STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

Connecticut General Life Insurance Company

900 Cottage Grove Road
Hartford, CT 06152-0001

NAIC Number: 62308

October 20, 2011

EXAMINATION REPORT PREPARED BY INDEPENDENT CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE

Pursuant to Title 24-A M.R.S.A. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of Connecticut General Life Insurance Company. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

Honorable Eric A. Cioppa
Superintendent
Maine Bureau of Insurance

10/28/11
Date

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McGladrey

RSM McGladrey, Inc.
3 Farm Glen Blvd.
Farmington, CT 06032
O 908.303.9394 F 410.308.5551
www.mcgladrey.com

October, 24 2011

Mr. Eric A. Cioppa,
Superintendent of Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

Pursuant to Title 24-A MRSA§ 221(5), a targeted Market Conduct examination (the Examination) of selected focus areas including complaint handling, appeals, policyholder services, provider relations, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

Connecticut General Life Insurance Company

Connecticut General Life Insurance Company's (CGLIC or the Company) records were examined at the Company's offices located in Eden Prairie, Minnesota.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of Examination of Connecticut General Life Insurance Company is, herewith, respectfully submitted.

RSM McGladrey, Inc.
Independent Market Conduct Examiner

SECTION I – EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) is conducting a targeted market conduct Examination of CGLIC to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those received by a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination includes but is not limited to the following:

1. Test the Company's processes to ensure that the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the insurer's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process, and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with the Company's representatives were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review (UR) and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, work plan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the Agreement to Purchase Services (the Agreement). Rider A also establishes the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used statistically valid random samples where appropriate for the areas tested. Also, where applicable and consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted findings regarding the Company's claims, pre-authorizations, utilization review and appeals handling practices. The issues identified during the Examination are noted below in order of priority:

Finding #1

The Examiners identified twelve (12) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A. § 2843 of the Maine Insurance Code. Specifically, the claims were denied for exceeding the maximum number of yearly visits for a Biologically Based Mental Illness, which is in violation of Maine's Mental Health Parity Laws.

Finding # 2

The Examiners identified eighteen (18) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A. § 2436-1A concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine statute stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. Six (6) of the 18 claims noted above were not processed within the 30 day timeframe, in part as a result of the Company's internal workflow, wherein claims are not timely or effectively transferred between Cigna Health Care (CHC) and Cigna Behavioral Health (CBH).

Finding # 3

The Examiners identified nine (9) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A. § 2436-3 concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine statute stipulates that if an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date.

The Company's failure to adjudicate four (4) of the identified claims within the 30 day timeframe is the result of the Company's internal workflow, wherein claims are not effectively transferred between CHC and CBH.

Finding # 4

The Examiners identified two (2) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A.§ 2164-D concerning Unfair Claim Practices, wherein the Company improperly denied the claims on the basis that they were filed in an untimely manner in excess of one (1) year.

Finding # 5

The Examiners identified one (1) of three (3) pre-authorization denials as a possible violation of Maine Insurance Rule 850, § 8 (E) (2), wherein the Company failed to notify the member or provider of the determination within two (2) working days of obtaining all necessary information.

Finding # 6

The Examiners identified one (1) of two (2) Second Level appeals as a possible violation of Maine Insurance Rule 850, § 9 D (3) (f), wherein the Company's adverse decision letter does not contain the names, titles and qualifying credentials of the person or persons participating in the Second Level grievance review process.

SECTION II – SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of Maine law, including 24-A M.R.S.A §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act and Bureau of Insurance Rule Chapters 191 and 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

RSM McGladrey, Inc. personnel participated in this Examination in their capacity as market conduct examiners. RSM McGladrey, Inc. provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III – COMPANY PROFILE

CGLIC is domiciled in Connecticut as a wholly owned subsidiary of CIGNA Corporation. During the period of the Examination, CIGNA HealthCare offered PPO products for large group markets through CGLIC.

CGLIC uses CBH for behavioral care management. CBH is a wholly-owned subsidiary of Connecticut General Corporation (CGC) and CGC is a wholly-owned subsidiary of CIGNA Corp. CBH was founded in 1974 and is based in Eden Prairie, Minnesota.

CBH arranges for the provision of behavioral health care services to individuals through its network of participating behavioral health care providers, offers behavioral health care management services, employee assistance programs and work/life programs to employer sponsored benefit plans. CBH contracts with mental health and substance abuse facilities and licensed, independent providers to complete its network. Providers include psychiatrists; psychologists; master's level social workers; marriage, family, and child counselors; and substance abuse specialists.

SECTION IV – EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed statistically valid samples, where applicable, to review and test specific attributes associated with policies that were marketed and sold to state of Maine residents. These populations included large group policies, small group policies with more than 20 covered employees, and State of Maine employee plan and city and local governmental plans. Also, where applicable, the samples included individual policies and groups with 20 or fewer employees for which the policyholders had elected mental health parity. Administrative services business, with the exception of the State of Maine employee plan, was excluded from the sample testing. The Examiners' sampling methodology was reviewed and approved by the Bureau.

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.
- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, pre-authorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- The population of denied and zero-paid claims which had a primary, secondary or tertiary behavioral health diagnosis.
- Claim related policies and procedures.

Additionally, the Examiners received training related to the Company's claim handling and processing systems.

In response to the Examiners' requests, the Company provided a population of 2,156 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a random sample of 130 denied and zero-paid claims using a 95% confidence level.

The Examiners also conducted interviews with Company representatives and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of utilization reviews (UR) and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed, as well as the disposition of the claim as a result of the UR.
- A listing of all UR requests that were denied during the Period.
- A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

The Company provided the requested documentation in response to the Examiners' request including three (3) URs performed during the Period. All three URs were for behavioral health services that had a partial or full denial of coverage. The Examiners tested each of the three (3) URs.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.
- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider network specialists in the Company and their authorization levels for approving behavioral health-related services.

The Examiners identified three (3) denied pre-authorization requests through a review of data provided by the Company. The Company provided the requested documentation for the denied pre-authorization requests, which the Examiners tested.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The Examiners also requested the related policies and procedures the Company had in place for the Period. Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the State of Maine.
- A listing of training to educate the specialists on the Company's policies and procedures.
- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.
- The Company's definition of a complaint as applied to complaints relating to residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiners' data request, the Company provided the requested documentation and a listing of two (2) complaints received during the Period. Both complaints were related to behavioral health issues. The Examiners tested both complaints.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Examiners confirmed that the Company maintained a complaint log for the Period and identified 466 pharmacy-related complaints. Of the 466 pharmacy-related complaints, the Examiners tested 43 pharmacy complaints for compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

Appeals and Grievances

- Written policy and procedures for processing First and Second Level appeals and grievances for residents of the state of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.
- The Company's definition of appeals and grievances as applied to those received in connection with residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

The Examiners identified three (3) appeals (including administrative and clinical levels I and II). The Company provided the requested documentation for the appeals, which the Examiners tested. The Examiners tested all appeals in the population.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, complaints and appeals relating to claims or requests for authorization for services denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and state of Maine).
- Written policies and procedures provided to and used by the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges ("the Charges").
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.

- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the state of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.
- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners reviewed a random sample of 43 claims from the 130 denied and zero-paid claim sample and compared the network status on the date of service to the Company listing of providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain CGLIC functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V – RESULTS OF THE EXAMINATION

The Examination identified forty-three (43) potential individual violations of Maine insurance laws. In addition, other findings were noted regarding inconsistencies with the Company's policies and procedures or represent the Examiners' observations for possible improvements in the Company's practices. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The testing of a sample of 130 denied and zero-paid claims included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing. The Examiners determined that during the Period, the Company did not impose any more restrictive filing requirements on providers who filed behavioral health related claims when compared to medical claim submissions.

Testing identified potential violations regarding three (3) Maine statutes. The Maine statutes and the exceptions noted are as follows:

1. 24-A M.R.S.A. § 2843 (5-C) (4) reads:

   (4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

The Company denied twelve (12) of the 130 denied and zero-paid claims, or 9.2%, for exceeding the number of yearly visits for a specific condition. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2843	The Company denied claims based on the number of visits the member plans allowed. The claims were related to Attention Deficit Disorder, which is a Biologically Based Mental Illness. The member's plan benefits do not limit the number of visits per calendar year. These errors are in violation of Maine Mental Health Parity Laws.	12	9.2%
TOTAL		**12**	**9.2%**

2. 24-A M.R.S.A. § 2436 reads in part:

1-A. Claimant, including a health care provider, may submit simultaneously a claim for payment with all carriers potentially liable for payment of the claim whether primary or secondary. Payment or denial of a claim by each carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim whether or not another carrier with which it is attempting to coordinate has acted on the claim. Any payment made must be in accordance with rules adopted by the superintendent relative to coordination of benefits.

The Company failed to adjudicate eighteen (18) of the 130 denied and zero-paid claims, or 14.0 %, within 30 days. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2436 (1-A)	The Company failed to adjudicate the claims within 30 days as required by Maine Statutes.	18	14.0%
TOTAL		**18**	**14.0%**

3. 24-A M.R.S.A. § 2436 reads in part:

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 ½% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a healthcare provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, Chapter 375, subchapter 2-A.

The Company failed to pay late payment interest for nine (9) of the 130 denied and zero-paid claims, or 14%. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2436 (3)	The Company failed to pay late payment interest when the claims were not processed within 30 days.	9	14.0%
TOTAL		**9**	**14.0%**

4. 24-A M.R.S.A. §2164-D, Unfair Claim Practices, reads, in part:

2. Prohibited activities. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if:

A. It is committed in conscious disregard of this section and any rules adopted under this section; or [1997, c. 634, Pt. A, §1 (NEW).]

B. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct. [1997, c. 634, Pt. A, §1 (NEW).] [1997, c. 634, Pt. A, §1 (RPR).]

3. Unfair Practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

Two (2) of the 130 denied and zero-paid claims, or 1.5%, involved a potential violation of Maine's Unfair Claim Practices Act. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2164-D	CGLIC received a member's behavioral health claim regarding a January 18, 2005 date of service on February 7, 2005, within the required one-year time frame. CBH did not receive the claim until March 29, 2006 when it was faxed from the provider. CBH incorrectly denied the claim for being filed in excess of one year from the date of service.	1	0.77%
24-A M.R.S.A. § 2164-D	CGLIC received a member's behavioral health claim regarding a February 15, 2005 date of service, which was received on February 25, 2005, within the required one-year time frame. CBH incorrectly denied the claim for being filed in excess of one year from the date of service.	1	0.77%
TOTAL		**2**	**1.5%**

Utilization Review and Pre-Authorization

Utilization Review

The Examiners tested the population of three (3) UR files the Company previously denied during the Period. Testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that UR denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the

situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified 3 UR files that were denied by the Company due to not meeting the medical necessity criteria as defined by the Company.

Further, the claims were not overturned through the Company's appeal process. The complete files as provided by the Company were reviewed and referred for peer-to-peer review.

No exceptions were noted in the UR files referred for Peer Review.

Pre-Authorization

The Examiners tested the population of 3 Pre-Authorization requests, which were denied by the Company. Also, the testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's policies and procedures.

Through the testing, the Examiners identified a potential violation regarding one (1) Maine Rule. The Maine Rule and the exception noted are as follows:

1. Rule 850, § 8 (E) (2) reads in part:

   2. For initial determinations, a health carrier or the carrier's designated URE shall make the determination and so notify the covered person and their provider within 2 working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.

One (1) of the three (3) pre-authorization requests, or 33.0%, involved requests wherein the Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information, as required by the referenced statute. The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850 § 8 (E) (2)	The Company failed to notify the member or provider of CGLIC's determination within two working days of obtaining all necessary information as required by Maine Statute.	1	33.0%
TOTAL		**1**	**33.0%**

Additional Observations

The Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g. M.D., D.O., etc.).

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified one (1) Pre-Authorization Request that was denied by the Company for not meeting the medical necessity criteria as defined by the Company and had not been overturned through the Company's appeal process.

The complete files provided by the Company were reviewed and referred for peer-to-peer review. No exceptions were noted in the Pre-Authorization Request referred for peer review.

Complaints, Appeals and Grievance Handling

Complaints

The Examiners tested the population of two (2) complaints, which included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general complaint handling process. No exceptions were noted.

Pharmacy Complaints

No exceptions were noted.

Appeals

The Examiners tested the population of three (3) appeals, which included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures.

Testing identified one (1) potential violation of one (1) Maine Rule. The Maine Rule and the exceptions noted are as follows:

1. Chapter 850 § 9 D (3) (f) that states the following:

   The review panel shall issue a written notice to the covered person within 5 working days of completing the review meeting. A decision adverse to the covered person shall include requirements set forth in subsection 9 (C)(1)(b)(i-vi).

   The Examiners reviewed two Second Level appeal files and identified one (1) instance, or 50.0%, in which the Company's letter failed to include all necessary requirements. The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9 D (3) (f)	The Company's adverse decision letter does not contain the names, titles and qualifying credentials of the person or persons participating in the second level grievance review process.	1	50.0%
TOTAL		**1**	**50.0%**

- NOTE: The date of the file identified above was prior to June 15, 2007. The same violation, not necessarily the same file, was also identified during the examination of the Company by the Maine BOI in November 2006. It is the Examiners' understanding that the Company developed a corrective action plan which was approved by the Maine BOI; however the Examiners' did not conduct any independent testing to determine if the plan had been fully implemented.

Additional Observations

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners did not identify any appeals that were denied and not overturned by the Company for not meeting the medical necessity criteria as defined by the Company. Therefore, no files were referred for peer-to-peer review.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine Statutes including Maine mental health parity requirements, which are

mandated benefits and are administered pursuant to the Company's standard policies and procedures applicable to mandated benefit processing. The following issues were identified:

1. The Company has two distinct business entities that are operated under the parent Company, CIGNA Insurance Company. CIGNA HealthCare is responsible for the processing of medical health-related functions such as pre-authorizations, utilization review, claims and appeals. Similarly, CIGNA Behavioral Health is responsible for processing behavioral health-related functions, including pre-authorizations, utilization review, claims and appeals. The two entities are operated as individual and separate operations with information shared and transmitted between the two organizations.

   During the course of the examination, the Examiners identified that this internal workflow is contributing to the incorrect processing of mental health related pre-authorizations, utilization reviews, claims and appeals. As a result, the Company's processing is not in compliance with Maine Laws such as Mental Health Parity Laws.

   The Examiners identified five (5) instances, or 11.6%, of the forty three (43) claim samples reviewed that involved medical and mental health diagnosis and procedure codes, which required joint handling by both CHC and CBH. The claims were transmitted back and forth between CHC and CBH and as a result, the files were not processed in a timely manner as mandated under 24-A M.R.S.A. § 2436 (See Claims Finding 2 above). The Company's internal workflow contributed to the claims processing delays as noted above and has impacted the accurate claims adjudication in compliance with Maine's Mental Health Parity Laws.

   Additionally, the Examiners identified one (1) additional claim sample file of the forty three (43) sample selections was initially received by CHC on May 11, 2005 and referred to CBH on May 25, 2005 for processing. The Examiners called this matter to the Company's attention, which confirmed the claim was never received nor adjudicated by CBH. The

Company responded to the Examiners noting the claim has since been processed with late payment interest.

2. 24-A M.R.S.A. § 2153 states the following:

No person shall make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title on any policy or class of policies misrepresenting the true nature thereof.

The Examiners' review of the provider directories noted that the name of the Company, Connecticut General Life Insurance Company or "CGLIC," is not identified on the cover of the directory or within the directory itself; rather only CIGNA HealthCare is identified on and within the Company's documentation.
In addition, the name of the Company is only disclosed in small print on the back cover of the directory, along with the other subsidiaries of CIGNA.

3. In the state of Maine, CGLIC does not write individual policies nor does it write group policies for less than 50 lives. As the claims population provided by CGLIC did not include individual policies, the Examiners inquired if the claims population included claims for individual policies pertaining to group member policies that were converted to an individual policy for purposes such as COBRA benefits. The Company informed the Examiners that CGLIC conversion policies are on a CT-sitused trust policy, not a ME-sitused policy. As such, no claims transactions were included in the claims population provided to the Examiners. The Company further indicated that for CHC, conversions are issued on a ME-sitused policy and a few claims may be included in the population. According to the Company, during the examination period, there were four individual policies sold in Maine through the Nationwide Conversion Trust. The Trust does not appear on the Bureau's list of

approved out-of-state groups. As such, the Company had responsibility to secure approval of the group prior to marketing and selling the coverage in the state of Maine,

Provider Network

The accuracy of a provider's network status on the date of service was tested through a review of 43 claim files. The following issue was identified:

In one (1), or 2.3%, of the 43 claims reviewed, a discrepancy was noted. Specifically, the provider was identified as Out-of-Network per claim data but was listed as In-Network on the provider spreadsheet on the date of service.

ADDENDUM – COMPANY'S RESPONSE

BUREAU'S REVIEW OF COMPANY RESPONSE

The Bureau has reviewed the Company's response to the draft report and has attached it as an addendum to our report. As a result of our review of the Company's response, the original Finding # 6, Finding # 8 and Finding # 9 were removed from the report. The reference to the Company's infrastructure in Finding # 2, Finding # 3 and on page 27 was changed to reference the Company's internal workflow. No further changes were deemed necessary based on the information provided in the response.

ADDENDUM

Jeremy L. Murphy
Regulatory Affairs Manager
Legal & Public Affairs

CIGNA

Routing 300
1571 Sawgrass Corporate Pkwy
Suite 140
Sunrise, FL 33323
Telephone 954.514.6642
Facsimile 954.514.6596
Jeremy.murphy@cigna.com

December 30, 2010

RSM McGladrey, Inc.
1954 Greenspring Drive
Suite 400
Attn: Barry Wells, Examiner in Charge
Timonium, Maryland 21093

Re: Response to State of Maine Bureau of Insurance Market Conduct Examination Report
(Period January 1, 2005 - December 31, 2008)
Connecticut General Life Insurance Company NAIC: 62308

Mr. Wells,

Thank you for your continued assistance with this examination. To the report received via email November 12, 2010 (confirmed as the final report December 16, 2010), we respond as follows:

Finding #1
The Examiners identified twelve (12) of 130 denied and zero-paid claims as possible violations of Title 24-A, § 2843 of the Maine Insurance Rule. Specifically, the claims were denied for exceeding the maximum number of yearly visits for a Biologically Based Mental Illness, which is in violation of Maine's Mental Health Parity Laws.

Company Response:
As noted in the Company's response to Concern #5, the Examiners had identified several claims that were denied by the Company because the expenses exceeded the maximum number of yearly visits. These claims were for outpatient psychiatric services for the treatment of Attention Deficit Disorder. As Attention Deficit Disorder is a Biologically Based Mental Illness, there should not have been a limit placed on the number of visits per calendar year. However, with respect to the 8 claims involved, the processors erred in their application of the appropriate benefit. In these instances, the processors checked the coverage for mental illness instead of the coverage for Biologically Based Mental Illness benefits; as a result the wrong benefits limitation was applied.

The Examiners had indicated that this appeared to be a systemic issue however the Company respectfully disagrees. As noted, this issue involved only 8 claims that were processed over a 2 year period (3 processors made this error in 2007 and 2 in 2008). The Company submits that this is not indicative of a systemic issue but rather of a training opportunity. The Company confirms that it will take the necessary steps to re-train and educate its claim staff regarding the appropriate processing guidelines and verification of benefits.

Finding # 2

The Examiners identified eighteen (18) of 130 denied and zero-paid claims as possible violations of Title 24-A §2436-1A of the Maine Insurance Rule concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine Rule stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. Six (6) of the 18 claims noted above were not processed within the 30 day timeframe, in part as a result of the Company's infrastructure, wherein claims are not timely or effectively transferred between Cigna Health Care (CHC) and Cigna Behavioral Health (CBH).

Company Response:

The Company advises that it had provided its claim data at the service line level rather than unique claim level. With respect to the services lines sampled during the examination, the Company agrees that those noted above were processed in excess of the required timeframes.

However it respectfully disagrees that this was due to an issue with its infrastructure. Both CGLIC and CHC-ME delegate the utilization review and claims administration of behavioral health benefits to CIGNA Behavioral Health. The issues identify during the exam were not indicative of an issue with the Company's overall infrastructure but rather with the handling of a very specific classification of claims. The Company concedes that it had experienced issues with ensuring that some of the mixed services claims (i.e. those claims that involved both medical and behavioral health benefits appearing on the same claim form) were consistently adjudicated on a timely and efficient basis. This issue appears to be due to instances where CIGNA's internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. CIGNA is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

Finding # 3

The Examiners identified nine (9) of 130 denied and zero-paid claims as possible violations of Title 24-A §2436-3 of the Maine Insurance Rule concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine Rule stipulates that if an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date.

The Company's failure to adjudicate four (4) of the identified claims within the 30 day timeframe is the result of the Company's infrastructure, wherein claims are not effectively transferred between Cigna Health Care (CHC) and Cigna Behavioral Health (CBH).

Company Response:

During the examination, the Company advised that its claim data had been provided at the service line level rather than the individual claim level. With respect to the service lines that were sampled, the Company agreed that in some instances the claims, of which those services were a part, were not processed within the required time frames.

As for the nine instances noted above, the Company confirms that it paid the appropriate interest on six of the sampled service lines as required. However it also wishes to clarify that with regard to two of those claims, no LPI was due as there was no payment because the entire amount was applied to the member's deductible.

As for the four claims that were said to have been paid late due to the Company's infrastructure, the Company continues to respectfully disagree. Both CGLIC and CHC-ME delegate the utilization review and claims administration of behavioral health benefits to CIGNA Behavioral Health. The issues identified during the exam were not indicative of an issue with the Company's overall infrastructure but rather with the handling of a very specific classification of claims. The Company concedes that it had experienced issues with ensuring that some of the mixed services claims (i.e., those claims that involved both medical and behavioral health benefits appearing on the same claim form) were consistently adjudicated on a timely and efficient basis. This issue appears to be due to instances where CIGNA's internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. CIGNA is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

Finding # 4

The Examiners identified two (2) of 130 denied and zero-paid claims as possible violations of Title 24-A, §2164-D of the Maine Insurance Rule concerning Unfair Claim Practices, wherein the Company improperly denied the claims on the basis that they were filed in an untimely manner in excess of one (1) year.

Company Response:

As noted during the examination, the Company's claim data was provided at the service line level rather than the unique claim level. The two service lines sampled were part of the same claim and the Company agrees that this claim was incorrectly denied; the claim was reprocessed during the examination.

Finding # 5

The Examiners identified one (1) of three (3) pre-authorization denials as a possible violation of Rule 850, Section 8(E)(2) of the Maine Insurance Rule, wherein the Company failed to notify the member or provider of the determination within two (2) working days of obtaining all necessary information.

Company Response:

The Company agrees that in this one instance (Sample 4304-03) it did not notify the member or provider of the determination within two working days of obtaining all necessary information.

Finding # 6

The Examiners identified one (1) of two (2) Second Level appeals as a possible violation of Title 24-A, §4312(3) of the Maine Insurance Rule, wherein the Company's adverse decision letter does not contain the required disclosure regarding external review rights.

Company Response:

The Company disagrees that its letters are non-compliant as they have already been corrected pursuant to a prior examination by the State of Maine. However it does agree that the letter in Sample File 4509.01 did not contain the information required by Maine Insurance Rule, Tile 24-A, 4312(3) as it was printed prior to the Company's corrective action which occurred June 15, 2007. As this letter involved an issue that was already previously reviewed and corrected as part of a prior Department examination, the Company respectfully asks that this finding be removed from the examiners Final Report as having already been addressed with the Department.

Finding # 7

The Examiners identified one (1) of two (2) Second Level appeals as a possible violation of Rule 850, § 9 D(3) (f) of the Maine Insurance Rule, wherein the Company's adverse decision letter does not contain the names, titles and qualifying credentials of the person or persons participating in the Second Level grievance review process.

Company Response:

The Company continues to respectfully disagree that its letters are non-compliant as this issues has already been addressed and corrected pursuant to a prior examination by the Maine Department of Insurance. The Company agrees only that the letter found in Sample File 4509.02 did not contain the information required by Chapter 850, §9D(3)(f) as it was printed prior to implementation of the Company's corrective action which occurred on June 15, 2007. As this issue has already been addressed and corrected, the Company respectfully asks that this finding be removed from the Final Report as involving an issue that has already been addressed with the Department.

Finding # 8

The Examiners identified that the Company's Maine Administrative First Level appeal acknowledgement letter does not fully comply with Rule 850, § 9 C(1) of the Maine Insurance Rule, which states in part that the aggrieved party must be advised that they have the right to submit written material to the reviewer. The Examiners noted that the letter does not include this disclosure. Follow up with the Company determined that this issue pertains to the Maine first level appeal acknowledgement letter in use. Consequently, because the acknowledgement letter is utilized for all of the Company's first level administrative appeals involving Maine members, this matter is deemed to be a general business practice that is non-compliant with Maine statutes.

Company Response:

There was only 1 appeal that was received during the examination period and that appeal involved a medical necessity determination.

Chapter 850, Section 9(C)(1) only applies to administrative appeals as "adverse utilization review determination"(i.e. medical necessity) appeals are specifically excepted and are governed instead by "section 8(G)"; section 8(G) does not have any similar acknowledgement letter requirements nor does it require that notice of the right to submit "written materials" be given. As the only appeal received by the Company was a medical necessity appeal falling under Section 8(G), the Company respectfully disagrees that the appeal acknowledgment letter in question is not compliant with Chapter 850, Section 9(C)(1) and respectfully requests that this finding be removed from the Final Report.

Also, as advised by the Company in response to IDR # 4514, even though its administrative appeals acknowledgement letters did not contain the requisite information, that notice was provided in the initial denial letter. The initial denial letter advises that members may submit any material supporting their position to the reviewer. The Company also confirmed that it would work with the Central Appeals Unit however to reprogram the acknowledgement letters so that they also reiterated the information provided on the initial denial language.

As a result, since the only appeal file reviewed was a medical necessity appeal and since the Company confirmed that the requisite notice was given by the initial denial letters, it respectfully asks that this finding be removed from the Final Report.

Finding # 9

The Examiners review of the provider directories identified a possible violation of Maine Insurance Rule, Title 24-A, §2153, wherein the Company's name is not clearly identified on the cover of the directory. The Company's name, Connecticut General Life Insurance Company, is only disclosed in small print on the back cover of the directory, along with the other subsidiaries.

Company Response:

Connecticut General Life Insurance Company (CGLIC) respectfully disagrees with the finding that the directories would be confusing to its members and in violation of the requirements of Title 24-A, Sec. 2153. CGLIC's members utilize the provider network that is contracted with CIGNA HealthCare of Maine, Inc. by virtue of an intercompany network access agreement. As the directories provided are the only print directories that would be given to a CGLIC member, there would be no cause for confusion as these would represent the providers available to those members.

Additional Observations:

1. The Company has two distinct business entities that are operated under the parent Company, CIGNA Insurance Company. CIGNA HealthCare is responsible for the processing of medical health-related functions such as pre-authorizations, utilization review, claims and appeals. Similarly, CIGNA Behavioral Health is responsible for processing behavioral health-related functions, including pre-authorizations, utilization review, claims and appeals. The two entities are operated as individual and separate operations with information shared and transmitted between the two organizations.

   During the course of the examination, the Examiners identified that this infrastructure is contributing to the incorrect processing of mental health related pre-authorizations, utilization reviews, claims and appeals. As a result, the Company's processing is not in compliance with Maine Laws such as Mental Health Parity Laws.

   The Examiners identified five (5) instances, or 11.6%, of the forty three (43) claim samples reviewed that involved medical and mental health diagnosis and procedure codes, which required joint handling by both CHC and CBH. The claims were transmitted back and forth between CHC and CBH and as a result, the files were not processed in a timely manner as mandated under Maine Insurance Rule, Title 24-A, Section 2436 (See Claims Finding 2 above). The Company's infrastructure contributed to the claims processing delays as noted above and has impacted the accurate claims adjudication in compliance with Maine's Mental Health Parity Laws.

   Additionally, the Examiners identified one (1) additional claim sample file of the forty three (43) sample selections was initially received by CHC on May 11, 2005 and referred to CBH on May 25, 2005 for processing. The Examiners called this matter to the Company's attention, which confirmed the claim was never received nor adjudicated by CBH. The Company responded to the Examiners noting the claim has since been processed with late payment interest.

   Company Response:

   CIGNA continues to respectfully disagree that there is an issue with its infrastructure and also wishes to clarify the corporate relationship that was noted above (as taken from the Draft Report). CGLIC, CHC-ME and CIGNA Behavioral Health are all affiliates under Connecticut General

Corporation which is a wholly owned subsidiary of CIGNA Corporation; "CIGNA Insurance Company" should be changed to reflect the appropriate relationships.

Both CGLIC and CHC-ME delegate the utilization review and claims administration of behavioral health benefits to CIGNA Behavioral Health. The issues identified during the exam were not indicative of an issue with the Company's infrastructure but rather with the handling of a very specific classification of claims. The Company concedes that it had experienced issues with ensuring that some of the mixed services claims (i.e. those claims that involve both medical and behavioral health benefits appearing on the same claim form) were consistently adjudicated on a timely and efficient basis. This issue appears to be due to instances where CIGNA's internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. CIGNA is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

2. Maine Insurance Rule, Title 24-A, §2153 that states the following:

   "No person shall make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title on any policy or class of policies misrepresenting the true nature thereof."

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   In addition, the name of the Company is only disclosed in small print on the back cover of the directory, along with the other subsidiaries of CIGNA.

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groups. As such, the Company had responsibility to secure approval of the group prior to marketing and selling the coverage in the state of Maine,

Company Response:
The Company agrees.

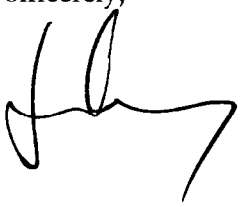
Provider Network
The accuracy of a provider's network status on the date of service was tested through a review of 43 claim files. The following issue was identified:

In one (1), or 2.3%, of the 43 claims reviewed, a discrepancy was noted. Specifically, the provider was identified as Out-of-Network per claim data but was listed as In-Network on the provider spreadsheet on the date of service.

Company Response:
In its response to IDR #4611, the Company acknowledged the noted discrepancy and directed the claims department to reprocess the claim as In Network.

Again, thank you for the continued assistance. If you should have any concerns or questions, please do not hesitate to contact me by phone at 954.514.6642 or by email at jeremy.murphy@cigna.com.

Sincerely,



Jeremy L. Murphy
Regulatory Affairs Manager
Legal & Public Affairs

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Kendra L. Coates, CPA, CFE, CIE, Director of Financial Analysis, being duly sworn according to law, deposes and says that in accordance with the authority vested in her by Eric A. Cioppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, she has overseen an examination on the condition and affairs of the

Connecticut General Life Insurance Company

For the time period of January 1, 2005 to December 31, 2008, and that the foregoing report of examination, subscribed to by her, is true to the best of her knowledge and belief.

The examination was performed by RSM McGladrey, Inc. on behalf of the State of Maine, Bureau of Insurance.

Kendra L. Coates, CPA, CFE, CIE
Director of Financial Analysis

Subscribed and sworn to before me

This 28th day of October, 2011

Notary Public

My commission expires:

KARMA Y. LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2016