REPORT OF MARKET CONDUCT EXAMINATION

CIGNA HEALTH AND LIFE INSURANCE COMPANY

2701 North Rocky Point Drive, Suite 800
Tampa, FL 33607

NAIC Company Code 67369

NAIC Examination Tracking System Number ME114-3

Examination Period:

January 1, 2015 through December 31, 2015

February 21, 2018

Honorable Eric A. Cioppa
Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Superintendent Cioppa:

Pursuant to 24-A M.R.S. §§ 211 and 221, and in accordance with your instructions, a targeted market conduct examination ("Examination") has been made of:

Cigna Health and Life Insurance Company

The Examination reviewed Cigna Health and Life Insurance Company's ("Company") Maine appeal handling practices and claim denials for the Accident and Health line of business. The Examination covered the period from January 1, 2015, through December 31, 2015 ("Review Period"). The Maine Bureau of Insurance ("Bureau") staff conducted the on-site phase of the Examination, from October 17, 2016, through October 28, 2016, at the Company's offices located at 8505 East Orchard Road, Greenwood Village, CO. Additional examination work conducted at the Bureau included preliminary review of information provided by the Company, transactional testing, and follow-up communications.

The following report is respectfully submitted.

Mary Masi

Mary Masi, CPCU, MCM, CIE
Senior Market Conduct Examiner

Pursuant to 24-A M.R.S. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of Cigna Health and 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

2-21-18

Date

Superintendent
Maine Bureau of Insurance

TABLE OF CONTENTS

COMPANY PROFILE

Cigna Health and Life Insurance Company's 2015 annual statement, under Management Discussion & Analysis provides: Cigna Health and Life Insurance Company (CHLIC or the Company) is a wholly-owned subsidiary of Connecticut General Life Insurance Company (CGLIC), which is an indirect wholly-owned subsidiary of Cigna Corporation (Cigna). The Company and its subsidiaries are major providers of health care and related benefits in the U.S., the majority of which are offered through employers and other groups. Principal products and services are group life and health insurance. The Company also offers Medicare Prescription Drug program (PDP) products and has international operations that offer products to businesses and individuals in selected markets. The Company is domiciled in the state of Connecticut and is licensed in all states. Prior to March 5, 2010, when it was re-domesticated and renamed, the Company was known as Alta Health & Life Insurance Company. On April 1, 2008, the Company was acquired by CGLIC. This transaction was accounted for as a purchase under an Asset and Stock purchase agreement entered into between CGLIC and Great-West Life & Annuity Insurance Company.

In June 2013, Cigna entered into a ten-year pharmacy benefit management services agreement with Catamaran Corporation (now known as "Optum"). Under this agreement, the Company utilizes Optum's technology and service platforms, retail network contracting and claims processing services.

The Company's 2015 Maine Annual Report Supplement (Rule 945) reflects that there were 32,839 covered lives (line 5a[1]) in force as of December 31, 2015. The Report also reflects that the Company realized over $70 million in total revenues (line 14).

[1]See, http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule945/rule945_reports.html

EXECUTIVE SUMMARY

In 2009, 24-A M.R.S. §221 was amended with the addition of subsection 5. Subsection 5, Examination of Health Carriers, states in its entirety that "[t]he superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State."

This examination was called as a statutorily required examination.

The examination was a targeted examination of the Company's Accident and Health product line focusing on whether the Company is complying with certain provisions of Maine Bureau of Insurance Rule 850. Rule 850 sets forth certain rights and protections available to individuals who are insured by health plans in Maine. The examiners specifically tested compliance with sections 8 and 9 of Rule 850. These sections list the required notices that must be sent to Maine consumers with all adverse benefit determinations and adverse appeal decision letters. These notices ensure, among other things, that Maine consumers are provided with specific instructions on how to proceed with an appeal of an adverse decision and that they are made aware of their rights to appeal, to contact the Bureau of Insurance, to proceed with an external review of a carrier's appeal decision, and to file a complaint against their health insurer. These sections of Rule 850 also describe the requirements that are the responsibilities of the insurers who will be conducting first and second level appeal reviews. As more fully detailed in the body of this report, the examiners tested the Company's compliance with sections 8 and 9 of Rule 850 by reviewing each of 138 randomly selected appeal files. In response to the Bureau's request for complete copies of the files to be tested, the Company provided several discs containing the file material. The Company did not initially provide all requested materials at the time of the on-site portion of the examination, and the files provided were not complete. During the course of the examination, however, the Company worked with the examiners to ensure they had access to complete files.

The examiners found that the Company was responsive to Bureau requests and comments, and provided meaningful feedback to the written criticisms issued by the examiners. The written criticisms, commonly referred to as "Crits," are the means by which the examiners notify the Company of potential violations of Rule 850 noted during the Examination.

Two types of appeals were tested; those involving health care treatment decisions (HC) and those not involving health care treatment decisions (NHC). Each group includes both level one appeals (L1) and level two (L2) appeals. The benchmark for claims practices is 93% compliance. Overall, the Company was 26% compliant in its L1HC files, 33% compliant in its L2HC files, 10% compliant in its L1NHC files, and 80% compliant in its L2NHC files.

Some tests were marked "n/a" because Rule 850 did not apply to the sample file being tested. For example, denials that were overturned on appeal resulted in appeal decision letters that were not adverse to the consumer. The tests that applied only to "adverse" decisions were therefore marked as "n/a".

Overall, the examiners found that the Company was not compliant with Bureau Rule 850 in its handling of first and second level appeals.

SCOPE OF EXAMINATION

The objective of the Examination was to review appeal files and denied claims for the Company's Accident and Health product line to ensure that they contained the appeal rights information required by Rule 850. The examiners used transactional testing[1] to determine compliance with the applicable regulations.

The Examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223. It was conducted in a manner that was consistent with the standards set forth in the Market Regulation Handbook (MRH) as required by 24-A M.R.S. § 223(2). The MRH was used for purposes of sample determination and overall guidance. Some unacceptable or non-compliant practices may not have been discovered in the course of the Examination. Failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by test rather than by exception. Each test applied is stated, and the results are reported.

[1] Transactional testing is the review of actual appeals.

METHODOLOGY

Using the standards set forth in the MRH as guidance in accordance with 24-A M.R.S. § 223(2), the examiners reviewed the Company's handling of appeal files and denied claims to ensure that all appeal decision letters and denied claims contained the appeal rights required by Maine law. All files reviewed were initiated during the Review Period. A random sample of denied and appealed claims was selected and tested to ensure that they contained the appeal rights information required by Rule 850.

FINDINGS

1. Claims – 1st Level Appeals of Adverse Health Care Treatment Decisions

Standard: All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1).

Bureau Rule Chapter 850 § 3(A)

A. TEST 1: Did the Company comply with the subsections of Rule 850 § 8 that are applicable to Level 1 appeals involving adverse health care treatment decisions?

B. REVIEW PROCESS: A total population of 66 files was reviewed. Five files did not qualify as appeals, therefore, 61 files were reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier notify the covered person of the covered person's opportunity to review the claim file and to present evidence and testimony as part of the internal appeals process? Ch. 850 § 8(G)(1)(a)(i)

Result: 50 pass, 2 fail, 9 n/a; 96% compliance

Subsection 2: Did the health carrier notify the covered person that it would provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond? Ch. 850 § 8(G)(1)(a)(ii)

Result: 40 pass, 2 fail, 19 n/a; 95% compliance

Subsection 3: Did the health carrier notify the covered person that it would provide the covered person with any new or additional rationale on which a final determination was based sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond? Ch. 850 § 8(G)(1)(a)(iii)

Result: 31 pass, 15 fail, 15 n/a; 67% compliance

Subsection 4: Did the health carrier provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier? Ch. 850 § 8(G)(1)(a)(iv)

Result: 41 pass, 19 fail, 1 n/a; 68% compliance

Subsection 5: Did the health carrier make the rights in this subparagraph (listed in Subsections 1 through 4) known to the covered person within 3 working days after receiving an appeal request? Ch. 850 § 8(G)(1)(a)(v)

Result: 35 pass, 25 fail, 1 n/a; 58% compliance

Subsection 6: Are the appeals evaluated by an appropriate clinical peer or peers? The clinical peers shall not have been involved in the initial adverse determination, unless the appeal presents additional information the decision maker was unaware of at the time of rendering the initial adverse health care treatment decision. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision. Ch. 850 § 8(G)(1)(b)

Result: 43 pass, 0 fail, 18 n/a; 100% compliance

Subsection 7: For standard appeals, did the health carrier or the carrier's designated URE notify in writing both the covered person and the attending or ordering provider of the decision within 30 days following the request for an appeal? Additional time is permitted where the carrier or the carrier's designated URE can establish the 30-day time frame cannot reasonably be met due to the carrier's or designee's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier or the carrier's designated URE shall provide written notice of the delay to the covered person and the attending or ordering provider. The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 30 days after the carrier's or designee's receipt of all necessary information. Ch. 850 § 8(G)(1)(c)

Result: 39 pass, 3 fail, 19 n/a; 93% compliance

Subsection 8: Did the appeal decision contain the names, titles and qualifying credentials of the person or persons evaluating the appeal? Ch. 850 § 8(G)(1)(c)(i)

Result: 35 pass, 0 fail, 26 n/a; 100% compliance

Subsection 9: Did the appeal decision contain a statement of the reviewers' understanding of the reason for the covered person's request for an appeal? Ch. 850 § 8(G)(1)(c)(ii)

Result: 5 pass, 30 fail, 26 n/a; 14% compliance

Subsection 10: Did the appeal decision contain a reference to the specific plan provisions upon which the decision is based? Ch. 850(8)(G)(1)(c)(iii)

Result: 33 pass, 2 fail, 26 n/a; 94% compliance

Subsection 11: Did the appeal decision contain the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position? Ch. 850 § 8(G)(1)(c)(iv)

Result: 35 pass, 0 fail, 26 n/a; 100% compliance

Subsection 12: Did the appeal decision contain a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination? The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. Ch. 850 § 8(G)(1)(c)(v)

Result: 35 pass, 0 fail, 26 n/a; 100% compliance

Subsection 13: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 8(G)(1)(c)(vi)

Result: 34 pass, 0 fail, 27 n/a; 100% compliance

Subsection 14: Did the appeal decision contain notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights? Notice of external review rights must be provided to the enrollee as required by 24-A M.R.S. §4312(3). A description of the process for submitting a written request for second level appeal must include the rights specified in subsection G-1. Ch. 850 § 8(G)(1)(c)(vii)

Result: 0 pass, 35 fail, 26 n/a; 0% compliance

Subsection 15: Did the appeal decision contain notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 8(G)(1)(c)(viii)

Result: According to U.S. Department of Labor (DOL) Technical Release No. 2011-01, plans and issuers are advised to check the listed DOL and Centers for Medicare and Medicaid Services (CMS) websites within a reasonable time before the beginning of a plan year to ensure that their notices contain up-to-date information regarding the applicable offices of health insurance consumer assistance established under the federal ACA. Plans and issuers

are not required to update their information more than once per year.[1] During the Examination, the Company provided the examiners with documents showing that it performed its yearly update of its list in August of 2014, and that no office of health insurance consumer assistance was listed for the State of Maine at that time. The Bureau confirmed that Maine's consumer assistance program, Consumers for Affordable Health Care (CAHC), was temporarily removed from the federal lists during that time due to a gap in funding. For this reason, the examiners did not test for this provision.

Subsection 16: Did the appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Ch. 850 § 8(G)(1)(c)(ix)

Result: 0 pass, 35 fail, 26 n/a; 0% compliance

- Note: All files failed this test because the appeal decision letter did not include the Bureau's website address.

Finding 1

The Company did not comply with the applicable subsections of Bureau Rule 850 § 8 in its handling of first level appeals involving adverse health care treatment decisions.

16 files contained all required notices and followed all required procedures tested.

45 files had at least one violation.

The Company was 26% compliant.

2. Claims – 2nd Level Appeals of Adverse Health Care Treatment Decisions

Standard: All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1).

Bureau Rule Chapter 850 § 3(A)

A. TEST 2: Did the Company comply with the subsections of Rule 850 § 8 that are applicable to Level 2 appeals involving adverse health care treatment decisions?

B. REVIEW PROCESS: A total population of 12 files was reviewed.

C. RESULTS BY TEST SUBSECTION:

[1] Technical Release No. 2011-01, Employee Benefits Security Administration, United States Department of Labor, https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-01 (last accessed 8/8/2017).

Subsection 1: Did the health carrier provide an opportunity for a second level appeal and that the covered person has been provided adequate notice of the right to appear in person? Ch. 850 § 8(G-1)(1)

Result: 10 pass, 2 fail, 0 n/a; 83% compliance

Subsection 2: Did the health carrier's review panel include one or more panelists who are disinterested clinical peers? Ch. 850 § 8(G-1)(2)

Result: 7 pass, 1 fail, 4 n/a; 88% compliance

Subsection 3: Did the health carrier's review panel schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review? Ch. 850 § 8(G-1)(3)(a)

Result: 12 pass, 0 fail, 0 n/a; 100% compliance

Subsection 4: Did the health carrier notify the covered person in writing at least 15 days in advance of the review date? Ch. 850 § 8(G-1)(3)(a)

Result: 10 pass, 2 fail, 0 n/a; 83% compliance

Subsection 5: Did the health carrier's review panel issue a written decision to the covered person within 5 working days after completing the review meeting? Ch. 850 § 8(G-1)(3)(f)

Result: 12 pass, 0 fail, 0 n/a; 100% compliance

Subsection 6: Did the appeal decision contain the names, titles and qualifying credentials of the person or persons evaluating the appeal? Ch. 850 § 8(G)(1)(c)(i)

Result: 4 pass, 4 fail, 4 n/a; 50% compliance

Subsection 7: Did the appeal decision contain a statement of the reviewers' understanding of the reason for the covered person's request for an appeal? Ch. 850 § 8(G)(1)(c)(ii)

Result: 1 pass, 7 fail, 4 n/a; 13% compliance

Subsection 8: Did the appeal decision contain a reference to the specific plan provisions upon which the decision is based? Ch. 850 § 8(G)(1)(c)(iii)

Result: 9 pass, 0 fail, 3 n/a; 100% compliance

Subsection 9: Did the appeal decision contain the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position? Ch. 850 § 8(G)(1)(c)(iv)

Result: 9 pass, 0 fail, 3 n/a; 100% compliance

Subsection 10: Did the appeal decision contain a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination? The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. Ch. 850 § 8(G)(1)(c)(v)

Result: 9 pass, 0 fail, 3 n/a; 100% compliance

Subsection 11: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 8(G)(1)(c)(vi)

Result: 8 pass, 0 fail, 4 n/a; 100% compliance

Subsection 12: Did the appeal decision contain notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights? Notice of external review rights must be provided to the enrollee as required by 24 A M.R.S. § 4312(3). Ch. 850 § 8(G)(1)(c)(vii)

Result: 1 pass, 7 fail, 4 n/a; 13% compliance

Subsection 13: Did the appeal decision contain notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 8(G)(1)(c)(viii)

Result: According to U.S. Department of Labor (DOL) Technical Release No. 2011-01, plans and issuers are advised to check the listed DOL and Centers for Medicare and Medicaid Services (CMS) websites within a reasonable time before the beginning of a plan year to ensure that their notices contain up-to-date information regarding the applicable offices of health insurance consumer assistance established under the federal ACA. Plans and issuers are not required to update their information more than once per year. During the Examination, the Company provided the examiners with documents showing that it performed its yearly update of its list in August of 2014, and that no office of health insurance consumer assistance was listed for the State of Maine at that time. The Bureau confirmed that

Maine's consumer assistance program, Consumers for Affordable Health Care (CAHC), was temporarily removed from the federal lists during that time due to a gap in funding. For this reason, the examiners did not test for this provision.

Subsection 14: Did the appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Ch. 850 § 8(G)(1)(c)(ix)

Result: 0 pass, 8 fail, 4 n/a; 0 % compliance

- Note: All files failed this test because the appeal decision letter did not include the Bureau's website address.

Finding 2

The Company did not comply with the applicable subsections of Bureau Rule 850 § 8 in its handling of second level appeals involving adverse health care treatment decisions.

4 files contained all required notices and followed all required procedures tested.

8 files had at least one violation.

The Company was 33% compliant.

3. Claims – 1st Level Appeals of Adverse Benefit Determinations

Standard: All requests for review of "adverse benefit determinations," other than "health care treatment decisions," are subject to the grievance review procedures set forth in section 9.

Bureau Rule Chapter 850 § 3(A)

A. TEST 3: Did the Company comply with the subsections of Rule 850 § 9 that are applicable to Level 1 appeals of adverse benefit determinations that did not involve health care treatment decisions?

B. REVIEW PROCESS: A sample population of 60 files was reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier provide notice of the right to file a complaint with the Bureau of Insurance? Ch. 850 § 9(A)(6)

Result: 48 pass, 12 fail, 0 n/a; 80% compliance

Subsection 2: Did the health carrier provide a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria? Ch. 850 § 9(A)(8)

Result: 58 pass, 2 fail, 0 n/a; 97% compliance

Subsection 3: Did the health carrier provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier? The health carrier shall make these rights known to the covered person within 3 working days after receiving a grievance. Ch. 850 § 9(B)(2)

Result: 43 pass, 17 fail, 0 n/a; 72% compliance

Subsection 4: Did the health carrier issue a written decision to the covered person within 30 days after receiving a grievance? Ch. 850 § 9(B)(2)(a)

Result: 58 pass, 2 fail, 0 n/a; 97% compliance

Subsection 5: Did the appeal decision contain the names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers)? Ch. 850 § 9(B)(2)(b)(i)

Result: 51 pass, 1 fail, 8 n/a; 98% compliance

Subsection 6: Did the appeal decision contain a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts? Ch. 850 § 9(B)(2)(b)(ii)

Result: 40 pass, 11 fail, 9 n/a; 78% compliance

Subsection 7: Did the appeal decision contain a reference to the specific plan provisions on which the benefit determination is based? Ch. 850 § 9(B)(2)(b)(iii)

Result: 50 pass, 1 fail, 9 n/a; 98% compliance

Subsection 8: Did the appeal decision contain the reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination? Ch. 850 § 9(B)(2)(b)(iv)

Result: 50 pass, 1 fail, 9 n/a; 98% compliance

Subsection 9: Did the appeal decision contain a reference to the evidence or documentation used as the basis for the decision? The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. Ch. 850 § 9(B)(2)(b)(v)

Result: 51 pass, 0 fail, 9 n/a; 100% compliance

Subsection 10: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 9(B)(2)(b)(vi)

Result: 60 n/a

Subsection 11: Did the appeal decision contain a description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph C(3)(c)? Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S. § 4312(3). Ch. 850 § 9(B)(2)(b)(vii)

Result: 49 pass, 1 fail, 10 n/a; 98% compliance

Subsection 12: Did the appeal decision contain notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 9(B)(2)(b)(viii)

Result: According to U.S. Department of Labor (DOL) Technical Release No. 2011-01, plans and issuers are advised to check the listed DOL and Centers for Medicare and Medicaid Services (CMS) websites within a reasonable time before the beginning of a plan year to ensure that their notices contain up-to-date information regarding the applicable offices of health insurance consumer assistance established under the federal ACA. Plans and issuers are not required to update their information more than once per year. During the Examination, the Company provided the examiners with documents showing that it performed its yearly update of its list in August of 2014, and that no office of health insurance consumer assistance was listed for the State of Maine at that time. The Bureau confirmed that Maine's consumer assistance program, Consumers for Affordable Health Care (CAHC), was temporarily removed from the federal lists during that time due to a gap in funding. For this reason, the examiners did not test for this provision.

Subsection 13: Did the appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Ch. 850 § 9(B)(2)(b)(ix)

Result: 0 pass, 51 fail, 9 n/a; 0% compliance

- Note: All files failed this test because the appeal decision letter did not include the Bureau's website address.

Finding 3

The Company did not comply with the applicable subsections of Bureau Rule 850 § 9 in its handling of first level appeals of adverse benefit determinations that did not involve health care treatment decisions.

6 files contained all required notices and followed all required procedures tested.

54 files had at least one violation.

The Company was 10% compliant.

4. Claims – 2nd Level Appeals of Adverse Benefit Determinations

Standard: All requests for review of "adverse benefit determinations," other than "health care treatment decisions," are subject to the grievance review procedures set forth in section 9.

Bureau Rule Chapter 850 § 3(A)

A. TEST 4: Did the Company comply with the subsections of Rule 850 § 9 that are applicable to Level 2 appeals of adverse benefit determinations that did not involve health care treatment decisions?

B. REVIEW PROCESS: A total population of 5 files was reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier provide adequate notice to the covered person that s/he has the option to appear in person before the carrier? Ch. 850 § 9(C)(1)

Result: 5 pass, 0 fail, 0 n/a; 100% compliance

Subsection 2: Did the health carrier appoint a second level grievance review panel for each grievance subject to review under this subsection? A majority of the panel shall consist of employees or representative of health carrier who were not previously involved in the grievance. Ch. 850 § 9(C)(2)

Result: 5 pass, 0 fail, 0 n/a; 100% compliance

Subsection 3: Did the health carrier's review panel schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review? The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. The health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. Ch. 850 § 9(C)(3)(a)

Result: 5 pass, 0 fail, 0 n/a; 100% compliance

Subsection 4: Did the health carrier notify the covered person in writing at least 15 days in advance of the review date? The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. Ch. 850 § 9(C)(3)(a)

Result: 5 pass, 0 fail, 0 n/a; 100% compliance

Subsection 5: Did the health carrier's review panel issue a written decision to the covered person within 5 working days after completing the review meeting? Ch. 850 § 9(C)(3)(f)

Result: 5 pass, 0 fail, 0 n/a; 100% compliance

Subsection 6: Did the appeal decision contain the names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers)? Ch. 850 § 9(B)(2)(b)(i)

Result: 1 pass, 0 fail, 4 n/a; 100% compliance

Subsection 7: Did the appeal decision contain a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts? Ch. 850 § 9(B)(2)(b)(ii)

Result: 1 pass, 0 fail, 4 n/a; 100% compliance

Subsection 8: Did the appeal decision contain a reference to the specific plan provisions on which the benefit determination is based? Ch. 850 § 9(B)(2)(b)(iii)

Result: 1 pass, 0 fail, 4 n/a; 100% compliance

Subsection 9: Did the appeal decision contain the reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination? Ch. 850 § 9(B)(2)(b)(iv)

Result: 1 pass, 0 fail, 4 n/a; 100% compliance

Subsection 10: Did the appeal decision contain a reference to the evidence or documentation used as the basis for the decision? The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. Ch. 850 § 9(B)(2)(b)(v)

Result: 1 pass, 0 fail, 4 n/a; 100% compliance

Subsection 11: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request? Ch. 850 § 9(B)(2)(b)(vi)

Result: 5 n/a

Subsection 12: Did the appeal decision contain a description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph C(3)(c)? Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S. § 4312(3). Ch. 850 § 9(B)(2)(b)(vii)

Result: 5 n/a

Subsection 13: Did the appeal decision contain notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act? Ch. 850 § 9(B)(2)(b)(viii)

Result: According to U.S. Department of Labor (DOL) Technical Release No. 2011-01, plans and issuers are advised to check the listed DOL and Centers for Medicare and Medicaid Services (CMS) websites within a reasonable time before the beginning of a plan year to ensure that their notices contain up-to-date information regarding the applicable offices of health insurance consumer assistance established under the federal ACA. Plans and issuers are not required to update their information more than once per year. During the Examination, the Company provided the examiners with documents showing that it performed its yearly update of its list in August of 2014, and that no office of health insurance consumer assistance was listed for the State of Maine at that time. The Bureau confirmed that Maine's consumer assistance program, Consumers for Affordable Health Care (CAHC), was temporarily removed from the federal lists during that time due to a gap in funding. For this reason, the examiners did not test for this provision.

Subsection 14: Did the appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance. Ch. 850 § 9(B)(2)(b)(ix)

Result: 0 pass, 1 fail, 4 n/a; 0% compliance

- Note: The file failed this test because the appeal decision letter did not include the Bureau's website address.

Finding 4

The Company did not comply with the applicable subsections of Bureau Rule 850 § 9 in its handling of second level appeals of adverse benefit determinations that did not involve health care treatment decisions.

4 files contained all required notices and followed all required procedures tested.

1 file had at least one violation.

The Company was 80% compliant.

RECOMMENDATION

The Bureau recommends that the Company enact practices and procedures to ensure compliance with Rule 850.

ACKNOWLEDGMENT

The courtesy and hospitality extended by the officers and employees of the Company during the course of the Examination are gratefully acknowledged. The Examination was conducted and is respectfully submitted by the undersigned.

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Mary Masi, CPCU, MCM, CIE, Senior Market Conduct Examiner, 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 made an Examination on the condition and affairs of

Cigna Health and Life Insurance Company

as of December 31, 2015, and that the foregoing report of Examination, subscribed to by her, is true to the best of her knowledge and belief.

The following examiner from the Bureau assisted:

Allan C. Armstrong, MCM, CWCLA

Mary Masi

Mary Masi, CPCU, MCM, CIE
Senior Market Conduct Examiner

Subscribed and sworn to before me

This 21 day of February, 2018

Karma Lombard

Notary Public

My commission expires:

KARMA LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2023