Market Conduct Report

Cigna Health and Life Insurance Company
Cigna HealthCare of CT, Inc.
Connecticut General Life Insurance Company

July 2, 2018

Connecticut Insurance Department

TABLE OF CONTENTS

I. INTRODUCTION

Cigna Health and Life Insurance Company, Cigna HealthCare of CT, Inc. and Connecticut General Life Insurance Company (hereinafter collectively referred to as the "Companies") have their home offices in Bloomfield, Connecticut. By authority granted under §38a-15 of the Connecticut General Statutes, this examination was conducted by Market Conduct examiners of the State of Connecticut Insurance Department at the Companies' offices in Bloomfield, Connecticut.

II. SCOPE OF EXAMINATION

From May 1, 2017 through January 30, 2018, the Market Conduct Division of the Connecticut Insurance Department examined the market conduct practices of Cigna Health and Life Insurance Company, Cigna HealthCare of CT, Inc. and Connecticut General Life Insurance Company, using a sample period of January 1, 2014 through December 31, 2016. The examination was limited to Connecticut business.

The purpose of the examination was to evaluate the Companies' market conduct practices and treatment of policyholders in the State of Connecticut. The examination focused on the solicitation of new business, marketing and sales, agent licensing and appointment, underwriting and rating, policyholder service, complaint handling, network adequacy, provider credentialing, claim processing and company operations.

The Market Conduct examination was conducted pursuant to Connecticut Insurance Department policies and procedures, and the standards proposed in the NAIC Market Regulation Handbook.

III. COMPANY PROFILE

The Companies are wholly owned subsidiaries of Cigna Corporation (Cigna) (the ultimate Parent Company.) Connecticut General Life Insurance Company is domiciled in the State of Connecticut and commenced business on June 22, 1865 under the General Assembly of the State of Connecticut. Cigna Health and Life Insurance Company is domiciled in the State of Connecticut and originally commenced business on May 2, 1963 as Orange State Life Insurance Company. Cigna HealthCare of CT is licensed in Connecticut as a health care center and commenced business on January 27, 1986.

Direct premiums written as of December 31, 2016 were as follows:

Cigna Health and Life Insurance Company

	Connecticut	Total (All States)
Accident & Health	376,699,801	11,852,320,185

Cigna HealthCare of CT, Inc.

	Connecticut	Total (All States)
Accident & Health	9,759,374	9,759,374

Connecticut General Life Insurance Company

	Connecticut	Total (All States)
Life	14,882,481	259,189,749
Accident & Health	526,296	139,918,700

IV. MARKET CONDUCT REPORTS

The examiners reviewed copies of all market conduct examination reports that had been issued to the Companies by other state insurance departments during the examination period. The reports were reviewed to ensure that corrective actions were taken regarding all recommendations made by the respective Insurance Departments.

V. AGENCY ORGANIZATION

The Companies market new business through the offices of independent agents as well as direct sales staff.

The Companies maintain ongoing training programs for their agents. The Companies supply new agents with a product portfolio, which provides detailed descriptions of products and coverages. Changes in coverage are mandated by statute or the Companies' policies and are communicated through written notices as they occur. In addition, the Companies host periodic training seminars for agents.

VI. RECORDS SELECTED FOR REVIEW

The Companies supplied a listing of all individual and group health new business produced, terminations, declinations, complaints/appeals, and claims denied during the period under review. The examiners selected a random sample of files

using a sampling methodology described in the NAIC Market Regulation Handbook. A sample of five hundred ninety (590) new business contracts, terminations and declinations and eight hundred nineteen (819) claims were selected for review.

The new health business files were reviewed to evaluate the solicitation and sales practices of producers and agents. In general, applications were examined for completeness, appropriate signatures and dates of application. The application process was reviewed to assure that medical underwriting was applied equitably and to verify that adverse selection had not occurred.

In addition, the producer licensing history and the application date for each policy in the samples were noted in order to identify any individuals or organizations that were not licensed or appointed at the time of sale. The licensing and appointment review is described in more detail in Section VII. Producer Licensing and Appointment.

VII. PRODUCER LICENSING AND APPOINTMENT

The lists of the new business written during the sample period, identifying the producer for each policy, were compared to the Department's licensing records to determine whether each producer was licensed in the State of Connecticut and whether each agent was appointed by the Companies.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Companies' records of licensed and appointed producers agree with Insurance Department's records.

Standard 2: Producers are properly licensed and appointed in the jurisdiction where the application was taken.

The following information was noted in conjunction with the review of these standards:

- The Companies maintain an automated producer database that interfaces with new group health business processing, policy maintenance and producer compensation.

- The Companies perform due diligence procedures on individuals prior to contracting with them.

- The Companies' appointment procedures are designed to comply with the Department's requirements, which mandate that an agent must be appointed within 15 days from the date that the Company receives the application.

Findings:

Comparisons were made between the Companies' records of licensed and appointed producers and the Insurance Department's records. A review of the Companies' records revealed twenty-nine (29) individuals acting as agents who were not appointed by the Companies within the timeframe required by statute.

Standard 3: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

The Companies have procedures to provide notification of termination to the Department.

Findings:

The examiners reviewed the Companies' termination lists and verified that no producers were terminated for cause during the examination period.

Standard 4: The Companies' policies of producer appointments and terminations do not result in unfair discrimination against policyholders.

Findings:

The examiners noted no evidence of unfair discrimination against policyholders as a result of producer appointments and terminations.

Standard 5: Records of terminated producers adequately document reasons for terminations.

The examiners reviewed the Companies' terminated producer files to ensure that records are documented sufficiently.

Findings:

The examiners verified the listing of terminated agents and reviewed the reasons for termination for each agent. Based on the examiners' review, in one instance,

the Companies failed to notify the Department of an agent's termination for cause as required.

In Summary:

It is recommended that each Company review its appointment system to ensure that no new health business is accepted from, nor commissions paid to, individuals acting as agents of the Company when they are not appointed as required by statute. In addition, it is recommended that the Companies review their policies and procedures to insure that all terminations for cause are properly reported to the Department.

VIII. UNDERWRITING AND RATING

The new group health business underwriting files were reviewed to determine the use and accuracy of rating methodology, accuracy of issuance, consistent (non-discriminatory) practices and use of proper forms. The Companies' policies, forms and rates were reviewed for proper filing with the Insurance Department and compliance with applicable statutes and regulations.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The rates charged for the policy coverages are in accordance with filed rates, if applicable, or the Companies' rating plans.

The following information was noted in conjunction with the review of this standard:

- Rates are systematically computed based on applicant information and rating classification assigned.
- The Companies have written underwriting policies and procedures.
- The Companies provided copies of Department approved rates for the new group health business submissions reviewed during the examination period.

Findings:

The examiners reviewed four (4) small group rating files and no exceptions were noted.

Standard 2: The Companies do not permit illegal rebating, commission cutting or inducements.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures to pay producers' commissions in accordance with Companies' approved written contracts.

Findings:

The examiners reviewed the Companies' policies and procedures and verified that controls are in place to monitor and prevent illegal rebating, commission cutting and inducements.

Standard 3: All forms, including contracts, riders, endorsement forms and certificates, are filed with the Insurance Department, if applicable.

The following information was noted in conjunction with the review of this standard:

- The Companies have compliance policies and procedures in place to review and track all forms, rates, contract riders and endorsements.

- The Companies have a process to log and document Department approved forms, rates, contract riders, endorsements and content of summary of benefits and coverage (SBC) in accordance with Connecticut requirements.

Findings:

The examiners reviewed the Companies' policy forms through a review of the new group health business files and no exceptions were noted.

Standard 4: The Companies' underwriting practices are not to be unfairly discriminatory. The Companies adhere to applicable statutes, rules and regulations and Companies' guidelines in selection of risks.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies and procedures prohibit unfair discrimination.

- Written underwriting guidelines are designed to reasonably assure consistency in rating of policies.

- The Companies have policies and procedures in place for the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials, dependent coverage for individuals to age 26, lifetime/annual limits on the dollar amounts of essential health benefits and PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.

- The Companies have established policies and procedures to ensure compliance with restrictions on establishing lifetime/annual limits on the dollar amounts of essential health benefits for any individual.

- The Companies have established policies and procedures regarding compliance with PPACA-related restrictions on the assessment of cost-sharing upon insured's for preventative items and services.

Findings:

The Companies' underwriting practices do not appear discriminatory.

Standard 5: File documentation adequately supports decisions made.

Findings:

See Section VIII. Underwriting and Rating, Additional Concerns.

Standard 6: Policies and endorsements are issued or renewed accurately, timely and completely.

The examiners reviewed the sample new group health business and renewal files to ensure that the Companies' underwriting policies and procedures were consistently applied for each sample file reviewed.

Findings:

The Companies' practices for the issuance of policies and endorsements appear to be accurate and timely for the sample files reviewed.

Standard 7: Applications rejected and not issued are not found to be discriminatory.

The Companies' underwriting policies and procedures prohibit unfair discrimination.

Findings:

The examiners selected one hundred eighty (180) rejected applications for review. The examiners reviewed the sample files selected and no exceptions were noted.

Standard 8: Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

The Companies have procedures in place for the issuance of cancellation and renewal notices.

Findings:

The examiners selected one hundred eighty (180) cancellation files for review. The examiners reviewed the sample files selected and no exceptions were noted.

Standard 9: Pertinent information on applications that form a part of the policies is complete and accurate.

Findings:

The examiners reviewed the Companies' sample new health business files, and no exceptions were noted.

Standard 10: Companies comply with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

The examiners reviewed the Companies' procedures for providing information pertaining to continuation of benefits, for processing applications and for notification to policyholders of the beginning and termination of benefit periods and premium notices.

Findings:

The examiners reviewed the Companies' underwriting procedures and sample new business files and no exceptions were noted.

Standard 11: The Companies comply with the provisions of HIPAA regarding limits on the use of pre-existing exclusions.

The Examiners reviewed the Companies' policies and procedures for provisions related to applicants/proposed insured under the age of 19 to verify that coverage is not denied based on a pre-existing condition.

Findings:

The Companies' pre-existing conditions appear to be in accordance with the requirements of HIPAA and Connecticut statutes and regulations.

Standard 12: The Companies issue coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of 1 to 50.

The Examiners reviewed the Companies' policies and procedures regarding guaranteed availability and renewability of individual and small group health insurance coverage in accordance with statutes and regulations.

Findings:

The Companies' small group business appears to comply with Connecticut requirements.

Standard 13: The Companies refer eligible individuals entitled to portability under the provisions to HRA.

Findings:

The examiners verified that the Companies have procedures in place for individuals eligible for HRA. No exceptions were found for the small group new health business sample files reviewed.

Additional Concerns:

The examiners noted, through a review of the Cigna Health and Life Insurance Company termination files, where the Company was unable to provide three (3) group termination files for regulatory review. In addition, the Company was unable to provide twenty-two (22) individual termination files for regulatory review. The Department is concerned that the Companies could not provide documentation for regulatory review.

In Summary:

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

IX. POLICYHOLDER SERVICE

New business, underwriting files and policy transactions were reviewed for accuracy and timeliness of handling.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Premium notices and billing notices are sent out with an adequate amount of advance notice.

The following information was noted in conjunction with the review of this standard:

- Verification that billing notices are generated automatically based on contract renewal dates and payment cycles.
- If premiums are not received, as required, an overdue premium notice is mailed, noting that non-payment will cause the policy to lapse.

Findings:

The examiners reviewed the Companies' policies and procedures and no identifiable occurrences were noted.

Standard 2: Policy issuance and insured requested cancellations are timely.

The following information was noted in conjunction with the review of this standard:

- When the policyholder requests cancellation, the cancellation is processed and any premium due is provided to the policyholder.
- The Companies provide written notice to the policyholders when a policy cancels.

Findings:

The examiners verified that the Companies have procedures in place to process policyholder requested cancellations and Company cancellations, and such transactions appear to be processed timely in compliance with statutory requirements.

Standard 3: All communication directed to the Companies is answered in a timely and responsive manner by the appropriate department.

The following information was noted in conjunction with the review of this standard:

- The Companies have a customer call center to respond to policyholder and member concerns.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Standard 4: Reinstatement is applied consistently and in accordance with policy provisions.

The Companies have standardized reinstatement guidelines in place to ensure that requests are reviewed and either approved or denied by underwriting.

Findings:

The examiners reviewed the Companies' policies and procedures and sample underwriting files. No identifiable occurrences were noted.

Standard 5: Policy transactions are processed accurately and completely.

The Companies have policies and procedures in place for processing policyholder transactions including conversions, plan changes and enrollment updates.

Findings:

The examiners reviewed the Companies' transaction procedures through a sampling of new business files. No identifiable occurrences were noted.

Standard 6: Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

The Companies have policies and procedures in place for tracking and issuing evidence of creditable coverage.

Findings:

The examiners reviewed the Companies' policies and procedures and no identifiable occurrences were noted.

X. MARKETING AND SALES

The Companies provided samples of all marketing and sales materials used in Connecticut during the period under examination. The marketing and sales materials were analyzed to identify any pieces that had a tendency to mislead or misrepresent any aspect of the Companies' products or benefits to policyholders. In addition, the marketing and sales materials were reviewed to verify compliance with statutes and regulations related to the disclosure of certain information regarding the Companies' identity, financial standing and organization.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the advertising and sales material process.
- All advertising and sales materials are reviewed in a consistent format through an online submission and tracking process.
- All advertising and producer generated material is subject to compliance review.
- Prior to final approval, all advertising and sales materials are reviewed to ensure that any necessary changes identified during the initial review were made.

- Approved submissions are endorsed for use for a specific period, which is incorporated into the approval number on the piece.

Findings:

The companies appear in compliance.

Standard 2: The Companies' internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Companies have developed training programs for their producers.

Findings:

The examiners reviewed the Companies' training programs and established policies and procedures. The Companies' internal producer training materials appear to be adequate and in compliance.

Standard 3: The Companies' communications to producers are in compliance with applicable statutes, rules and regulations.

The Companies maintain an extensive on-going training program. Written policies and procedures govern that all communications are reviewed and approved by the Companies' compliance units.

Findings:

The examiners verified that the Companies have communication procedures in place for all producers.

Standard 4: Outline of coverage is in compliance with applicable statutes, rules and regulations.

Findings:

The examiners reviewed the Companies' outlines of coverage and no exceptions were noted.

XI. COMPLAINTS

The examiners reviewed forty-nine (49) sample Department complaint files and two hundred two (202) sample Non-Department Complaints, Grievances and Appeal files during the examination period. Included in our review were

grievances and appeals involving mental health and substance abuse disorders. See concerns identified through a review of complaints and appeals in Section XII. Claims.

Department Complaint Handling

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All complaints or grievances are recorded in the required format on the Companies' complaint registers.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the complaint handling process.
- All complaints are recorded in a consistent format in the complaint log.
- An automated tracking database is used to record and maintain complaint information.

Findings:

- The examiners verified the Companies' complaint logs for the examination period. No exceptions were noted.

Standard 2: The Companies have adequate complaint handling procedures in place and communicate such procedures to policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' Plan Descriptions have been reviewed and approved by the Department's Life and Health Division.
- The complaint handling procedures are included in the Plan Descriptions.

Findings:

The examiners verified that the Companies' Plan Descriptions include all complaint handling procedures as required by statute.

Standard 3: The Companies should take adequate steps to finalize and dispose of Department complaints in accordance with applicable statutes, rules and regulations and contract language.

Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

Non-Department Complaints (Grievance/Appeal/Concerns)

The Companies have established the following complaint and appeal policies that are available to members and providers as outlined in the Plan Descriptions:

A. Inquiry/Complaint

A member or provider may contact the Companies' member relations to question problems or concerns.

B. Grievance

A complainant, who has not been satisfied at the inquiry/complaint level, may request a review of the previous decision. A complainant has one hundred eighty (180) days. Notification of the decision must occur within thirty (30) days of receipt of the grievance by the Companies.

C. Appeal

A complainant has sixty (60) days from receipt of notification of the Grievance decision to appeal. The member will be notified of the Committee's decision within three (3) business days.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 4: The time frame within which the Companies respond to complaints, grievances and appeals is in accordance with applicable statutes, rules and regulations.

Findings:

The examiners verified that the Companies responded to complaints, grievances and appeals in a timely manner.

Standard 5: The health carriers document complaints, grievances and appeals and establish and maintain grievance/appeal procedures in compliance with statutes, rules and regulations.

Findings:

The examiners verified that the Companies' complaint, appeal and grievance logs for the examination period were complete and found no identifiable occurrences.

Standard 6: The health carriers file, with the Commissioner, a copy of their complaints, grievances and appeals, including all forms.

Findings:

The examiners verified that the plan descriptions filed with the Department appear to be in compliance.

Additional Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

XII. CLAIMS

The Companies provided a listing of all claims submitted during the period under examination. The review consisted of a sampling of eight hundred twenty-nine (829) denied claims. The files were reviewed to determine the accuracy and timeliness of claim and interest payments.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The initial contact by the Companies with the claimant is within the required time frame and claims are settled in a timely manner.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the claim handling process.
- All claim notifications are logged into the claim system.
- Claim management monitors claim accuracy and timeliness.

Findings:

Pursuant to §38a-816(15) of the Connecticut General Statutes, the Companies are required to pay clean claims within twenty (20) days for claims filed electronically and sixty (60) days for claims filed in paper format. The Department requested that the Companies provide a listing of all clean claims paid in excess of twenty (20) and sixty (60) days for the examination period. The examiners found twenty thousand eight hundred ninety (20,890) claims that were not paid within twenty (20) and sixty (60) days for which interest was paid and one thousand four hundred two (1,402) claims that were not paid within twenty (20) and sixty (60) days where interest was owed.

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated and resolved pursuant to required claim settlement practices.

Standard 2: Claim files are adequately documented.

The following information was noted in conjunction with the review of this standard:

- copy of the HCFA form or electronic proof of loss
- applicable clinical/other investigative correspondence
- written communication, telephone or other communication
- proof of payment

Findings:

The Examiners reviewed the sample files and no exceptions were noted.

Standard 3: The Companies have appropriate policies in place for the archival and disposal of claim forms.

Findings:

The examiners reviewed the policies and procedures and no identifiable occurrences were found.

Standard 4: The Companies' claim forms are appropriate for the type of product.

Findings:

The examiners noted that the claim forms were appropriate and in accordance with the Companies' policies and procedures.

Standard 5: Canceled benefit checks and drafts reflect appropriate claim handling practices.

The following information was noted in conjunction with the review of this standard:

- Claim procedures were verified to ensure that the check/draft claim process was handled accurately and was appropriate.

Findings:

The examiners verified that processes were in place and no exceptions were noted.

Standard 6: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

The following information was noted in conjunction with the review of this standard:

- All litigated claims were reviewed for the examination period.

Findings:

The examiners reviewed the policies and procedures and no identifiable occurrences were found. Specific claim errors are identified below.

Standard 7: The group health plan complies with the requirements of Federal and State law for Mental Health Parity, (including PPACA and HIPAA.)

The following information was noted in conjunction with the review of this standard:

- A review of the Companies' responses to the Mental Health Parity Annual Compliance Survey for the period under review.

- A review of the Companies' responses to Consumer Report Cards on Health Insurance Carriers in Connecticut for the period under review.

Findings:

The examiners reviewed the Companies' Mental Health Parity Annual Compliance Survey, which included the Companies' responses to the analysis and testing for any cost share features, penalties and benefit limitations and classifications (inpatient in and out-of-network, outpatient in and out-of-network, emergency and prescription drugs) that apply to mental health and substance abuse disorders vs. medical/surgical conditions. In addition, the examiners reviewed the Companies' responses in the Survey regarding non-quantitative treatment limitations (medical management, prior authorization and step therapy). Finally, the examiners also reviewed the Companies' response to the Consumer Report Card on Health Insurance Carriers in Connecticut, for the period under review.

During the course of the on-site examination, the Department, as part of our review, had some concerns with some of the claim expenses and denial statistics as noted in the 2016 Consumer Report Card. The Companies indicated that there was a technical error regarding the total PMPM claim expense calculation. The Company indicated they revised the calculations and send in the revisions to the life and health division in July 2017.

Additional Concerns:

In addition to the standards reviewed in this section, the examiners have the following concerns:

- The examiners noted, through a review of Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company complaints and denied claims, several instances where the Companies were incorrectly denied claims rather than forward to the delegated vendors. It is noted that the Department, in prior examination reports, had concerns over the number of claims being denied by the Companies rather than forwarded to the delegated vendor. The Companies assured the Department that all vendor claims were being forwarded to vendors and all future vendor claims were being forwarded by established claim protocols. It is noted by the Department that the process was corrected by June 2016. The Department is concerned that it took the Companies two years from the prior examination to complete corrective actions measures.

- The examiners noted, through a review of Connecticut General Life Insurance individual denied claims, one (1) instance where the Company incorrectly denied an ambulance claim. The Company reprocessed the claim in the amount of $510, including interest and the Department language. In addition,

the policy is a Nationwide Conversion Trust Hospital and Surgical (Basic Indemnity) Plan and has not been refiled or updated with the Department since July 1985.

- The Department is concerned that the Company is using policy forms not in compliance with Connecticut requirements.

- The examiners noted, through a review of Connecticut General Life Insurance denied mental health claims, two (2) instances where the Company correctly denied claims, but used the incorrect remark code, therefore the denial language on the explanation of benefits was not correct.

In addition, the examiners have identified the following concerns through a review of the complaints and appeals:

- The examiners noted, through a review Connecticut General Life Insurance Company appeals, where a member went to an in-network provider who utilized an out-of-network lab without notifying the member, and the company processed at the claim at the out-of-network benefit level. The Department maintains the position that if a member selects an in-network provider, then it is reasonable for the member to expect that all related and allied healthcare is in-network. At the Department's request, the Companies undertook corrective action measurers which included appeal process change and policy update, provider education/enforcement of contracts and a claim report analysis for additional provider follow-up. All fifty-five (55) appeals were overturned and paid at the in-network benefit level, including late pay interest. The examiners are concerned that the company failed to adopt reasonable standards for the prompt investigation of claims.

- The examiners noted, through a review of the Cigna HealthCare of CT, Inc. dental appeals, that there were several instances in the EOB's/EOP's, that incorrectly noted the availability of external appeal through the Department. Standalone dental HMO plans are not eligible for the State of Connecticut external review program. The Company notes that it is currently in the process of updating all dental HMO and PPO EOB's to remove reference to the external review process specific to Connecticut members. The Department is concerned that the Company provided notification which tended to be misleading and insufficient for covered members.

- The examiners noted, through a review of Connecticut General Life Insurance Company appeals, one (1) instance where an appeal determination was not sent within timeframes according to Connecticut requirements. The Department recommends that the Company review its policies and procedures regarding timely notification requirements.

- The examiners noted, through a review of Connecticut General Life Insurance Company appeals, one (1) instance where an appeal determination did not address the members request for a network adequacy exception. The Department recommend s that the Company review its policies and procedures regarding sufficient information being contained in the appeals correspondence.

- The examiners noted, through a review of Connecticut General Life Insurance Company's appeals, one (1) instance where the Company did not follow their internal guidelines on timeliness for acknowledgement of administrative appeals, in addition, the company failed to disclose rights to contact the Connecticut Insurance Department, or the Office of HealthCare Access. The Department is concerned that the Company failed to provide proper notification according to Connecticut requirements.

- The examiners noted, through a review of the Connecticut General Life Insurance Company appeals, one (1) instance where the appeal was eventually overturned and after review the examiners found that in each case no new information was provided to justify the decision.

- The examiners noted, through a review of the Cigna Health and Life Insurance Company Department complaints, one (1) instance where a claim was denied in error and interest was not paid. The Company issued a check for $24, and included the Department language. The Department's concern is the Company did not properly investigate the claim at the time it was originally received.

- The examiners noted, through a review of The Cigna Health and Life Insurance Company Department complaints, one (1) instance where the company was denying claims for Medicare COB Coverage, when the member was not eligible for Medicare. The Department had the Company go back and reprocess the claims. The Company processed 1,123 claims with a total claim payment of $283,489 and total interest payments of $1,638. The Department's concern is the Company did not properly investigate the claim at the time it was originally received.

- The examiners noted three (3) instances, through a review of the sample grievances and appeals, that contained insufficient and incomplete documentation for regulatory review.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements. In addition, Docket Numbers 13-145 and 13-146, executed on December 20, 2013, Cigna HealthCare of CT and Connecticut General Life Insurance Company were cited for failure to establish proper policies and procedures to ensure that all claims were investigated properly and paid in a timely manner.

XIII. NETWORK ADEQUACY

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carriers file a quality assurance plan with the Commissioner for each managed care plan that the carrier offers in the state and files updates whenever it makes a material change to an existing managed care plan. The carriers make the quality assurance plans available to regulators.

The following information was noted in conjunction with the review of this standard:

- the Companies' procedures for making referrals within and outside their networks
- the Companies' methods for assessing the health care needs of covered persons and their satisfaction with services
- the Companies' systems for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning

Findings:

The examiners noted that guidelines in place appear to be appropriate.

Standard 2: The carrier has provided documentation to the Commissioner that they are currently NCQA and URAC accredited.

The following information was noted in conjunction with the review of this standard:

- The Companies provided copies of accreditation status and proof of accreditation.

- The Companies provided copies of corrective actions to address deficiencies in NCQA standards, if applicable.

Findings:

The Companies are currently NCQA accredited and no exceptions were noted.

Standard 3: The health carriers file with the Commissioner all required contract forms and any material changes to a contract proposed for use with their participating providers and intermediaries.

Findings:

The examiners noted that guidelines in place appear to be appropriate.

Standard 4: The health carriers execute written agreements with each participating provider that are in compliance with statutes, rules and regulations.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 5: The health carriers' contracts with intermediaries are in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies' statutory responsibilities to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

- The Companies shall have the right to approve or disapprove participation status of a subcontracted provider in their own or a contracted network for the purpose of delivering covered benefits to the carriers' covered persons.

- The Companies shall maintain copies of all intermediary health care subcontracts at their principal place of business in the state, or ensure that they have access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 6: The health carriers provide notice to members advising them of Primary Care Physicians who have terminated with the plan as required by Connecticut Statute.

The following information was noted in conjunction with the review of this standard:

- The Companies have developed selection standards for primary care professionals and each health care professional specialty.

- The standards are used in determining the selection of health care professionals by the health carriers, their intermediaries and any provider networks with which they contract.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 7: The health carriers provide, at enrollment, a Provider Directory listing all providers participating in their network. They also make available, on a timely and reasonable basis, updates to their directory.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XIV. PROVIDER CREDENTIALING

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carriers establish and maintain programs for credentialing and re-credentialing in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies have established written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carriers contract and shall apply those standards consistently.
- The Companies have assured that the carriers' medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.
- The Companies have established a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documentation.

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 2: The health carriers verify the credentials of a health care professional before entering into a contract with that health care professional.

The following information was noted to ensure providers are properly credentialed prior to appearing in the provider directory:

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 3: The health carriers require all participating providers to notify the health carriers' designated individual of changes in the status of any information that is required to be verified by the health carriers.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carriers provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XV. COMPANY OPERATIONS

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies have up-to-date, valid internal or external audit programs.

The following information was noted in conjunction with the review of this standard:

- The Companies have an internal audit department that has performed reviews of a variety of operational functions.
- Audit reports are distributed to all relevant operational and management personnel.
- External audits are performed on a regular basis.

Findings:

The Companies have performed a number of audits during the examination period. The examiners reviewed the audit reports provided and found no exceptions during the examination period.

Standard 2: The Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures in place for all operational functions.
- System tests are performed on a regular basis.

Findings:

The examiners reviewed and verified that the Companies have programs in place to protect the integrity of computer information and appear to be in compliance.

Standard 3: The companies have anti-fraud plans in place.

The following information was noted in conjunction with the review of this standard:

- The Companies have written anti-fraud plans.
- The Companies have a Special Investigative Unit (SIU) dedicated to the prevention and handling of fraud.
- Potential fraud activity is tracked by the SIU and investigated. Activity is reported to the regulator, as necessary.

Findings:

The examiners reviewed the written anti-fraud plans and investigative policies and procedures. For the examination period, the Companies had no reportable incidents.

Standard 4: The Companies have valid disaster recovery plans.

Findings:

The examiners reviewed and verified that the Companies have valid disaster recovery programs in place and no incidences were reported during the examination period.

Standard 5: Records are adequate, accessible, consistent and orderly and comply with record retention requirements.

Findings:

The Companies appear in compliance.

Standard 6: The Companies are licensed for the lines of business that are being written.

The examiners reviewed the Certificates of Authority for the Companies and compared them to the lines of business that the Companies write in the State of Connecticut.

Findings:

The examiners verified that the Companies are duly authorized for the lines of business being written.

Standard 7: The Companies have procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies allow for sharing customer and personal information with affiliates, but do not share such information with non-affiliates.
- The Companies' policies require a consumer privacy notice to be provided to policyholders on an annual basis.
- The Companies have developed and implemented information technology security practices to safeguard the customer's personal and health information.
- The Companies' internal audit function conducts reviews of privacy policies and procedures.

Findings:

The examiners reviewed and verified that the Companies have valid programs in place. No incidences were reported during the examination period.

Standard 8: The Companies have a comprehensive written information security program for the protection of non-public customer information.

The examiners reviewed and verified that the Companies have a written security program in place for the protection of non-public customer information. In addition, the examiners verified that the Companies have proper cyber security policies and procedures in the areas of breach notification, administrative, physical and technical safeguards to protect consumer information and security incident response procedures.

Standard 9: The Companies cooperate on a timely basis with examiners performing the examinations.

Findings:

The Department received cooperation during the examination process.

XVI. SUMMARY OF RECOMMENDATIONS

Report
Section

VII. Producer Licensing and Appointment:

It is recommended that the Companies review their appointment systems to ensure compliance with current appointment requirements.

VIII. Underwriting and Rating

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

XII. Claims:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements.

XVII. ACKNOWLEDGMENT

The courtesy and cooperation of Cigna Health and Life Insurance Company, Cigna HealthCare of CT, Inc. and Connecticut General Life Insurance Company during the course of the examination are acknowledged.

Stephen DeAngelis, Meg Salamone, Karen Mayer, Bob Chester and Shannon Parise participated in the preparation of this report.

Tammy Cook, MLAS, CTT+
Manager
Market Conduct
Regulatory Affairs

Legal & Public Affairs

Sent via electronic mail

June 12, 2018

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Steve DeAngelis
Principal Examiner
State of Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford, CT 06103

Re: Market Conduct Examination of Cigna Health and Life Insurance Company ("CHLIC" or "Company"), Connecticut General Life Insurance Company ("CGLIC" or "Company"), and Cigna HealthCare of Connecticut, Inc. ("CHC-CT")
Draft Report – Response Addendum Out-of-Network Laboratories

Dear Mr. DeAngelis:

Thank you for speaking with me on June 5, 2018 regarding the Companies' response to the proposed Draft Report and Consent Orders. Per your request, I've attached the out-of-network laboratory write up recommended to be included in the CID's Final Report. The Department's request is repeated below with the Companies response comments appearing in bold font.

> In addition, the examiners have identified the following concerns through a review of the complaints and appeals:
>
> The examiners noted, through a review Connecticut General Life Insurance Company appeals, where a member went to an in-network provider who utilized an out-of-network lab without notifying the member, and the company processed at the claim at the out-of-network benefit level. The Department maintains the position that if a member selects an in-network provider, then it is reasonable for the member to expect that all related and allied healthcare is in-network. Members should not be balanced billed and should only be subject to in-network cost shares unless the member was informed about in-network alternatives in sufficient time to make a meaningful choice. The Company overturned the members appeal in question, and reprocessed the claim with interest. At the Department's request, the Companies undertook corrective action measurers which included appeal process change and policy update, provider education/enforcement of contracts and a claim report analysis. All fifty-five (55) appeals were overturned and paid at the in-network benefit level, including late pay interest. The examiners are concerned that the company failed to adopt reasonable standards for the prompt investigation of claims.

Company Response:
In addition, the examiners have identified the following concerns through a review of the complaints and appeals:

The examiners noted, through a review of Connecticut General Life Insurance Company appeals, where a member went to an in-network provider who utilized an out-of-network lab and the company processed the claim at the out-of-network benefit level. The Department maintains the position that if a member selects an in-network provider, then it is reasonable for the member to expect that all related and allied healthcare be considered in-network. In situations where members were advised by participating providers to utilize out-of-network laboratories, members should not be balanced billed for the services. As a result of the Department's review, the Company overturned the member appeals in question and reprocessed the claims with applicable interest. At the Department's request, the Companies undertook corrective action measures which included appeal process changes and policy updates, provider education/enforcement of contracts and a claim report analysis. All fifty-five (55) appeals were overturned and reimbursed at the in-network benefit level, including late pay interest, and subsequently the CT policies for out-of-network member appeals were updated. The Company wished to note that there are many circumstances beyond the carrier's control and where the carrier cannot reasonably investigate provider-to-patient referral or communication information, during the timely adjudication of a claim. Further, there are situations where a member selects an in-network provider, but makes a conscious decision to go to a non-participating laboratory not listed in the Company's network provider directory; also beyond the carrier's control and without the carrier having a reasonable mechanism to investigate information about provider-to-patient interactions. The Company believed that the actions undertaken as described above constitute reasonable carrier claim investigation standards, within the provisions of the statute. The examiners are concerned that the company failed to adopt reasonable standards for the prompt investigation of claims relating to member appeals, where members were being balanced billed by out-of-network laboratories when referred by participating providers.

The Company wishes to thank the Department for discussing the out-of-network laboratory concerns highlighted in its May 17, 2018 response letter and being amendable to update the Department's comments within the Final Report.

Please contact me if the Department has further questions or concerns at 860.907.5696 or email me at Tammy.Cook@Cigna.com.

Respectfully,

Tammy Cook

Tammy Cook

C: Deb Hutton, State Government Affairs Director, Cigna
Gail Bogossian, Senior Counsel, Cigna
Joseph Pandolfo, State Compliance Manager, Cigna

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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IN THE MATTER OF: DOCKET MC 18-23
CIGNA HEALTHCARE OF CT, INC.:

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STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Cigna HealthCare of CT Inc. and the State of Connecticut Insurance Department by and through Timothy Curry, Deputy Insurance Commissioner, to wit:

I

WHEREAS, pursuant to a Market Conduct examination, the Commissioner alleges the following with respect to Cigna HealthCare of CT, Inc.:

1. Cigna HealthCare of CT, Inc., hereinafter referred to as Respondent, is domiciled in the State of Connecticut and is licensed to transact the business of a health care center in the State of Connecticut under license number 95660.

2. From May 1, 2017 through January 30, 2018, the Department conducted an examination of Respondent's market conduct practices in the State of Connecticut covering the period from January 1, 2014 through December 31, 2016.

3. During the period under examination, Respondent failed to follow established practices and procedures to ensure compliance with statutory requirements, resulting in instances of:

   a. fifteen (15) producers acting as agents of Respondent without required appointment

   b. failure to pay claims in a timely manner

   c. failure to provide proper information on certain EOB's

4. The conduct as described above violates §§38a-702m and 38a-816 of the Connecticut General Statutes, and §38a-819-54 of the Regulations of Connecticut State Agencies, and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2, 38a-41 and 38a-817 of the Connecticut General Statutes.

II

1. WHEREAS, Respondent admits to the allegations contained in paragraphs three and four of Article I of this Stipulation; and

2. WHEREAS, Respondent agrees to undertake a complete review of its practices and procedures to enhance compliance with Connecticut statutes in the areas of concern, as described in the Market Conduct Report and this Stipulation; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a summary of actions taken to comply with the recommendations in the Market Conduct Report within ninety (90) days of the date of this document; and

4. WHEREAS, Respondent agrees to pay a fine in the amount of $28,500 for the violations described herein; and

5. WHEREAS, Respondent, being desirous of terminating this proceeding without the necessity of a formal proceeding or further litigation, does consent to the making of this Consent Order and voluntarily waives:

   a. any right to a hearing; and

   b. any requirement that the Insurance Commissioner's decision contain a statement of findings of fact and conclusions of law; and

   c. any and all rights to object to or challenge before the Insurance Commissioner or in any judicial proceeding any aspect, provision or requirement of this Stipulation.

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. That the Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. That Respondent is fined the sum of Twenty-Eight Thousand Five Hundred Dollars ($28,500) for the violations herein above described.

EDWARD P. POTANKA

By: _____

(Representative of Insurance Company)

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 26th day of July 2018 for and on behalf of Cigna HealthCare of CT, Inc., that he/she is the Assistant Secretary of such company, and he/she has authority to execute and file such instrument.

By: Edward P. Potenka

State of Connecticut
County of Hartford

Personally appeared on this 26 day of July 2018 Edward P. Potenka signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

Donna Gaudet
Notary Public/Commissioner of the Superior Court

Donna Gaudet
NOTARY PUBLIC
State of Connecticut
My Commission Expires 7/31/2022

My Commission Expires 7/31/2022
State of Connecticut
NOTARY PUBLIC
Donna Gaudet

Section Below To Be Completed by State of Connecticut Insurance Department

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Dated at Hartford, Connecticut this 13th day of August 2018.

Timothy Curry
Deputy Insurance Commissioner