decision to the member within thirty days after receipt of a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty days after receipt of a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision.

H. During the Examination Period, in 16 of 51 (31% of) formal appeals, Humana Health Plan, Inc. failed to mail a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.

I. During PEP 2, in 1 of 5 (20% of) adverse decisions in formal appeals related to denials of claims that had already been provided, Humana Health Plan, Inc. failed to provide written notice of its adverse decision to the member within sixty days after receipt of the written appeal, or failed to notify the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

J. During the Examination Period, in 8 of 23 (35% of) formal appeals, when at the conclusion of the formal appeal process the utilization review agent denies the appeal, Humana Health Plan, Inc. failed to notify the member with notice of the option to proceed to an external independent review.

III. Freestanding Urgent Care Centers.

A. During the Examination Period, Humana Health Plan, Inc. failed to credential or recredential freestanding urgent care providers.

IV. Contract Termination; Duty To Report; Provision For Continued Services During Insolvency.

A. During the Examination Period, in 38% of provider contracts reviewed, Humana Health Plan, Inc. failed to include a statement that requires the provider to provide services to enrollees under certain circumstances if Humana were to become insolvent or the language was incorrect.

CONCLUSIONS OF LAW

I. Jurisdiction.

The Director has the authority to enter and enforce this Order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals.

A. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2533(C) by failing to provide a health care appeals information packet to the member within five business days after the date the appeal was initiated.

B. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2533(D) by failing to notify the member of the right to appeal or failed to issue an explanation of benefits document that provided the member the correct timeframe to file an appeal.

C. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2534(A) by an initial determination letter that appeared to provide the company discretion in deciding if an appeal that was certified by a provider would be heard as an expedited appeal.

D. During PEP 3, Humana Health Plan, Inc. violated A.R.S. § 20-2534(B) by failing, in requests for expedited medical review, to inform the member and the member's treating provider of the expedited decision within one business day.

E. During PEP 3, Humana Health Plan, Inc. violated A.R.S. § 20-2534(C) by failing, in requests for an expedited medical review where there was an

adverse decision, to notify the member or the member's treating provider by telephone and mail of the adverse decision or of the member's option to immediately proceed to an expedited appeal.

F. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2535(B) by failing, in requests for informal reconsideration, to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

G. During PEPs 2 and 4, Humana Health Plan, Inc. violated A.R.S. § 20-2535(D) by failing, in informal reconsiderations, to mail notice of its decision to the member within thirty days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty days after receipt of a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision.

H. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2536(B) by failing, in formal appeals, to mail a written acknowledgment to the member and the member's treating provider within five business days after receiving the formal appeal.

I. During PEP 2, Humana Health Plan, Inc. violated A.R.S. § 20-2536(E)(2) by failing, in adverse decisions of formal appeals relating to denials of claims that had already been provided, to provide written notice of its adverse decision to the member within sixty days after receipt of the written appeal, or failed to notify the member in writing of the utilization review

agent's decision and the criteria used and the clinical reasons for that decision.

J. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-2536(G) by failing, in formal appeals when at the conclusion of the formal appeal process the utilization review agent denies the appeal, to notify the member with notice of the option to proceed to an external independent review.

III. Freestanding Urgent Care Centers.

A. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-1077(3) by failing to credential or recredential freestanding urgent care providers.

IV. Contract Termination; Duty To report; Provision For Continued Services During Insolvency.

A. During the Examination Period, Humana Health Plan, Inc. violated A.R.S. § 20-1074(B) by failing in provider contracts to include a statement that requires the provider to provide services to enrollees under certain circumstances if Humana were to become insolvent or the language was incorrect.

ORDER

IT IS HEREBY ORDERED THAT:

1. Utilization Review and Health Care Appeals. Within 90 days of the filed date of this Order, Humana Health Plan, Inc. shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 1) regarding its utilization review and health care appeals violations set forth in this Consent Order. CAP 1 shall provide specific steps Humana Health Plan, Inc. has taken or will take by certain dates to assure that by a specified implementation date, Humana Health Plan, Inc. is:

    a. Providing a health care appeals information packet to the member within five business days after the date the appeal was initiated.

    b. Notifying the member of the right to appeal or issuing an explanation of benefits document that is providing the member the correct timeframe to file an appeal.

    c. Sending an initial determination letter that does not appear to provide the company discretion to decide if an appeal that was certified by a provider would be heard as an expedited appeal.

    d. In requests for expedited medical review, notifying the member and the member's treating provider of the expedited decision within one business day.

    e. In requests for expedited medical review where there was an adverse decision, notifying the member or the member's treating provider by telephone and mail of the adverse decision and of the member's option to immediately proceed to an expedited appeal.

f. In requests for informal reconsideration, mailing a written acknowledgment to the member within five business days after receipt of the request, or mailing a written acknowledgment to the member's treating provider within five business days after receipt of the request or not failing to do either.

g. Mailing a notice of its decision to the member within thirty days after receipt of a request for informal reconsideration, or mailing notice of its decision to the member's treating provider within thirty days after receipt of a request for informal reconsideration, or including the criteria used and the clinical reasons for the decision.

h. In formal appeals, mailing a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.

i. In adverse decisions of formal appeals related to denials of claims that had already been provided, providing a written notice of its adverse decision to the member within sixty days after receipt or written appeal, or notifying the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

j. In formal appeals, when at the conclusion of the formal appeal process the utilization review agent denies the appeal, notifying the member with notice of the option to proceed to an external independent review.

2. Freestanding Urgent Care Centers. Within 90 days of the filed date of this Order, Humana Health Plan, Inc. shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 2) that provides specific steps Humana has taken or will take by certain dates to credential and recredential freestanding urgent care providers.

3. Contract Termination; Duty To Report; Provision For Continued Services During Insolvency. Within 90 days of the filed date of this Order, Humana Health Plan, Inc. shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 3) that provides specific steps Humana has taken or will take to include, in provider contracts, a statement requiring the provider to provide services to enrollees under certain circumstances if Humana were to become insolvent or including the language in statute.

4. Progress in Development of the CAPs. Until the Director approves each CAP or CAP item, Humana Health Plan, Inc. shall report to the Director each month on its progress in the development of each CAP or CAP item. Each such monthly report shall include a current draft of that CAP or CAP item. The first monthly CAP development reports are due to the Director 30 days from the date of this Order.

5. Corrective Action Plan Requirements. Each CAP described above shall:

   a. Specify any items of CAP 1 ('a' through 'j'), CAP 2 and CAP 3 that the Director has either approved as ready for implementation or accepted as implemented before the date of the report and for each one:

      i. documentation of the implementation or progress toward implementation, as applicable,

      ii. a plan for post implementation review and follow-up, and

      iii. the name and contact information for one individual responsible for ongoing implementation of the CAPs.

   b. Specify any items of CAP 1 ('a' through 'j'), CAP 2 or CAP 3 that the Director has not approved as ready for implementation or accepted as implemented as of the date of the report and for each one include:

i. enough detail to allow the Director to determine whether the CAP will accomplish its purpose,

ii. testing before final implementation of the CAP or any item of the CAP,

iii. post implementation Quality Improvement review and follow-up, and

iv. the name and contact information for one individual responsible and accountable for ongoing implementation of the CAP or any item of the CAP.

c. Provide for Humana Health Plan, Inc. to report to the Director each month regarding implementation of each approved CAP or any item of the CAP, in a form that includes documentation and is approved by the Director. If the CAP or any item of the CAP has been implemented, provide documentation that demonstrates the results of the changes. If the CAP or any item of the CAP is in the process of implementation, provide documentation that demonstrates the progress that has been made toward implementation.

d. Provide that within 10 business days of receiving notice that the Director has approved the CAP or any item of the CAP, Humana Health Plan, Inc. shall submit to the Director evidence that Humana Health Plan, Inc. has communicated the CAP or any item of the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memos, bulletins, e-mails, correspondence, procedure manuals, print screens and training materials.

6. Civil Penalty. Humana Health Plan, Inc. shall pay a civil penalty of $44,375.00 to the Director for deposit in the State General Fund for violations cited above as

Conclusions of Law. Humana Health Plan, Inc. shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report of the Health Insurance Compliance Examination of Humana Health Plan, Inc. upon the filing of this order.

DATED at Phoenix, Arizona this 20th day of June, 2008.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. Humana Health Plan, Inc. has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. Humana Health Plan, Inc. believes that it is able and prepared to comply fully with the order, notwithstanding any of its other business and regulatory requirements.

2. Humana Health Plan, Inc. admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact and consents to the entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.

3. Humana Health Plan, Inc. is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Humana Health Plan, Inc. irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Humana Health Plan, Inc. states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Humana Health Plan, Inc. acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.

6. Gary Goldstein, M.D., who holds the office of Chief Executive Officer – Humana West Region, is authorized to enter into this Order for Humana Health Plan, Inc. and on its behalf.

Humana Health Plan, Inc.

6/2/08
Date

By _____
Gary Goldstein, M.D.
Chief Executive Officer – Humana West Region
Humana Health Plan, Inc.

COPY of the foregoing mailed/delivered this 24th day of Jun, 2008, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Paul J. Hogan
Market Oversight Division Chief
Dean Ehler
Assistant Director
Rates & Regulations Division
Steve Ferguson
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David Lee
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