STATE OF MISSOURI

DEPARTMENT OF COMMERCE & INSURANCE

P.O. Box 690, Jefferson City, Mo. 65102-0690

***In Re*:**	)	
	)	
HUMANA HEALTH PLAN, INC.	)	**Market Conduct Examination No. 373681**
(NAIC # 95885)	)	
	)	

ORDER OF THE DIRECTOR

NOW, on this 19th day of December, 2023, Director, Chlora Lindley-Myers, after consideration and review of the market conduct examination report of Humana Health Plan, Inc. (hereinafter "Humana"), examination report number #373681, prepared and submitted by the Division of Insurance Market Regulation (hereinafter "Division") pursuant to §374.205.3(3)(a)[1], does hereby adopt such report as filed. After consideration and review of the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation"), relating to the market conduct examination #373681, the examination report, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such report are deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4). The Director does hereby issue the following orders:

This order, issued pursuant to §374.205.3(4) and §374.046.15. RSMo, is in the public interest.

IT IS THEREFORE ORDERED that Humana and the Division having agreed to the Stipulation, the Director does hereby approve and agree to the Stipulation.

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[1] All references, unless otherwise noted, are to Revised Statutes of Missouri 2016.

IT IS FURTHER ORDERED that Humana shall not engage in any of the violations of statutes and regulations set forth in the Stipulation, shall implement procedures to place it in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri, and to maintain those corrective actions at all times, and shall fully comply with all terms of the Stipulation.

IT IS FURTHER ORDERED that Humana shall pay, and the Department of Commerce and Insurance, State of Missouri, shall accept, the Voluntary Forfeiture of $6,000.00, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 19th day of December, 2023.

Chlora Lindley-Myers
Director

IN THE DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF MISSOURI

***In Re*:**	)	
	)	
HUMANA HEALTH PLAN, INC.	)	**Market Conduct Examination No. 373681**
(NAIC # 95885)	)	
	)	

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter the "Division"), and Humana Health Plan, Inc. (hereinafter "Humana"), as follows:

WHEREAS, the Division is a unit of the Missouri Department of Commerce and Insurance (hereinafter the "Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State of Missouri;

WHEREAS, Humana has been granted a certificate of authority to transact the business of insurance in the State of Missouri;

WHEREAS, the Division conducted a market conduct examination of Humana, examination no. 373681;

WHEREAS, based on the market conduct examination of Humana, the Division alleges that:

1. Humana did not include eight complaints on its Complaint Register in violation of §375.936 (3),[1] §375.934 (2) and 20 CSR 100-8.040 (3) (D).

2. Humana did not maintain its Complaint Register in a manner that complaint handling could be readily ascertained in violation of §374.205.2 (2) and 20 CSR 100-8.040 (2).

[1] All statutory references, unless otherwise noted, are to the 2016 Revised Statutes of Missouri, as amended.

3. Humana submitted inaccurate grievance counts to the Department in 2018, 2019 and 2020 when it filed its Annual Reporting of Utilization Review Activities in violation of §376.1375 and §374.210.1 (2).

4. Humana's Certificates of Coverage did not contain updated second level grievance procedures that complied with an amended version of §376.1385.2 RSMo 2019.

5. Humana's credentialing procedures did not require a notice of receipt or acknowledgment to providers who submitted credentialing applications in violation of §376.1578.1.

6. Humana did not supply providers with a notice of receipt when providers submitted completed applications for credentialing or with access to a provider web portal for electronically submitted applications in violation of §376.1578.1.

7. Humana failed to make a decision on five completed credentialing applications within 60 days in violation of §376.1578.3.

8. Humana did not provide a complete provider file with all requested documents and correspondence in response to a formal request in violation of §374.205.2 (2) and 20 CSR 100-8.040 (6) (A).

9. Humana did not process four emergency room claims at the correct reimbursement rate in violation of §375.1007 (4) and §375.1005.

WHEREAS, the Division and Humana have agreed to resolve the issues raised in the market conduct investigation as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture (hereinafter "Stipulation") embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent

that no promise, inducement or agreement not herein expressed has been made, and acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** Humana agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those remedial actions at all times. Such remedial actions shall include the following:

1. Humana agrees to maintain complete and accurate complaint registers.

2. Humana agrees to timely submit to the Department complete and accurate Utilization Review Activities Reports.

3. Humana agrees to provide a notice of receipt or acknowledgment upon receiving credentialing applications.

4. Humana agrees to maintain a provider web portal that allows providers to receive notice of the status of an electronically submitted credentialing application.

5. Humana agrees to make a decision on all completed credentialing applications within 60 days of receipt.

6. Humana agrees to review all emergency room claims with a place of service code of "23" submitted between January 1, 2020 and the date of the Order approving this Stipulation to determine if the claims were processed with the correct reimbursement rate. If the correct rate was not utilized, Humana agrees to re-adjudicate the claim and make payment at the correct reimbursement rate. Interest shall be included with the payment at a rate to be determined pursuant to §374.191. All claim payments shall be made to the member unless Humana obtains documentation from the provider either indicating that no payment was received by the provider for the service, or that the provider has issued a refund to the member if payment was received. A letter or EOB will be included with the payment explaining why an additional payment was made

on the claim.

C. **Compliance.** Humana agrees to file documentation pursuant to §374.205 with the Division, in a format acceptable to the Division, within 90 days of the entry of an Order approving this Stipulation, of any remedial action taken to implement compliance with the terms of this Stipulation, including documentation of any re-adjudicated claim payments..

D. **Voluntary Forfeiture.** Humana agrees, voluntarily and knowingly, to surrender and forfeit the sum of $6,000, such sum payable to the Missouri State School Fund, in accordance with §§374.049.11 and 374.280.2.

E. **Non-Admission.** Nothing in this Stipulation shall be construed as an admission by Humana, this Stipulation being part of a compromise settlement to resolve disputed factual and legal allegations arising out of the above referenced market conduct examination.

F. **Waivers.** Humana, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights to procedural requirements, including notice and an opportunity for a hearing, and review or appeal by any trial or appellate court, which may have otherwise applied to the market conduct examination no. 373681.

G. **Amendments.** No amendments to this Stipulation shall be effective unless made in writing and agreed to by authorized representatives of the Division and Humana.

H. **Governing Law.** This Stipulation shall be governed and construed in accordance with the laws of the State of Missouri.

I. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation, on behalf of the Division and Humana, respectively.

J. **Counterparts.** This Stipulation may be executed in multiple counterparts, each of which shall be deemed an original and all of which taken together shall constitute a single

document. Execution by facsimile or by electronically transmitted signature shall be fully and legally effective and binding.

K. **Effect of Stipulation.** This Stipulation shall not become effective until entry of an Order by the Director of the Department (hereinafter "Director") approving this Stipulation.

L. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: December 8, 2023

Teresa Kroll
Chief Market Conduct Examiner
Division of Insurance Market Regulation

DATED: 2023-11-21

Aaron Fruit
Digitally signed by Aaron Fruit
Date: 2023.11.21 16:17:59 -05'00'

Aaron Fruit
Associate Director, Regulatory Compliance
Humana Health Plan, Inc.

MARKET CONDUCT EXAMINATION REPORT
Health Business of

Humana Health Plan, Inc.
NAIC # 95885

MISSOURI SBS EXAMINATION # 373681

NAIC MATS #MO-HICKSS1-151

May 22, 2023

Home Office
500 West Main Street
Louisville, KY 40202

STATE OF MISSOURI
DEPARTMENT OF COMMERCE & INSURANCE

JEFFERSON CITY, MISSOURI

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May 22, 2023

Honorable Chlora Lindley-Myers, Director
Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101

Director Lindley-Myers:

In accordance with your market conduct examination warrant, a targeted market conduct examination has been conducted of the specified lines of business and business practices of

Humana Health Plan, Inc. (NAIC #95885)

hereinafter referred to as "Humana" or "Company." This examination was conducted as a desk examination at the offices of the Missouri Department of Commerce and Insurance (DCI).

FOREWORD

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DCI.

During this examination, the examiners cited errors considered potential violations made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- "Company" refers to the Humana Health Plan, Inc.
- "CSR" refers to the Missouri Code of State Regulation
- "DCI" refers to the Missouri Department of Commerce and Insurance
- "Director" refers to the Director of the Missouri Department of Commerce and Insurance
- "NAIC" refers to the National Association of Insurance Commissioners
- "Health care provider" or "Provider" refers to a health care professional who is a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law
- "RSMo" refers to the 2016 version of the Revised Statutes of Missouri, unless otherwise specified in the report.

SCOPE OF EXAMINATION

The DCI has authority to conduct this examination pursuant to, but not limited to, §§354.465.1, 374.110, 374.190, 374.205, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DCI regulations. The primary period covered by this review is January 1, 2018 through December 31, 2020, unless otherwise noted. Errors found outside of this time period may also be included in the report.

The examination was a targeted examination involving the following lines of business and business functions: Health Insurance - Complaint Handling, Claims, Grievance Procedures, Provider Credentialing and Utilization Review.

The examination was conducted in accordance with the standards in the NAIC's *2020 Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *2020 Market Regulation Handbook* when conducting reviews that are subject to a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices it is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, the examiners only reviewed a sample of the Company's practices, procedures, products and files. Therefore, some noncompliant practices, procedures, products and files may not have been found. As such, this report may not fully reflect all of the practices and procedures of the Company.

COMPANY PROFILE

Humana Health Plan, Inc. is licensed by the DCI under Chapter 354, RSMo, to write Health Maintenance Organization (HMO) business as set forth in its Certificate of Authority. The Company was incorporated as a for-profit corporation under the laws of the state of Kentucky on August 23, 1982, and it was first licensed to operate as a HMO in Missouri on March 30, 1987. A wholly owned subsidiary of Humana Inc., the Company is the surviving corporation of mergers with three affiliated HMOs – Humana Health Plan of Missouri, Inc. (1987), Humana Health Plan of Kansas, Inc. (1988) and Humana Kansas City, Inc. (2001). During the time period of the examination, the Company's service area encompassed the Missouri counties of Bates, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Henry, Jackson, Johnson, Lafayette, Platte, and Ray.

EXECUTIVE SUMMARY

The DCI conducted a targeted market conduct examination of Humana Health Plan, Inc. The examiners found the following areas of concern:

COMPLAINT HANDLING

- In eight instances, the Company did not record the complaints in its complaint register. The Company failed to maintain a complete and up to date complaint log. Reference: §375.936(3) RSMo.

- The Company did not maintain its complaint register in a manner in which the company could provide the complaint register to the DCI so that complaint handling practices could be readily ascertained. Reference: §374.205.2(2), RSMo.

GRIEVANCE PROCEDURES

- The Company submitted inaccurate grievance counts in its 2018, 2019 and 2020 Annual Reporting Utilization Activities. Reference: §376.1375 RSMo.
- The Company Certificates of Coverage do not contain updated second level grievance procedures. Reference: §376.1385.2 RSMo.

PROVIDER CREDENTIALING

- The Company's procedures do not require notice of receipt be sent to Providers after receiving their credentialing applications for all 20 files. Reference: §376.1578.1 RSMo.
- The Company failed to supply Providers with a notice of receipt when the Providers submitted completed credentialing applications for all 20 supplied files. Reference: §376.1578.1 RSMo.
- The Company failed to make a decision on five completed credentialing applications within sixty days. Reference: §376.1578.3 RSMo.
- The Company failed to provide a complete provider file. Reference: §374.205.2(2) RSMo and 20 CSR 100-8.040(6)(A).

CLAIMS

- The Company failed to provide an equitable settlement for four Emergency Room claims by paying claims at lower reimbursement rate than was due. Reference: §375.1007(4) RSMo.

EXAMINATION FINDINGS

I. COMPLAINT HANDLING

The complaint handling portion of the examination provides a review of the Company's complaint handling practices. The examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 20 - Complaint Handling Standard 1: All complaints are recorded in the required format on the regulated entity's complaint register.

To test for this standard, the examiners requested and reviewed a copy of the Company's complaint register, complaints the DCI received, and noted any complaints received through the review of files to assess whether the Company included all complaints on the complaint register.

Finding 1: The Company failed to include eight complaints on the complaint register.

Reference: §375.936(3), RSMo, and 20 CSR 100-8.040(3)(D)

Finding 2: The Company did not maintain its complaint register in a manner in which it could be provided to the DCI so that complaint handling could be readily ascertained. Three requests for a complete complaint log had to be submitted during the examination.

Reference: §374.205.2(2) RSMo, and 20 CSR 100-8.040(2)

B. NAIC Market Regulation Handbook Chapter 20 - Complaint Handling Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

To test for this standard, the examiners requested and reviewed a copy of the Company's complaint handling procedure manual.

The examiners found no errors in this review.

C. NAIC Market Regulation Handbook Chapter 20 - Complaint Handling Standard 3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

To test for this standard, the examiners reviewed a census of nine complaint files, provided by the Company, to determine if the regulated entity responses fully address the issues raised.

The examiners found no errors in this review.

D. NAIC Market Regulation Handbook Chapter 20 - Complaint Handling Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

To test for this standard, the examiners reviewed a census of nine complaint files to assess whether the company responded to complaints in a timely manner.

The examiners found no errors in this review.

II. GRIEVANCE PROCEDURES

The grievance procedures portion of the examination is designed to evaluate how well the Company handles grievances. The Missouri definition of a "grievance" is set forth in §376.1350(17), RSMo.

A. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 1: The health carrier treats as a grievance any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services,

including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier.

To test for this standard, the examiners reviewed the nine complaint files requested in Complaint Handling Standard 3, above, to assess whether the Company is correctly identifying and treating grievances as complaints which meet the definition in §376.1350(17), RSMo.

The examiners found no errors in this review.

B. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 2: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners requested the Company provide its grievance log in conjunction with the complaint log requested in Complaint Handling Standard 1 above. Since the Company maintains a consolidated log (i.e., all complaints, including complaints that constitute grievances, are maintained in the same log), the examiners reviewed the complaint log to assess whether it meets the standards in §§376.1375, 376.1378, 354.445, RSMo and 20 CSR 400-7.110.

Finding 1: The Company submitted inaccurate grievance counts to the DCI in 2018, 2019, and 2020 in conjunction with its submission of its Annual Reporting of Utilization Review Activities.

Reference: §§376.1375 and 374.210.1(2) RSMo

C. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 3: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

To test for this standard, the examiners requested and reviewed the Company's procedures specific to grievances in conjunction with the request for complaint handling procedures in Complaint Handling Standard 2 above. In addition, the examiners verified whether the Company filed its grievance procedures with the DCI and that the Company informs enrollees of those procedures. The examiners also reviewed the member Certificate of Coverage documents to determine if the provisions communicate clear procedures on how to file a grievance.

Finding 1: The Company Certificates of Coverage, CHMO-2004-C MO do not contain updated second level grievance procedures.

Reference: §376.1385.2 RSMo. 2019

D. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 4: The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners reviewed the nine complaint files requested in Complaint Handling Standard 3 above to assess whether the Company correctly processed grievances pursuant to §376.1382, RSMo.

The examiners found no errors in this review.

III. PROVIDER CREDENTIALING

The provider credentialing portion of the examination is designed to ensure that companies offering managed care plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

A. NAIC Market Regulation Handbook Chapter 24 - Provider Credentialing Standard 1: The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations.

The examiners requested and reviewed the Company's credentialing policies and procedures applicable during the scope of the exam to ensure that the policies and procedures were consistent with Missouri law.

Finding 1: The Company's credentialing procedures do not require notice of receipt of the providers' credentialing application be sent to the practitioners within two working days.

Reference: §376.1578.1 RSMo

B. NAIC Market Regulation Handbook Chapter 24 - Provider Credentialing Standard 2: The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

To test this standard, the examiners requested and reviewed the credentialing data provided by the Company. Examiners selected a sample of 20 provider credentialing files to evaluate compliance with the requirements of §376.1578 RSMo. Examiners reviewed 20 provider credentialing files. In conducting this review, the examiners were mindful that §376.1578 was amended effective August 28, 2020. The examiners found the following errors in this review.

Field Size	3,103
Sample Size	20
Type of Sample	Random
Number of Errors	20

Finding 1: The Company failed to provide all 20 Providers with a notice of receipt when the Providers submitted complete applications.

Reference: §376.1578.1 RSMo

Finding 2: The Company failed to make a decision for five of the 20 sampled completed credentialing application within sixty days.

Reference: §§376.1578.3 RSMo and 376.1578.1 RSMo 2020

Finding 3: The Company failed to provide a complete provider credentialing file upon request. The file was missing requested documentation which was available to the Company.

Reference: §374.205.2(2) RSMo, and 20 CSR 100-8.040(6)(A)

IV. CLAIMS

The claims portion of the examination provides a review of the Company's compliance with Missouri statutes and regulations regarding claims handling practices such as the timeliness of handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 1: The initial contact by the regulated entity with the claimant is within the required time frame.

From the data supplied by the Company, a random sample of 83 claim files were reviewed for compliance with the acknowledgement time standards in 20 CSR 100-1.030. The examiners also requested and reviewed claim manuals. The results of this review are summarized below.

Field Size	653
Sample Size	83
Type of Sample	Random
Number of Errors	0
Error Ratio	0.00%

No errors were found in this review.

B. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 2: Timely investigations are conducted.

The same random sample of 83 claims noted above in Claims Standard 1 were reviewed for compliance with the claim investigation standards in 20 CSR 100-1.050(1)(C) and (4). Claim manuals were also evaluated for timeliness standards.

No errors were found in this review.

C. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 3: Claims are resolved in a timely manner.

The same random sample of 83 claims noted above in Claims Standard 1 were reviewed for compliance with the claim determination standards in 20 CSR 100-1.050(1)(A). Claim manuals were also evaluated for timeliness standards.

No errors were found in this review.

D. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 4: The regulated entity responds to claims correspondence in a timely manner.

The same random sample of 83 claims noted above in Claims Standard 1 were reviewed for compliance with the claim determination standards in 20 CSR 100-1.030(2). Claim manuals were also reviewed for timeliness standards.

No errors were found in this review.

E. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 6: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

From the data supplied by the Company, a census of 30 Emergency Room (ER) claim files were reviewed for compliance with the claim determination standards in 20 CSR 100-8.040(3). Claim manuals were also reviewed for claim determination processes. The results of this review are summarized below.

Field Size	30
Sample Size	30
Type of Sample	Census
Number of Errors	4
Error Ratio	13.33%

Finding 1: The Company failed to provide an equitable settlement for four claims. The Company timely allowed the claims but failed to process claims at the correct reimbursement rate resulting in the underpayment of the claims.

Reference: §375.1007(4) RSMo

V. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri statutes and regulations require companies to respond to criticisms and formal requests within ten (10) calendar days. In the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the subsequent timeframe. If the response was not received within the allotted time, the response was not considered timely.

A. Criticism Time Study

Number of Calendar Days to Respond	Number of Criticisms	Percentage of Total
0 to 10 days	8	72.7%
Over 10 days with extension	3	27.2%
Over 10 days without extension or after extension due date	0	0%
Totals	11	100%

No errors were found in this review.

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	13	81.25%
Over 10 days with extension	3	18.75%
Over 10 days without extension or after extension due date	0	0%
Totals	16	100%

No errors were found in this review.

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Humana Health Plan, Examination Number 373681, MATS #MO-HICKSS1-151. This examination was conducted by Examiner-In-Charge John Korte, CIE; Aubrey Snyder, CIE; and Kembra Springs. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 22, 2023. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

December 8, 2023
Date

Teresa Kroll
Chief Examiner, Market Conduct