KENTUCKY

DEPARTMENT OF INSURANCE

FINAL REPORT

MARKET CONDUCT EXAMINATION

HUMANA INSURANCE COMPANY

1100 Employers Blvd.
De Pere, WI 54115

For the Period

January 1, 2014 through August 1, 2019

PUBLIC PROTECTION CABINET
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
1-800-595-6053
http://insurance.ky.gov

Andy Beshear
Governor

Ray A. Perry
Deputy Secretary

Kerry B. Harvey
Secretary

Sharon P. Clark
Commissioner

September 10, 2020

Sharon P. Clark, Commissioner
Kentucky Department of Insurance
500 Mero Street, 2 SE 11
Frankfort, Kentucky 40601

RE: Market Conduct Examination (MC #2019-09)

Dear Commissioner Clark:

Pursuant to appointment 2019-09 by the Department of Insurance, and in accordance with the provisions of KRS 304.2-100, KRS 304.2-210, KRS 304.2-230, Kentucky Administrative Regulations Title 806, other applicable laws, and the procedures established by the National Association of Insurance Commissioners, a targeted examination of the market conduct activities has been conducted regarding:

HUMANA INSURANCE COMPANY
1100 EMPLOYERS BLVD.
DE PERE, WI 54115

The report, based on the activities of the Company from January 1, 2014 through August 1, 2019 is hereby respectfully submitted.

Sincerely,

Signature on file with original document

Russ Hamblen, PIR, AIC, MCM
Chief Market Conduct Examiner
Examiner-in-Charge

TITLE PAGE

TARGET MARKET CONDUCT EXAMINATION

NAME OF COMPANY:	Humana Insurance Company
NAIC COMPANY CODE:	73288
NAIC GROUP CODE:	119
NAIC EXAM TRACKING SYSTEM NO.:	KY-KY031-24
DEPARTMENT OF INSURANCE NUMBER:	301104
DATE INCORPORATED:	December 18, 1968
STATE OF DOMICILE:	Wisconsin
DATE BUSINESS COMMENCED:	April 25, 1986
DATE ADMITTED IN KENTUCKY:	April 25, 1986
STATUTORY HOME OFFICE:	1100 Employers Blvd. De Pere, WI 54115
TIMEFRAME OF COMPANY OPERATIONS EXAMINED:	January 1, 2014 through August 1, 2019
LENGTH OF TIME FOR EXAMINATION:	June 11, 2019 through July 31, 2020
EXAMINATION COORDINATOR:	Charles Dixon, Jr., MCM Senior Compliance Professional/ Commercial & Specialty Regulatory Compliance 500 West Main Street Louisville, Kentucky 40202
PARTICIPATING JURISDICTION:	Kentucky Department of Insurance Phone: (502) 564-1936

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FOREWORD

The findings of this report are based on a targeted examination of the business practices of Humana Insurance Company in the Commonwealth of Kentucky. The examination process is governed by, and performed in accordance with, the standards and procedures of the National Association of Insurance Commissioners (NAIC) and the Kentucky Department of Insurance (Department). This targeted market conduct examination report is one by test, wherein each test applied during the examination is stated and the results reported.

The examination was performed primarily as a desk audit. Initial risk focused interviews were conducted at the Company's administrative office in Louisville, Kentucky. The opening date of the examination was June 11, 2019.

ABBREVIATIONS

Audit Command Language	ACL™
Corrective Action Plan	CAP
Criticism	CRIT
Humana Insurance Company	Humana, HIC or Company
Information Request	IR
Information Technology	IT
Insurance Services Office	ISO
Kentucky Administrative Regulations	KAR
Kentucky Department of Insurance	KDOI, DOI or Department
Kentucky Revised Statutes	KRS
National Association of Insurance Commissioners	NAIC
Third-Party Administrator	TPA

EXECUTIVE SUMMARY

A targeted market conduct examination of Humana Insurance Company was called for the scope of January 1, 2014 through August 1, 2019 to determine compliance by the Company with Kentucky insurance statutes and Departmental regulations.

This examination resulted from a DOI consumer/legal complaint, which involved a question whether the Company was properly granting appellate rights to consumers within self-funded Non-ERISA plans.

The legal division referred this complaint to market conduct for further investigation, and in turn, became the basis of this regulatory action.

A companion examination was conducted regarding Humana Health Plan, Inc. (HHP) (MC 2019-08) which tested in kind areas.

SCOPE OF EXAMINATION

EXAMINATION AUTHORITY

Pursuant to the directive of the Department, and in accordance with the provisions of KRS 304.2-100, KRS 304.2-210, KRS 304.2-230, Kentucky Administrative Regulations (KAR) Title 806, other applicable laws, and the procedures established by the National Association of Insurance Commissioners (NAIC), a targeted examination of market conduct activities has been performed regarding:

HUMANA INSURANCE COMPANY
1100 EMPLOYERS BLVD.
DE PERE, WI 54115

The Company's activities for the period from January 1, 2014 through August 1, 2019, were examined. Unless otherwise noted, all review and exam results apply only to that period.

PURPOSE

The purpose of this examination was to determine compliance by the Company with Kentucky insurance statutes and Departmental regulations related to Non-ERISA Self-Funded entities.

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify, comment on or criticize specific Company practices does not constitute an acceptance of the practices by the Department.

ERROR TOLERANCE

Where applicable, the Department utilizes an error tolerance guideline established by the NAIC, except in certain instances where the Department applies a stricter error tolerance standard. The error tolerance percentages applied are as follows:

AREA	ERROR TOLERANCE PERCENTAGE APPLIED
Utilization Review	5%

FILE SAMPLING

Unless otherwise noted, file sampling was based on a review of files that were randomly selected by using Audit Command Language (ACL™) software and applied to the computer data files provided by the Company. Where possible, sample sizes were chosen based primarily on guidelines developed by the NAIC.

CERTIFICATE OF AUTHORITY

The Company has a valid Kentucky Certificate of Authority to transact business as a health maintenance organization, effective April 25, 1986. The Company is acting within the scope of its authority.

Examiner Note

HIC has been registered with the Department as a Utilization Review Entity since November 1, 1991.

HHP was registered as a Utilization Review Entity from May 1, 1991 through November 1, 2007.

UTILIZATION REVIEW

The Company reported 563 appeals within the scope of examination related to the administration of Non-ERISA self-funded plans for both Humana Insurance Company and Humana Health Plan, Inc. (MC 2019-08). Since all appeals are adjudicated in a standard format across both Companies, the examiner pulled a random sample of 86 from the population of both entities under review. (Humana Health Plan, Inc. – 14 appeals out of a population of 94, and Humana Insurance Company – 72 out of a population of 469).

The Company also provided a list of plan management agreements that exist for services between the Company and Non-ERISA self-funded groups. Contracts were reviewed to evaluate scope of work in relation to the third party administrator of the utilization review process, and to ensure general compliance with Kentucky law.

These agreements were reviewed without comment.

Lastly, the examiner reviewed written procedures for the handling of complaints, grievances and appeals. These procedures were reviewed to confirm adequacy of complaint controls, and to verify proper processes were in place to resolve consumer issues.

These also were reviewed without comment.

The following demonstrates the findings of the testing of the appeal sample for HIC.

- In nine (9) instances (out of a population of 72), the Company failed to ensure only a licensed physician made a utilization review decision as not medically necessary or experimental and investigational in the initial adverse benefit determination, in violation of **KRS 304.17A-607(1)(b)(1)**.

  Failure to ensure a licensed physician makes a utilization review decision as not medically necessary or experimental and investigational in the initial adverse benefit determination in 13% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-607(1)(b)(1).

- In nine (9) instances (out of a population of 72), the Company failed to include the state of licensure, medical licensure number and title of reviewer in the initial adverse benefit determination of a medical determination, in violation of **KRS 304.17A-607(1)(j)(2)**.

  Failure to include the state of licensure, medical licensure number and title of reviewer in the initial adverse benefit determination of a medical determination in 13% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-607(1)(j)(2).

- In eleven (11) instances (out of a population of 72), the Company failed to include a description of alternative benefits in the initial adverse benefit determination, in violation of **KRS 304.17A-607(1)(j)(3)**.

Failure to include a description of alternative benefits in the initial adverse benefit determination in 15% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-607(1)(j)(3).

- In fifty-seven (57) instances (out of a population of 72), the Company failed to include complete instructions regarding the internal appeal in the initial adverse benefit determination (including in the form of an explanation of benefit), in violation of **KRS 304.17A-607(1)(j)(4)**.

Failure to include complete instructions regarding the internal appeal process in the initial adverse benefit determination (including in the form of an explanation of benefit) in 79% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-607(1)(j)(4).

- In thirty-five (35) instances (out of a population of 72), the Company failed to include the state of licensure, medical license number, and title of reviewer in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(2)**.

Failure to include the state of licensure, medical license number, and title of reviewer in an adverse benefit determination upheld on appeal notification in 49% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-617(2)(e)(2).

- In eight (8) instances (out of a population of 72), the Company failed to provide a description of alternative benefits in an adverse benefit determination upheld on appeal, in violation of **KRS 304.17A-617(2)(e)(3)**.

Failure to provide a description of alternative benefits in an adverse benefit determination upheld on appeal in 11% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-617(2)(e)(3).

- In nineteen (19) (out of a population of 72), the Company failed to provide instructions for an external review in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(4)**.

Failure to provide instructions for an external review in an adverse benefit determination upheld on appeal notification in 26% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-617(2)(e)(4).

- In twenty (20) instances (out of a population of 72), the Company failed to provide instructions for filing a request for review with the Department on a coverage denial in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(4)**.

  Failure to provide instructions for filing a request for review with the Department on a coverage denial in an adverse benefit determination upheld on appeal notification in 28% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-617(2)(e)(4).

- In seventeen (17) instances (out of a population of 72), the Company failed to have an adverse benefit determination upheld on appeal notification signed by a Kentucky Medical Director, in violation of **KRS 304.17A-545(1)(d).**

  Failure to have an adverse benefit determination upheld on appeal notification signed by a Kentucky Medical Director in 24% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of KRS 304.17A-545(1)(d).

- In forty-two (42) (out of a population of 72), the Company failed to include the right to request a board eligible or certified physician if involving a specialty or subspecialty in the initial adverse benefit determination, in violation of **806 KAR 17:280 Section 4(1)(f)(2)(ii).**

  Failure to include the right to request a board eligible or certified physician if involving a specialty or subspecialty in the initial adverse benefit determination in 58% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 806 KAR 17:280 Section 4(1)(f)(2)(ii).

- In twenty-nine (29) instances (out of a population of 72), the Company failed to include the right of review of a coverage denial by the Department following completion of the internal appeal process in the initial adverse benefit determination in violation of **806 KAR 17:280 Section 4(f)(2)**.

  Failure to include the right of review of a coverage denial by the Department following completion of the internal appeal process in the initial adverse determination 40% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 806 KAR 17:280 Section 4(f)(2).

- In forty (40) instances (out of a population of 72), the Company failed to include the right to an external review by an independent review entity in the initial adverse benefit determination, in violation of **806 KAR 17:280 Section 4(f)2.**

Failure to include the right to an external review by an independent review entity in the initial adverse benefit determination in 56% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 806 KAR 17:280 Section 4(f)2.

- In nineteen (19) instances (out of a population of 72), the Company failed to provide instructions for initiating an external review in an adverse benefit determination upheld on appeal notification, in violation of **806 KAR 17:290 Section 2(1)(a)(3)(b)**.

Failure to provide instructions for initiating an external review in the* adverse benefit determination upheld on appeal notification *in 26% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 806 KAR 17:290 Section 2(1)(a)(3)(b).

- In nineteen (19) nineteen instances (out of a population of 72), the Company failed to provide in a clear and concise manner how to complete necessary forms, including a medical records release form or written authorization of representation for an external review in an adverse benefit determination upheld on appeal notification, in violation of **806 KAR 17:290 Section 2(a)(3)(b)**.

Failure to provide in a clear and concise manner how to complete necessary forms, including a medical records release form or written authorization of representation for an external review in an adverse benefit determination upheld on appeal notification in 26% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 806 KAR 17:290 Section 2(a)(3)(b).

- In nineteen (19) (out of a population of 72), the Company failed to include the availability of a simultaneous internal-external expedited review in the initial adverse benefit determination, in violation of **45 CFR § 147.136(c)(2)** and the guidance offered in **KDOI Bulletin 2011-08**.

Failure to include the availability of a simultaneous internal-external expedited review in the initial adverse benefit determination in 26% of the sample reviewed, exceeds the 5% error tolerance applied, and is in violation of 45 CFR § 147.136(c)(2) and the guidance offered in KDOI Bulletin 2011-08.

- The Company failed to comply in full or in part with their own utilization review policies and procedures filed with the Department, (MML-028-12, HCS-CL-02-141, Letter Templates, CIT -034-09, HCS-CL-02-143), in violation of **KRS 304.17A-607(1)(l).**

Failure to comply in full or in part with their own utilization review policies and procedures filed with the Department in violation of KRS 304.17A-607(1)(l). This is a systemic error.

- In fourteen (14) instances (out of a population of 72), the Company failed to provide a statement of the specific medical and scientific reasons for denying coverage or a statement to identify the provision of the schedule of benefits or exclusions that demonstrates coverage is not available in an initial adverse benefit determination, pursuant to **KRS 304.17A-617(2)(e)(1)**.

Failure to provide a statement of the specific medical and scientific reasons for denying coverage or a statement to identify the provision of the schedule of benefits or exclusions that demonstrates coverage is not available in an initial adverse benefit determination in 19% of the sample reviewed, exceeds the 5% error tolerance applied, in violation of KRS 304.17A-617(2)(e)(1).

- In fourteen (14) instances (out of a population of 72), the Company improperly denied retrospective emergency services as medical necessity. This represents a denial of coverage, therefore, subject to a review by the Department.

KRS 304.17A-640 states in part:

An emergency condition as one "…that a prudent layperson would reasonably have cause to believe constitutes a condition that in the absence of immediate medical attention would reasonably be expected to result in (a) placing the health of the individual … in serious jeopardy; (b) serious impairment to bodily functions..."

The Department interprets the prudent layperson standard to mean "did the patient act as other similarly situated laypersons would have…" In other words, did the member seek medical treatment in the same manner as other similarly informed persons with the same symptoms?

(Note definition of urgent care in KRS 304.17A-600(17) and preemptions of the ACA include severe pain or if the treating physician with knowledge of the member's condition determines a claim involving urgent care.)

Therefore, Company denial of emergency services based on the prudent person standard, is a violation of **KRS 304.17A-640(1)**.

Company denial of emergency services based on the prudent person standard in 19% of the sample reviewed, exceeds the 5% error tolerance applied, in violation of KRS 304.17A-640(1).

- The Company employs the explanation of benefits (EOB) as an initial adverse benefit determination. The EOB states in part:

  "…We will notify you of our decision in writing within 30 or 60 days of receiving your appeal, depending on the appeal process adopted by your plan. Please consult your Benefit Plan Document…"

  The Benefit Plan document does include the correct timeframe however, the thirty (30) day timeframe is required in the initial adverse benefit determination; the Department does not consider referring to a document as meeting this requirement.

  The Company fails to provide a member the correct timeframe for completion of an initial appeal in an adverse benefit determination when an EOB is utilized, in violation of **KRS 304.17A-617(2)(a).**

Failure to provide a member the correct timeframe for completion of an initial appeal in an adverse benefit determination when an EOB is utilized, is a violation of KRS 304.17A-617(2)(a). This is a systemic error.

- By procedure, the Company fails to provide a final adverse benefit determination to be completed in timeframes set forth in KRS 304.17A-617(2)(a) for all adverse benefit determinations upheld on initial appeal determination. Failure to do so violates **KRS 304.17A-617(2)(a).**

Failure to provide a final adverse benefit determination to be completed in timeframes set forth in KRS 304.17A-617(2)(a) for all adverse benefit determination upheld on initial appeal determination, is in violation of KRS 304.17A-617(2)(a). This is a systemic error.

- The Company employs policies regarding the second level appeal process (MML-022-08 and HCS-CL-01-014) and failed to provide/submit them to the Department pursuant to **KRS 304.17A-607(3).**

Failure to submit a copy of any changes regarding Company utilization review policies and procedures to the Department, is a violation of KRS 304.17A-607(3). This is a systemic error.

- A private review agent is mandated to provide to the Department the names of the entities for which the private review agent is performing utilization review in this state. Notice is required within thirty (30) days of any change.

  During the time period under review (August 1, 2014 through August 1, 2019), the Company failed to submit names of ASO self-funded Non-ERISA entities, in violation of **KRS 304.17A-607(4)**.

  The Company failed to submit names of ASO self-funded Non-ERISA entities to the Department, in violation of KRS 304.17A-607(4). This is a systemic error.

SUMMARY OF FINDINGS

The following is a list of issues the examiner deems material:

UTILIZATION REVIEW

- The Company failed to ensure only a licensed physician made a utilization review decision as not medically necessary or experimental and investigational in the initial adverse benefit determination, in violation of **KRS 304.17A-607(1)(b)(1)** (SEE PAGE 9)

- The Company failed to include the state of licensure, medical licensure number and title of reviewer in the initial adverse benefit determination of a medical determination, in violation of **KRS 304.17A-607(1)(j)(2).** (SEE PAGE 9)

- The Company failed to include a description of alternative benefits in the initial adverse benefit determination, in violation of **KRS 304.17A-607(1)(j)(3)**. (SEE PAGE 10)

- The Company failed to include complete instructions regarding the internal appeal in the initial adverse benefit determination including in the form of an explanation of benefit in accordance with **KRS 304.17A-607(1)(j)4**. (SEE PAGE 10)

- The Company failed to include the state of licensure, medical license number, and title of reviewer in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(2)**. (SEE PAGE 10)

- The Company failed to provide a description of alternative benefits in an adverse benefit determination upheld on appeal, in violation of **KRS 304.17A-617(2)(e)(3)**. (SEE PAGE 10)

- The Company failed to provide instructions for an external review in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(4)**. (SEE PAGE 10)

- The Company failed to provide instructions for filing a request for review with the Department on a coverage denial in an adverse benefit determination upheld on appeal notification, in violation of **KRS 304.17A-617(2)(e)(4)**. (SEE PAGE 11)

- The Company failed to have an adverse benefit determination upheld on appeal notification signed by a Kentucky Medical Director, in violation of **KRS 304.17A-545(1)(d).** (SEE PAGE 11)

- The Company failed to include the right to request a board eligible or certified physician if involving a specialty or subspecialty in the initial adverse benefit determination, in violation of **806 KAR 17:280 Section 4(1)(f)(2)(ii).** (SEE PAGE 11)

- The Company failed to include the right of review of a coverage denial by the Department following completion of the internal appeal process in the initial adverse benefit determination in violation of **806 KAR 17:280 Section 4(f)2.** (SEE PAGE 11)

- The Company failed to include the right to an external review by an independent review entity in the initial adverse benefit determination, in violation of **806 KAR 17:280 Section 4(f)2.** (SEE PAGE 11)

- The Company failed to provide instructions for initiating an external review in an adverse benefit determination upheld on appeal notification, in violation of **806 KAR 17:290 Section 2(1)(a)(3)(b)**. (SEE PAGE 12)

- The Company failed to provide in a clear and concise manner how to complete necessary forms, including a medical records release form or written authorization of representation for an external review in an adverse benefit determination upheld on appeal notification, in violation of **806 KAR 17:290 Section 2(a)(3)(b).** (SEE PAGE 12)

- The Company failed to include the availability of a simultaneous internal-external expedited review in the initial adverse benefit determination, in violation of **45 CFR § 147.136(c)(2) and** the guidance offered in **KDOI Bulletin 2011-08.** (SEE PAGE 12)

- The Company failed to comply in full or in part with their own utilization review policies and procedures filed with the Department, (MML-028-12, HCS-CL-02-141, Letter Templates, CIT -034-09, HCS-CL-02-143), in violation of **KRS 304.17A-607(1)(l).** (SEE PAGE 12)

- The Company failed to provide a statement of the specific medical and scientific reasons for denying coverage or a statement to identify the provision of the schedule of benefits or exclusions that demonstrates coverage is not available in an initial adverse benefit determination, pursuant to **KRS 304.17A-617(2)(e)(1)**. (SEE PAGE 13)

- The Company issued an adverse benefit determination with improper adverse benefit determination rights. Retrospective emergency services represents a denial of coverage, therefore, subject to a review by the Department. Therefore, Company denial of emergency services based on a medical determination versus on the utilization of a prudent person standard, is a violation of **KRS 304.17A-640(1).** (SEE PAGE 13)

- The Company failed to provide a member the correct timeframe for completion of an initial appeal in an adverse benefit determination when an EOB was utilized, in violation of **KRS 304.17A-617(2)(a).** (SEE PAGE 14)

- The Company, while allowing a second level appeal, failed to provide a final adverse benefit determination to be completed in mandated timeframes for adverse benefit

determination upheld on initial appeal determination in violation of **KRS 304.17A-617 (2)(a).** (SEE PAGE 14)

- The Company failed to provide/submit policies regarding the second level appeal process the Department in violation of **KRS 304.17A-607(3).** (SEE PAGE 14)

- The Company failed to submit names of the entities for which the private review agent is performing utilization review in violation of **KRS 304.17A-607(4)**. (SEE PAGE 15)

CORRECTIVE ACTION PLAN (CAP)

The DOI expects the Company to propose a detailed corrective action plan/summary of action taken, addressing material findings contained herein, **within 60 days.**

Additionally, the Company shall:

- Complete the approved corrective action proposed **within 12 months** of the date of the execution of the agreed order by the Kentucky Commissioner of Insurance; and

- Submit to the Department semi-annual reports stating the progress made to implement the CAP requirements. Reporting shall include, but not be limited to, progress, completion and updates of all CAP requirements. The Company shall provide the first semi-annual report **within 180 days** from the execution date of the agreed order by the Kentucky Commissioner of Insurance, with the final report to be submitted **within 365 days** from the same execution date. Should the corrective action be completed within the first 180 days, the second reporting requirement is voided.

PROPOSED CIVIL PENALTY

Pursuant to KRS 304.2-260(3)(a), KRS 304.3-200, and KRS 304.99-020, the Department proposes a civil penalty of **Ten Thousand Dollars ($10,000.00)** as settlement for the violations arising from the Market Conduct Examination of Humana Insurance Company.

SUBMISSION

The examiners would like to express appreciation to the Company for their cooperation extended during this examination.

The Examiner-in-Charge respectfully submits this examination report to the Commissioner, Department of Insurance, Commonwealth of Kentucky, for further action.

Signature on file with original document

Russ Hamblen, PIR, AIC, MCM
Chief Market Conduct Examiner
Examiner-in-Charge

The following analysts also participated in the examination: Kelly Kelly, RN, MCM, Market Conduct Consultant; Patrick Smith, PIR, MCM; and Shasta Pack, PIR, MCM.

AFFIDAVIT

Commonwealth of Kentucky)
) ss
County of Franklin)

I, Russ Hamblen, being of lawful age and being first duly sworn do state, upon oath, that I have been charged with examining Humana Insurance Company. I further state I have prepared the foregoing Report of Examination; I am familiar with the matters set forth therein; and I certify the report is true and complete to the best of my knowledge.

Signature on file with original document

Russ Hamblen, PIR, AIC, MCM
Chief Market Conduct Examiner
Examiner-in-Charge

Subscribed and sworn to before me this 4th day of December, 2020.

Signature on file with original document

Notary Public *Notary ID No.*

My Commission Expires: ***11-25-23***