REPORT ON EXAMINATION

of the

CARITEN INSURANCE COMPANY
CARITEN HEALTH PLANS, Inc.
1420 CENTERPOINT BLVD.
KNOXVILLE, TENNESSEE

as of

DECEMBER 14, 2009

DEPARTMENT OF COMMERCE AND INSURANCE

STATE OF TENNESSE

NASHVILLE, TENNESSE

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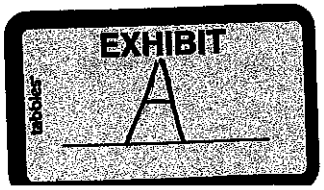
Dept. of Commerce & Insurance
Company Examinations



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Nashville, Tennessee

November 09, 2010

Honorable Leslie A. Newman
Commissioner
State of Tennessee
Department of Commerce and Insurance
Nashville, Tennessee 37243

Honorable Leslie Newman:

Pursuant to your instructions and in accordance with Tennessee insurance laws, regulations, and resolutions adopted by the National Association of Insurance Commissioners ("NAIC"), a market conduct review was made of the condition of affairs of the

CARITEN INSURANCE COMPANY
CARITEN HEALTH PLANS, Inc.
1420 CENTERPOINT BOULEVARD
KNOXVILLE, TENNESSEE

hereinafter and generally referred to as the "Company," and a report thereon is submitted as follows:

INTRODUCTION

This examination was called by the Commissioner of Commerce and Insurance, State of Tennessee ("Commissioner") and commenced on December 14, 2009. The examination was conducted by duly authorized representatives of the Department of Commerce and Insurance, State of Tennessee ("Department").

SCOPE OF THE EXAMINATION

This examination report covers the period from June 30, 2008 to the close of business December 14, 2009, and includes any material transactions and/or events occurring subsequent to the examination date and noted during the course of the examination. This report is a report by exception which means that only those areas found to be a violation of Tennessee statute are included.

The examination of the market conduct condition was conducted in accordance with guidelines and procedures contained in the *NAIC Market Conduct Examiners Handbook* and the Insurance Code of the State of Tennessee. During the course of the examination, procedure reviews accompanied by file reviews were utilized to determine policyholder equity in the following areas as of December 14, 2009:

Pharmacy Recoupments
Pharmacy Access
Pharmacy Benefit Manager Oversight
Pharmacy Benefit Claim Payments

A previous comprehensive market conduct examination was conducted as of June 30, 2008, by authorized representatives of the Department. Information obtained during the prior examination, but not related to the examination contributed to the triggers of the targeted examination.

COMPANY HISTORY

Cariten Insurance Company was incorporated as the National Burial Insurance Company, Memphis, Tennessee, on August 28, 1964, under the laws of the State of Tennessee. On September 12, 1977 the Company was purchased by Southern Affiliates, Inc., Knoxville, Tennessee. Southern Affiliates, Inc., subsequently changed its name to Bankers Affiliated Services, Inc, on October 13, 1977.

The Company has been acquired, sold, and undergone multiple charter changes since opening in 1964. On November 20, 1996 the Company shareholders voted to change the

Company's name to Cariten Insurance Company. The name change amendment was approved by the Commissioner on November 27, 1996. The Company was acquired by Humana on October 31, 2008. The acquisition occurred outside of the examination scope; however, individuals from Humana expanded their roles throughout the examination process.

Cariten Health Plan, Inc., was incorporated on September 13, 1995, as a for profit corporation under the provisions of the Tennessee Corporation Act, with the name "PHP Health Plan Inc." The HMO was certified on December 31, 1995 and commenced business on January 1, 2006. The Company amended the HMO name to "Cariten Health Plan Inc.," and was issued a new certificate of authority on January 7, 1997.

Both Cariten Insurance Company and Cariten Health Plan, Inc., agreed on March 5, 2005, to contract their pharmacy benefits through ProCare, Inc.("ProCare"), a pharmacy benefit manager.

The Cariten Companies were acquired by Humana in October 2008. ProCare remained as the pharmacy benefits manager until November 2009. Pharmacy benefits are currently managed by a subsidiary of Humana.

GENERAL OBSERVATIONS

Pharmacy Benefit Manager Oversight

The contract between the Company and ProCare provided for quarterly meetings between the Company and ProCare. The meetings were to provide direction, a review of ProCare's general performance, training, clinical recommendations, and discuss new drug opportunities. Between the time period of June 30, 2008 and December 14, 2009, only one onsite meeting took place on October 29, 2008. The Company requested reports and made the following statement, "Yes, the reports were received and reviewed by the Chief Medical Officer/designee in lieu of quarterly visits. ProCare always offered and encouraged the quarterly visits but Cariten often could not arrange to meet."

Additionally, and expanded upon with additional details below, the Company failed to enforce compliance with Tenn. Code Ann § 56-7-3105, by allowing the ProCare to recoup claim payments without the process described within Tenn. Code Ann § 56-7-3103, and limiting pharmacy access to members in violation of Tenn. Code Ann § 56-7-2359.

It is noted that the Company did not enforce its contracts as written to ensure proper oversight in the management of operations covering insured plan members.

MARKET CONDUCT ACTIVITIES

Operations and Management:

The Company was asked and did not provide all records requested during the examination.

> **Tenn. Code Ann. § 56-1-411 Extent of Examination**
> Every company, corporation, association, or person being examined, its officers, directors and agents, shall provide to the commissioner, the commissioner's deputy, or the person appointed by the commissioner for the purpose of the examination, convenient and free access at its office to all books, records, securities, documents and any and all papers relating to the property, assets, business and affairs of the company. The officers, directors and agents of the company, corporation, association or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

The Company did not provide a reporting package designed to oversee the operations of ProCare when requested by examiners. In response to a subpoena from the Tennessee Department of Commerce and Insurance (TDCI), ProCare provided documentation related to the reporting package agreed to by both parties. When asked why The Company did not provide the reports when originally requested by examiners, The Company responded, "...reports were directed to certain staff who are no longer with the company, and may or may not be available." Failing to provide and maintain documentation is a violation Tenn. Code Ann. § 56-1-411(b).

It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-411(b) and make available all records upon request. It is also recommended that the Company maintain record retention requirements to ensure information is available to regulators when requested.

> **Tenn. Code Ann. § 56-1-411 Extent of Examination**
> Every company, corporation, association, or person being examined, its officers, directors and agents, shall provide to the commissioner, the commissioner's deputy, or the person appointed by the commissioner for the purpose of the examination, convenient and free access at its office to all books, records, securities, documents and any and all papers relating to the property, assets, business and affairs of the company. The officers, directors and agents of the company, corporation, association or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

During the examination the Company failed to provide details related to meetings detailed in a contract between the Company and ProCare. In response to a subpoena from the TDCI, ProCare provided documentation related to a decision by the Company to forgo onsite quarterly meetings against ProCare's advice and that ProCare's information

indicated that "reports were received and reviewed by the Chief Medical Officer/designee in lieu of quarterly visits." Withholding documentation is a violation Tenn. Code Ann. § 56-1-411(b)(1).

It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-411(b)(1) and facilitate the examination by making all records freely accessible.

Pharmacy Recoupments:

ProCare, the Company's pharmacy benefit manager, is afforded a means to recoup pharmacy benefits which have been overpaid. Prior to any recoupments, ProCare is required to perform an audit according to Tenn. Code Ann. § 56-7-3103.

Tenn. Code Ann. § 56-7-3103 Audit of records of pharmacist or pharmacy
b) Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeal process as set forth in subsection (c).

c) Each pharmacy benefits manager, as defined in § 56-7-3102, conducting an audit shall establish an appeals process under which a pharmacist or pharmacy may appeal an unfavorable preliminary audit report to the pharmacy benefits manager on whose behalf the audit was conducted. The pharmacy benefits manager conducting any audit shall provide to the pharmacist or pharmacy, before or at the time of delivery of the preliminary audit report, a written explanation of the appeals process, including the name, address and telephone number of the person to whom an appeal should be addressed. If, following the appeal, it is determined that an unfavorable audit report or any portion of the audit report is unsubstantiated, the audit report or the portion shall be dismissed without the necessity of further proceedings.

The Company and ProCare, for the period under examination, did not provide evidence of audits of pharmacy records prior to monetary recoupments in compliance with Tennessee statutes. The Company and ProCare did not provide any audit reports for eight pharmacies where recoupments were made. Another nine pharmacies were audited, however, the audits were not finalized prior to recoupment, a violation of Tenn. Code Ann. § 56-7-3103(c). The recoupment violations were noted before Cariten Health and Cariten Insurance stopped using ProCare in November 2009.

It is recommended that the Company contact all pharmacies contracted with their former Pharmacy Benefit Manager, ProCare, and request a listing of all recoupments made without a proper audit being performed to comply with Tenn. Code Ann. § 56-7-3103(b). It is also recommended that the Company return all unaudited recoupments plus interest. Further it is recommended that the Company reports to the Commissioner all recoupment reimbursements on a monthly basis, until all pharmacies are made whole.

Pharmacy Access

Members of any health insurer or managed health insurer have the ability to select any pharmacy according to Tenn. Code Ann. § 56-7-2359.

Tenn. Code Ann. § 56-7-2359 Pharmacy and pharmacy access. - (a) No health insurance issuer and no managed health insurance issuer may:
1) Deny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy, contract or plan; provided, that nothing in this subdivision (a)(1) shall prohibit a managed health insurance issuer or health insurance issuer from establishing rates or fees that may be higher in non-urban areas, or in specific instances where a managed health insurance issuer or health insurance issuer determines it necessary to contract with a particular provider in order to meet network adequacy standards or patient care needs; and

2) Prevent any person who is a party to or beneficiary of any policy, contract or plan from selecting a licensed pharmacy of the person's choice to furnish the pharmaceutical services offered under any contract, policy or plan; provided, that the pharmacy is a participating provider under the same terms and conditions of the contract, policy or plan as those offered any other provider of pharmacy services.

It appears that the Company and ProCare terminated contracts with seven pharmacies after a recoupment dispute lead to litigation and complaint filing with the TDCI. The contract terminations then prevented the pharmacies from receiving reimbursements for services rendered and prevented insureds from utilizing the terminated pharmacies. The actions by the Company and ProCare are in violation Tenn. Code Ann. § 56-7-2359(a)(1) and (2).

It is recommended that the Company notify all insureds that plan participants are allowed to utilize any pharmacy in the State of Tennessee. Further it is recommended that the Company ensures that all pharmacy benefits are paid on the same basis as pharmacies contracted with current and future pharmacy benefit managers.

Pharmacy Benefit Claim Payments

The Company and ProCare are required to promptly and accurately pay claims whether paper or electronic according to Tenn. Code Ann. § 56-7-109.

Tenn. Code Ann. § 56-7-109 Timely reimbursements of health insurance claims
"Pay" means that the health insurance entity shall either send the provider cash or a cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health insurance

entity. Payment shall occur on the date when the cash, cash equivalent or notice of credit is mailed or otherwise sent to the provider.

The Company was presented with bi-monthly remittance requests from ProCare under the scope of the examination. One remittance sought reimbursements for current pharmacy claims and another remittance requested funds for pharmacy claims where insureds were overcharged at the point of sale. ProCare refunded the over payments to the Company's insureds.

Under the scope of the examination, ProCare submitted eleven remittances. ProCare requested $2,213,554 in refund requests under the examination time period and before their contract was terminated. The remaining twenty-five remittances were for refunds totaling $277,965.

The Company contended that they do not maintain detailed records related to the remittance requests. All records related to individual refunds payments, amounts, number of affected insureds, etc., would have to be requested from ProCare. The examination team was unable to obtain the information from ProCare. A subpoena from the TDCI was also unable to produce any additional details related to the refund remittances and the impact on Tennessee consumers.

The Company is noted again for failing to maintain documentation, a violation Tenn. Code Ann. § 56-1-411(b), and not being able to present documentation to determine prompt pay compliance with Tenn. Code Ann. § 56-7-109.

It is recommended that the Company develop a comprehensive plan to properly address pharmacy claims for Tenn. Code Ann. § 56-7-109 compliance.

Tenn. Code Ann. § 56-8-105 Unfair Claims Practices – Any of the following acts by an insurer or person constitutes an unfair claims practice:
(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies

Further consideration is provided that ProCare and the Company under the first eleven rebate remittances failed to adopt and implement reasonable standards for the prompt investigation and settlement of pharmacy claims. By failing to effectively settle pharmacy claims the Company is not in compliance with Tenn. Code Ann. § 56-8-105(3).

It is recommended that the Company develop a means to ensure that pharmacy benefits are investigated and settled timely in compliance with Tenn. Code Ann. § 56-8-105(3).

COMMENTS AND RECOMMENDATIONS

COMMENTS:

- The Company failed to provide proper oversight of its pharmacy benefit manager, ProCare, during the scope of the examination. *The Company should enforce all contractual elements related to pharmacy benefit manager contracts to ensure proper oversight in the managers operations covering insured plan members*

RECOMMENDATIONS:

- *It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-411(b) and make available all records upon request. It is also recommended that the Company maintain record retention requirements to ensure information is available to regulators when requested.*

- *It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-411(b)(1) and facilitate the examination by making all records free and accessible.*

- *It is recommended that the Company contact all pharmacies contracted with their former Pharmacy Benefit Manager, ProCare, and request a listing of all recoupments made without a proper audit being performed to comply with Tenn. Code Ann. § 56-7-3103(b). It is also recommended that the Company return all unaudited recoupments plus interest. Further it is recommended that the Company reports to the Commissioner all recoupment reimbursements on a monthly basis, until all pharmacies are made whole.*

- *It is recommended that the Company notify all insureds that plan participants are allowed to utilize any pharmacy in the State of Tennessee. Further it is recommended that the Company ensures that all pharmacy benefits are paid on the same basis as pharmacies contracted with current and future pharmacy benefit managers.*

- *It is recommended that the Company develop a comprehensive plan to properly address pharmacy claims for Tenn. Code Ann. § 56-7-109 compliance.*

- *It is recommended that the Company develop a means to ensure that pharmacy benefits are investigated and settled timely in compliance with Tenn. Code Ann. § 56-8-105(3).*

CONCLUSION

Insurance examination practices and procedures, as promulgated by the NAIC and the Commissioner have been followed in connection with the verification and valuation of the policyholder equity of Cariten Insurance Company and Cariten Health Plans, Inc., of Knoxville, Tennessee.

In such a manner, it was determined, as of December 14, 2009, the Company has numerous areas where policyholder equity has not been established. Areas of concern range to how the Company interacts with PBMs directly affecting the pharmaceutical needs of insureds and residents in East Tennessee. Another area of concern regarding the facilitation of the examination process and preventing free access to documentation when requested on the Commissioner's behalf.

Respectfully submitted,

Derek R. Stepp, C.I.E, M.C.M
Insurance Examiner
State of Tennessee

AFFIDAVIT

The undersigned deposes and says that he has duly executed the attached examination report of Cariten Insurance Company and Cariten Health Plans, Inc., dates September 27, 2010, and made as of December 14, 2009, on behalf of The Department of Commerce and Insurance, State of Tennessee. Deponent further says he is familiar with such instrument and the contents thereof, and the facts therein set forth are true to the best of his knowledge, information and belief.

Derek R. Stepp, C.I.E, M.C.M
Insurance Examiner
State of Tennessee

Cariten Healthcare
a HUMANA affiliate

Cariten Health Plan • Cariten Insurance Company • Cariten TPA Services
HMO • POS • PPO • EAP • Workers' Compensation

January 20, 2011

Department of Commerce and Insurance
Horace E. Gaddis, Jr., CFE
500 James Robertson Parkway
Nashville, Tennessee

RE: Responses to Market Conduct Examination of
Cariten Insurance Company
Cariten Health Plan, Inc.

Dear Mr. Geddis,

Please find below the responses to the Market Conduct Examination Report received on December 27, 2011 for Cariten Health Plan, Inc. and Cariten Insurance Company.

ProCare Rx terminated its contract with Cariten Health Plan, Inc. and Cariten Insurance Company as of November 4, 2009. As a result, Cariten Health Plan, Inc. and Cariten Insurance Company transitioned all pharmacy services to Argus as of November 4, 2009.

Please contact me with any questions or concerns at office 770-350-2157 or my e-mail at jthorsen@humana.com

Sincerely,
Joan Thorsen/CS

Joan Thorsen
Regulatory Compliance Director

EXHIBIT
B

1420 Centerpoint Boulevard • Knoxville, Tennessee 37932 • tel: 865.470.7470 • 800.793.1495 • www.cariten.com

Pharmacy Benefit Manager Oversight

It is noted that the Company did not enforce its contracts as written to ensure proper oversight in the management of operations covering insured plan members.

Response

To the best of our knowledge and belief, the TN Code contains no requirement that Cariten Health Plan, Inc. or Cariten Insurance Company is required to hold quarterly meetings with ProCare Rx. As part of the oversight with Argus we do hold quarterly meetings.

Humana and Argus operations teams meet multiple times weekly via conference calls and on-line meetings, as well as on-site meetings (face to face) no less than quarterly, alternating between Louisville, KY and Kansas City, MO to ensure compliance with the current contract. Audit, Record Retention and Access will be addressed in responses to recommendations below.

Attached is a copy of the first quarter 2010 agenda which demonstrates Humana representation from Clinical, Operations, Formulary, Networks, Claims Processing, IT, Audit and Compliance. Humana and Argus have multiple other standing meetings including a weekly Round Table and Operations meeting to discuss current issues and hot topics.

Please see Pharmacy Attachment #1

Operations and Management

Recommendation

It is recommended that the Company establish a means to comply with Tenn. Code Ann. 56-1-411(b) and make available all records upon request. It is also recommended that the Company maintain record retention requirements to ensure information is available to regulators when requested.

Response

Please see 3.5 Plan Data on page 8 of the attached document Pharmacy attachment # 2 –"Humana shall provide necessary information to Provider regarding Plan benefits, Member eligibility, Member Copayments (if any), as well as changes and/or updates in Plan benefits that materially affect Copayments and/or Covered Services of Members covered under this Agreement. This information may be provided on paper or electronically by Humana, or its designee."

Please see Pharmacy Attachment #2-Redacted Boiler Plate

Recommendation

It is recommended that the Company establish a means to comply with Tenn. Code Ann. 56-1-411(b)(1) and facilitate the examination by making all records freely accessible.

Response

Humana requires claims processor to retain all records in accordance to all state and Federal laws. In addition to record retention on the claims processor side, Humana maintains an internal Electronic Data Warehouse that stores **all** claims records both current and archived that can be accessed at any time.

Please see Pharmacy Attachment #2-Redacted Boiler Plate

Pharmacy Recoupment's

Recommendation

It is recommended that the Company contact all pharmacies contracted with their former Pharmacy Benefit Manager, ProCare, and request a listing of all recoupment's made without a proper audit being performed to comply with Tenn. code Ann. 56-7-3103(b). It is also recommended that the Company return all unaudited recoupment's plus interest. Further it is recommended that the Company reports to the Commissioner all recoupment reimbursements on a monthly basis, until all pharmacies are made whole.

Response

We agree to the recommendation and will be developing an appropriate implementation plan to accomplish that goal. We agree to provide the Commissioner with monthly reports on the status of the project until completed.

Pharmacy Access

Recommendation

It is recommended that the Company notify all insured's that plan participants are allowed to utilize any pharmacy in the State of Tennessee. Further it is recommended that the Company ensures that all pharmacy benefits are paid on the same basis as pharmacies contracted with current and future pharmacy benefit managers.

Response

Cariten Insurance Company and Cariten Health Plan are complying with access requirements as indicated below which meets the intent of regulation 56-7-2359(a)(1).

Pharmacy reimbursement is proprietary and contractual between trading partners. Not all pharmacies in the State of Tennessee have agreed to Humana's Terms and Conditions and therefore are not participating in our Network and would not besubject to such Terms and Conditions. Members can go to an out of network pharmacy provider to get prescriptions filled, pay 100% cost out of pocket and submit a Direct Member Reimbursement form for payment which is available on our Website, www.Humana.com. These claims are paid according to the member's out of network benefits.

Please see Pharmacy attachment #3-Contracting P&P

Please see Pharmacy attachment #3a-Current Direct Member reimbursement form

Please see Pharmacy attachment #3b-List of pharmacies participating in Humana's pharmacy network in the State of Tennessee. This data was run as of January, 2011.

Pharmacy Benefit Claim Payments

Recommendation

It is recommended that the Company develop a comprehensive plan to properly address pharmacy claims for Tenn. Code Ann. 56-7-109 compliance.

Response

Humana meets or exceeds all Prompt Payment requirements in force today. Please see language currently in place today via Humana Pharmacy Provider Agreements.

> 4.4 Timing of Payment. Effective January 1, 2010 or such later time as required by federal and/or state law or CMS instructions, Humana, or its designee, agrees to pay or deny prescription claims for Covered Services rendered by Provider or its Participating Pharmacies or their respective employed and/or contracted Pharmacists, as applicable, in

accordance with timeliness of claims payment or prompt payment of claims time frames as are required by state or federal law, regulation and CMS instruction, but in no case, more than fourteen (14) calendar days for electronic claim transmission and no more than thirty (30) calendar days for paper claim submission, following receipt by Humana, or its designated Claims Processor/Administrator, of a properly completed claim transmission as defined in Sections 4.1, *Electronic Claim Submission,* and 4.2, *Paper Claim Submissions.* Payments and/or denials of payment for claims for Pharmacy Services rendered to Members will be transmitted to Provider. Accompanying each payment for Covered Services will be an explanation of such payment, including reasons for adjustment, where applicable. Payment detail shall be forwarded to Provider electronically, on tape in NCPDP format or in another format agreed upon by both parties. Provider represents and warrants that all of Provider's Participating Pharmacies and their respective employed and/or contracted Pharmacists shall look solely to Provider for reimbursement of Covered Services rendered to Members under the terms and conditions of this Agreement, and Provider will obtain and maintain written acknowledgment from each Participating Pharmacy, and where applicable each employed and/or contracted Pharmacist, of same.

Please see 4.4 on page 9 of Pharmacy attachment #2-Redacted Boiler Plate

Recommendation

It is recommended that the Company develop a means to ensure that pharmacy benefits are investigated and settled timely in compliance with Tenn. Code Ann. 56-8-105(3).

Response

Humana has well defined Audit and Recoupment policy and procedures in place which is attached for review. All Network Pharmacy Providers are contractually required to submit claims for adjudication via electronic claims submission. This allows all member eligibility, plan benefit and pricing information to be exchanged via real time between pharmacy and Humana's claims processing partner.

Please see Pharmacy attachments #4 Monitoring and Auditing and #4a Claims adjustment P&P.

Current contract language supports electronic claims processing for all Humana claims to allow for real time exchange of current member eligibility and claim information to contracted pharmacy providers.

All claims must be submitted electronically to Humana's designated Claims Processor/Administrator using the latest NCPDP standards. Exceptions will be allowed for Participating Pharmacies serving Members who present a temporary ID. In these cases, a tape or a Universal Claim Form will be accepted by Humana's Claims Processor/Administrator.

Please see 3.5 pg.8 of Pharmacy attachment #2 –Redacted Boiler Plate

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