STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Market Conduct Report

of

CIGNA Health Management, Inc.

September 30, 2019

From June 17, 2019 through September 17, 2019, the Market Conduct Division of the Connecticut Insurance Department examined the utilization review practices of CIGNA Health Management, Inc. (the Company), using a sample period of January 1, 2017 through December 31, 2017. The examination was limited to Connecticut enrollees.

CIGNA Health Management, Inc. has its home office in the State of Pennsylvania and is licensed as a utilization review entity in the State of Connecticut under license number 200000530. By authority granted under §38a-591 of the Connecticut General Statutes, this examination was conducted by Market Conduct examiners of the State of Connecticut Insurance Department (the Department) at the Department's offices in Hartford, Connecticut.

The purpose of the examination was to evaluate the Company's utilization review practices in the State of Connecticut. From a listing of utilization reviews performed by the Company, the examiners reviewed one hundred seventy-six (176) sample files, which included complaints and approved, denied and appeal certifications during the examination period.

The Department's findings are as follows:

- The examiners verified that eight (8) determinations not to certify care were not made within the required 15 days of the receipt of the request for review, upon the receipt of all information reasonably required to make denial determinations.

- The examiners verified that five (5) appeal determinations were not made within the required 30 days of the receipt of the request for review, upon the receipt of all information reasonably required to make appeal determinations.

- The examiners verified that one (1) appeal determination was not reviewed by an appropriate clinical peer for the service requested.

- The examiners verified that one (1) appeal determination failed to provide proper Connecticut external appeal language.

- The examiners verified that four (4) determinations not to certify care failed to provide access to the MCG criteria of such health carrier's Internet web site in order to access the clinical criteria online.

- The examiners verified that one (1) appeal determination failed to provide access to the MCG criteria of such health carrier's Internet web site in order to access the clinical criteria online.

- The examiners verified that one (1) sample file concerning a determination not to certify care did not provide the requisite forty-five (45) calendar days after the date of receipt of the notice to provide the specified information.

- The examiners verified that the Company did not have sufficient documentation for regulatory review.

- Failure to take corrective action to provide proper timely notifications of appeal determinations and determinations not to certify care as stipulated in Docket MC 16-37 and as indicated by the Respondent in the corrective action plan provided on September 2, 2016.

It is recommended that the Company review its policies and procedures to ensure that determinations not to certify care are made within the 15 day requirement, appeal determinations are made within the 30 day requirement, appeal determinations are reviewed by an appropriate clinical peer, and proper Connecticut external appeal language is provided for appeal determinations, a link to such rule, guideline, protocol or other similar criterion of such health carrier's Internet web site is included in determinations not to certify care and appeal determinations, to afford the forty-five calendar days as noted in the notification letter to provide the specified information, and to adhere to prior corrective action reports, as required by statute.

In addition, it is recommended that the Company review its policies and procedures to ensure that the Company's Explanation of Benefits contain the proper Connecticut external appeal language and that it provides a working link to the applicable MCG clinical criteria for inpatient initial denial and final determinations noted in an adverse determination letter. The Company is to work with the Department's Life & Health division to ensure that the concerns contained in this paragraph meet Connecticut requirements.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

IN THE MATTER OF CIGNA Health Management, Inc.	: :	DOCKET MC 19-95

STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between CIGNA Health Management, Inc. and the State of Connecticut Insurance Department by and through Andrew N. Mais, Insurance Commissioner ("Insurance Commissioner") to wit:

I

WHEREAS, pursuant to a market conduct examination, the Insurance Commissioner alleges the following with respect to CIGNA Health Management, Inc.:

1. CIGNA Health Management, Inc., hereinafter referred to as Respondent, is domiciled in the State of Pennsylvania and is licensed to transact the business of a utilization review entity in the State of Connecticut under license number 200000530.

2. From June 17, 2019 through September 17, 2019, the Department conducted an examination of Respondent's utilization review practices in the State of Connecticut covering the period from January 1, 2017 through December 31, 2017.

3. During the period under examination, Respondent failed to establish practices and procedures to ensure compliance in all instances with statutory requirements for:

   a. notification of a determination to certify care, admission or procedure within 15 days of the receipt of the request for review, upon the receipt of all information reasonably required to make denial determinations.

   b. notification of a determination to certify care, admission or procedure within 30 days of the receipt of the request for review, upon the receipt of all information reasonably required to make appeal determinations.

   c. providing an appropriate clinical peer to review an appeal request.

   d. providing proper Connecticut external appeal language.

   e. providing a reference to a web link to access the clinical criteria online.

   f. providing forty-five days after the date of receipt of the notice to provide the specified information.

   g. providing sufficient documentation for regulatory review.

   h. failure to take corrective action to provide proper Connecticut external appeal language in appeal determinations as stipulated in Docket MC 16-37 and as indicated by the Respondent in the corrective action plan provided on September 2, 2016.

4. The conduct as described above violates §38a-591b and §38a-591d of the Connecticut General Statutes, and §38a-591-8 of the Regulations of Connecticut State Agencies, and constitutes cause for the imposition of a fine or other administrative penalty under §38a-591k 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 review its utilization review practices and procedures identified as concerns during the market conduct examination, as described in the Examination of Utilization Review Practices Report and this Stipulation, and bring them into immediate compliance with Connecticut Statutes; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a full report of finding and a summary of actions taken to comply with the requirements of paragraph two of this section within ninety (90) days of the date of this document; and

4. 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 Final 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 conclusion 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

5. WHEREAS, Respondent agrees to pay a fine in the amount of $25,000.00 for the violations described herein.

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-Five Thousand Dollars ($25,000.00) for the violations herein above described.

CIGNA HEALTH MANAGEMENT, INC.

BY: _____

Scott Josephs, M.D.
Chief Medical Director
(Representative of Utilization Review Entity)

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 11 day of November, 2019 for and on behalf of CIGNA Health Management, Inc. that he/she is the Chief Medical Director of such company, and he/she has authority to execute and file such instrument.

Cigna Health Management, Inc.

BY: _____
Scott Josephs, Chief Medical Director

State of North Carolina

County of Wake

Personally appeared on this 11th day of November 2019, Scott Josephs, M.D. signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____
Notary Public/~~Commissioner of the Superior Court~~

J GREGORY WATKINS
NOTARY PUBLIC
WAKE COUNTY, N.C.
My Commission Expires 2-25-2022

Section Below To Be Completed by State of Connecticut Insurance Department

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Dated at Hartford, Connecticut this 25th day of November 2019.

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Andrew N. Mais
Insurance Commissioner