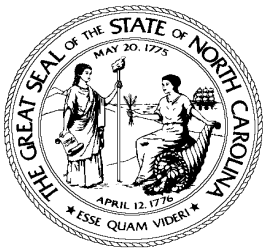

Report on

Market Conduct Examination

of

Cigna Health and Life Insurance Company

Bloomfield, Connecticut

by Representatives of the

North Carolina Department of Insurance

as of

August 17, 2017

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Raleigh, North Carolina
August 18, 2017

Honorable Mike Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
Albemarle Building
325 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Katharine L. Wade
Commissioner of Insurance
Connecticut Insurance Department
Post Office Box 816
Hartford, Connecticut 06142-0816

Honorable Commissioners:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of

Cigna Health and Life Insurance Company
(NAIC #67369)
NAIC Exam Tracking System Exam Number: NC-NC131-13
Bloomfield, Connecticut

hereinafter generally referred to as the Company, at the North Carolina Department of Insurance (Department) office located at 11 South Boylan Avenue, Raleigh, North Carolina and 325 N. Salisbury Street, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Department conducted a target examination of the Company. This examination commenced on January 19, 2017, and covered the period of January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through August 17, 2017. This action was taken due to analysis of the market conduct annual filing submission. All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive, and consisted of an examination of the Company's practices and procedures in utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring. The findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 0 percent tolerance level for timeliness of utilization review, member appeal and grievance acknowledgement, and determination letters. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals, and grievances. Sample sizes were generated using Audit Command Language software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with Company procedures and practices in the following areas:

Utilization Management – Failure to conduct timely reviews for utilization review requests; failure to provide compliant written decision notification letters to covered persons for utilization reviews and member appeals; failure to provide timely

acknowledgement letters to covered persons for member appeals; failure to reference the 'Health Insurance Smart NC' program in policy documents; failure to provide adequate notice to members of review panel meeting dates; and failure to pay late claim interest for one claim related to a retrospective review request.

Policyholder Grievances – Failure to provide timely written acknowledgement and decision letters to covered persons; failure to notify the covered person of the review meeting at least 15 days prior to the scheduled meeting date; and failure to include the qualifications of the person or persons reviewing the grievance in the written decision letter.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking "Insurance Industry" then "Legislative Services" under "Other Divisions".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions must be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Utilization Management Program. This program is integrated with other operational areas of the Company in adherence to the provisions of NCGS 58-50-61.

Policies and Procedures

The Company's Utilization Management Program document, as well as policies and procedures, were examined to determine compliance with appropriate North Carolina statutes. The policy titled '*North Carolina Appeals Policy for Customers (Version 6.1)',* which was effective during the examination period, outlines notice requirements for adverse appeal decisions. These notice requirements do not include reference to the availability of the 'Health Insurance Smart NC' program. Therefore, this policy does not adhere to the provisions of NCGS 58-50-61(k)(6).

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning. Written noncertifications are communicated to members as required by the provisions of NCGS 58-50-61.

The Company received a total of 4,430 utilization review requests during the examination period, consisting of prospective, concurrent, and retrospective requests. A random sample of 131 files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 based on the following:

- Within 16 files, the review was not completed and communicated within the timeframes required by the statute for the applicable review type conducted.
- Ten files contained a noncertification decision letter, which referenced the 'Managed Care Patient Assistance Program', however this program ceased to exist as of July 2012.
- One file contained a noncertification decision letter, which failed to reference the availability of the 'Health Insurance Smart NC' Program.

In addition, within one retrospective approved request file, the associated claim payment was processed beyond 30 days, however late payment interest was not paid. Therefore, the

Company did not adhere to the provisions of NCGS 58-3-225. The Company was instructed to process the interest payment for this claim, which totaled $.55.

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his or her appeal if a delay in the rendering of health care would be detrimental to the member's health.

Appeal Records Review

The Company received a total of 44 appeal requests during the examination period. All 44 files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 or NCGS 58-50-62 based on the following:

- Within ten files, the acknowledgement letter was not sent to the member within three business days from receipt of the appeal.
- No acknowledgement letter was sent within one file.
- One file contained an acknowledgement letter, which did not include the phone number for the company coordinator assigned to the appeal.
- One file did not contain a determination letter.
- Within three files, notification of the review meeting was not given to the member at least 15 days prior to the scheduled meeting date.

In addition, it was noted that within five files, the Company did not render a decision for the appeal within 15 calendar days, which was the intended timeframe stated on the acknowledgement letter for the file. The Company's standard is to complete the appeal review process within this timeframe for an appeal regarding a prospective service.

The average service time to process a member appeal was 23 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
8 - 14	9	20.5
15 - 21	11	25.0
22 - 30	20	45.5
31 – 45	4	9.0
Total	**44**	**100.0**

POLICYHOLDER GRIEVANCES

The Company received a total of 184 member grievance requests during the examination period. A random sample of 131 grievance files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62 as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62 based on the following:

- Within 31 files, the acknowledgment letter to the member was not sent within three business days from receipt of the grievance.
- Eight files did not contain a copy of the acknowledgment letter to the member.
- One file contained a decision letter that did not advise the member of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.
- One file did not contain a copy of the decision letter to the member.
- The review process was not completed within 30 days of receipt of grievance within two files.
- Seven files did not contain a letter to notify the covered person of the review meeting at least 15 days prior to the scheduled meeting date.
- Within 114 files, the written decision letter to the covered person did not include the professional qualifications of the person or persons reviewing the grievance.

The average service time to process a member grievance was 13 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	35	26.7
8 - 14	56	42.8
15 - 21	26	19.8
22 - 30	12	9.2
31 - 60	2	1.5
Total	**131**	**100.0**

PROVIDER NETWORK AVAILABILITY AND ACCESSIBILITY

The Company's policies and standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards were reviewed to ascertain compliance with the provisions of 11 NCAC 20.0301(3) and 20.0302(3).

The Company did not meet their standards applicable to the examination period for appointment wait times as defined in their policy and procedures and as displayed in the following chart:

Appointment Type	Standard	Actual Results (%)
Urgent – PCP, Specialist, Pediatrician	85% within 48 hours	81.0
Urgent – Ob/Gyn	Immediately	81.0
Emergency (all provider types)	Immediately	79.0

Based on the Company's response to the Department's review of these standards, it was noted that the Company took extensive corrective action subsequent to the examination period to address and improve appointment wait times for members in North Carolina.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must complete and implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to compliance with statutory requirements regarding member utilization review requests; member appeal and grievance written notification decisions and acknowledgement letters (including timeliness and content of notifications); and policies and procedures for member appeals.

CONCLUSION

A target examination has been conducted on the market conduct affairs of Cigna Health and Life Insurance Company for the period January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through August 17, 2017.

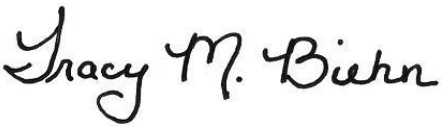
This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring.

In addition to the undersigned, Darla Wright, MCM, North Carolina Market Conduct Senior Examiner, participated in this examination.

Respectfully submitted,

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.



Tracy M. Biehn, MBA, MCM, LPCS
Deputy Commissioner
Market Regulation Division
State of North Carolina