MARKET CONDUCT REPORT ON EXAMINATION

OF

HUMANA INSURANCE COMPANY OF NEW YORK

AND

HUMANA HEALTH COMPANY OF NEW YORK, INC.

AS OF DECEMBER 31, 2017

EXAMINER: **TOMMY KONG, CFE, PIR**

DATE OF REPORT: **AUGUST 16, 2022**

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August 16, 2022

Honorable Adrienne A. Harris
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law and Public Health Law, and acting in accordance with the instructions contained in Appointment Numbers 31688 and 31690, dated December 4, 2017, attached hereto, I have made an examination into the affairs of Humana Insurance Company of New York, an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law, and Humana Health Company of New York, Inc., a health maintenance organization certified pursuant to Article 44 of the New York Public Health Law, as of December 31, 2017, and submit the following report thereon.

The examination was conducted at the main administrative office of Humana Insurance Company of New York and Humana Health Company of New York, Inc. located at 500 West Main Street, Louisville, Kentucky.

Wherever the designations "HICNY" or the "Company" appear herein, without qualification, they should be understood to indicate Humana Insurance Company of New York.

Wherever the designations “HHCNY” or the “HMO” appear herein, without qualification, they should be understood to indicate Humana Health Company of New York, Inc.

Wherever the designation the “Companies” appears herein, without qualification, it should be understood to indicate Humana Insurance Company of New York and Humana Health Company of New York, Inc., collectively.

Wherever the designation “Humana” appears herein, without qualification, it should be understood to indicate Humana Inc., the parent of Humana Insurance Company of New York and Humana Health Company of New York, Inc.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous market conduct examination of the Companies was conducted as of December 31, 2012. This market conduct examination of the Companies was performed to review the manner in which the two entities conduct their business practices and fulfill their contractual obligations to policyholders and claimants, and covers the five-year period January 1, 2013, through December 31, 2017. Transactions occurring subsequent to December 31, 2017, were reviewed where deemed appropriate.

This report on examination contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

Concurrently, an examination into the financial condition of the Companies was performed. Separate financial reports on examination for HICNY and HHCNY have respectively been submitted thereon.

2. DESCRIPTION OF THE COMPANIES

Humana Insurance Company of New York is a wholly-owned subsidiary of Humana Inc. HICNY was incorporated in the State of New York on May 20, 2005. The Company is a for-profit accident and health insurance company, which commenced writing business on August 17, 2006. HICNY offers coordinated medical and prescription drug coverage to Medicare eligible individuals under Medicare Advantage, and Medicare Prescription Drug Part D contracts with the Centers for Medicare and Medicaid Services ("CMS"). In addition, HICNY writes supplemental Medicare and stand-alone commercial dental and vision coverages.

Humana Health Company of New York, Inc. was incorporated in the State of New York on April 4, 2008, under its former name Arcadian Health Plan of New York, Inc. ("AHPNY"). AHPNY subsequently received a Certificate of Authority ("COA") pursuant to Article 44 of the New York Public Health Law to operate as a health maintenance organization, effective October 20, 2008. AHPNY commenced conducting business on January 1, 2009, in Onondaga County, and on April 29, 2009, with the New York State Department of Health's approval, the HMO amended its COA, which resulted in an expansion of its writing territory to include the additional New York State counties of Madison and Oneida.

On March 31, 2012, Humana Inc., a stock corporation publicly traded on the New York Stock Exchange, completed its acquisition of both AHPNY's then ultimate parent, Arcadian Management Services, Inc. and AHPNY. The acquisition was approved by the New York State Department of Health ("DOH"), effective March 30, 2012, following the Department's prior issuance of a non-objection letter dated December 6, 2011.

Following its acquisition, AHPNY received authorization from DOH to effectuate a corporate name change to Humana Health Company of New York, Inc. The name change on the HMO's amended COA was effective on July 15, 2013.

3. CLAIM FORMS

Part 86.4(a) of Insurance Regulation No. 95 (11 NYCRR 86.4(a)) requires the following fraud warning statement to be included on all claim forms:

> "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a

> crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

The Companies dental claim forms used during the examination period were the standard American Dental Association ("ADA") form and were not in compliance with Part 86.4(a) of Insurance Regulation No. 95 (11 NYCRR 86.4(a)) for that the forms used did not contain the fraud warning statement that is required by the regulation.

It is recommended that the Companies revise their standard dental claim forms to include the fraud warning statement prescribed by Part 86.4(a) of Insurance Regulation No. 95 (11 NYCRR 86.4(a)).

4. FRAUD PREVENTION PLAN

Section 409(c) of the New York Insurance Law states, in part:

> "(c) The plan shall provide for the following:
>
> (1) interface of special investigation unit personnel with law enforcement and prosecutorial agencies and with the financial frauds and consumer protection unit of the department of financial services;
>
> (2) reporting of fraud data to a central organization approved by the superintendent;
>
> (3) in-service education and training for underwriting and claims personnel in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities…
>
> (5) public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud…
>
> (7) the time and manner in which such plan shall be implemented and a demonstration that the fraud prevention and reduction measures outlined in the plan will be fully implemented..."

It was noted from a review of HICNY's anti-fraud plan that its plan lacked the aforementioned requirements of Section 409(c) of the New York Insurance Law.

It is recommended that HICNY revise its anti-fraud plan to include all the mandated requirements prescribed by Sections 409(c) (1), (2), (3), (4), (5) and (7) of the New York Insurance Law.

Part 98-1.21 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21) states, in part:

> "(b) A fraud and abuse prevention plan shall include the following provisions:
>
> (2) a description of the organization of the special investigations unit, including the titles and job descriptions of the various investigators and investigative supervisors, the minimum qualifications for employment in these positions in addition to those required by this regulation, the geographical location and assigned territory of each investigator and investigative supervisor, the support staff… If investigators employed by the unit will be responsible for investigating cases in more than one state, the plan must apportion that percentage of the investigators efforts which will be devoted to New York cases;
>
> (3) the rationale for the level of staffing and resources being provided for the special investigations unit which may include, but is not limited to, objective criteria such as number of enrollees, number of claims received with respect to New York MCOs on an annual basis, volume of suspected fraudulent and abusive New York claims currently being detected, other factors relating to the vulnerability of the MCO to fraud and abuse, and an assessment of optimal caseload which can be handled by an investigator on an annual basis…
>
> (8) for MCOs participating in programs authorized by title XIX, provision for the department and/or the New York State Medicaid Fraud Control Unit ("MFCU") to conduct private interviews of MCO personnel, subcontractors and their personnel, witnesses, and enrollees. MCO personnel and subcontractors and their personnel must cooperate fully in making MCO personnel, subcontractors and their personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trial and in any other process, including investigations at the MCOs and subcontractors own expense. In addition, the MCO must provide to the department, its authorized representatives, and/or the MFCU, originals and/or copies of all records and information requested, in the form requested, and allow access to the MCOs premises. All copies of records must be provided free of charge…
>
> (12) provision for establishment and consistent application of appropriate disciplinary policies for all employees who fail to comply with the MCOs standards of conduct, policies and procedures and applicable state and federal standards, as well as publication and dissemination of the disciplinary policies and the range of disciplinary actions for improper conduct;

(13) development of a fraud and abuse awareness program, appropriate for the size of the MCO, focused on the cost and frequency of fraud and abuse, and methods by which the MCO's enrollees, providers and other contractors can prevent it;

(14) development of a fraud and abuse detection procedures manual for use by officers, directors, managers, and claims, underwriting, member services, utilization management, complaint, and investigative personnel; and

(15) the timetable for the implementation of the fraud and abuse prevention plan, provided however, that the period preceding implementation shall not exceed six months from the date the plan is submitted…

(d) Every MCO required to file a fraud and abuse prevention plan shall file an annual report with the department no later than January 15th of each year on a form approved by the department describing the MCO's experience, performance and cost effectiveness in implementing the plan and its proposals for modifications to the plan, to amend its operations, to improve performance or to remedy observed deficiencies. The MCO must also report at least annually the number of complaints regarding fraud and abuse made to the MCO during the year. In addition, for each confirmed case of fraud and abuse identified through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, etc., the following shall be reported to the department on an ongoing basis when the case is confirmed:

(i) the name of the individual or entity that committed the fraud or abuse;
(ii) the source that identified the fraud or abuse;
(iii) the type of provider, entity or organization that committed the fraud or abuse;
(iv) a description of the fraud or abuse;
(v) the approximate range of dollars involved;
(vi) the legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
(vii) other data/information prescribed by the department.

The reports shall be reviewed and signed by an executive officer of the MCO responsible for the operations of the special investigations unit."

It was noted from a review of HHCNY's anti-fraud plan that it lacked the aforementioned requirements of Part 98-1.21 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21).

It is recommended that HHCNY revises its anti-fraud plan to include all the mandated requirements prescribed by Part 98-1.21 of the Administrative Rules and Regulations of the New York State Department of Health (10 NYCRR 98-1.21).

Section 409(a) of the New York Insurance Law states, in part:

> "Every insurer writing…individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, except for insurers that write less than three thousand of such policies…shall, within one hundred twenty days of the effective date of this amended section to be promulgated by the superintendent to implement this section, file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state..."

As of December 31, 2017, HICNY reported an enrolled population of 178,036 as such, the Company was required, pursuant to Section 409(a) of the New York Insurance Law, to file its fraud prevention plan with the Department, however it failed to do so.

It is recommended that HICNY comply with Section 409(a) of the New York Insurance Law by filing its fraud prevention plan with the Department.

5. POLICYHOLDER SERVICE

Section 3232-a(a) of the New York Insurance Law states, in part:

> "Every insurer who delivers or issues for delivery individual health insurance policies or group or blanket accident and health insurance policies shall provide to covered individuals written certification, in a form as the superintendent may approve, of:
>
> (1) the period of creditable coverage, as defined in section three thousand two hundred thirty-two of this article, of the individual under such policy and any continuation coverage of the individual pursuant to state or federal law…"

It was noted that HICNY no longer provides certificates of prior credible coverage to its Medicare Supplement insureds.

It is recommended that HICNY revise its policy and procedures to require HICNY to provide a certificate of credible coverage to its Medicare Supplement insureds, as required pursuant to Section 3232-a(a) of the New York Insurance Law.

6. RATING

Part 52.40(f)(1) of Insurance Regulation No. 62 (11 NYCRR 52.40(f)(1)) states, in part:

> "Policies may be experience-rated in accordance with a written plan or formula approved by the board of directors of the insurer or designee thereof…"

It was noted that HICNY's experience-rated formula for its specialty products (dental and vision) did not receive approval from its Board or a designee of the Board, as required by Part 52.40(f)(1) of Insurance Regulation No. 62 (11 NYCRR 52.40(f)(1)).

It is recommended that HICNY comply with Part 52.40(f)(1) of Insurance Regulation No. 62 (11 NYCRR 52.40(f)(1)) by obtaining its Boards or a designee of the Board's approval for the experience-rated formula that is in use for its specialty products.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____
Tommy Kong, CFE, PIR
Financial Services Examiner 2

STATE OF NEW YORK)
)SS.
)
COUNTY OF NEW YORK)

Tommy Kong, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
Tommy Kong, CFE, PIR

Subscribed and sworn to before me
this _____ day of _____ 2022

APPOINTMENT NO. **31688**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Tommy Kong

as a proper person to examine the affairs of the

Humana Insurance Company of New York

and to make a report to me in writing of the condition of said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 4th day of December, 2017

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. **31690**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Tommy Kong

as a proper person to examine the affairs of the

Humana Health Company of New York, Inc.

and to make a report to me in writing of the condition of said

Plan

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 4th day of December, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:

Lisette Johnson
Bureau Chief
Health Bureau