Report on

Market Conduct Examination

of

Connecticut General Life Insurance Company

Bloomfield, Connecticut

by Representatives of the

North Carolina Department of Insurance

as of

July 19, 2017

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Raleigh, North Carolina
July 19, 2017

Honorable Michael Causey
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Department of Insurance
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Honorable Katharine L. Wade
Commissioner
Connecticut Insurance Department
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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

Connecticut General Life Insurance Company – (NAIC # 62308)
NAIC Exam Tracking System Exam Number: NC-NC299-3
Bloomfield, Connecticut

hereinafter generally referred to as the Company, at the Company's office located at 25500 N Norterra Drive, Phoenix, Arizona and at the North Carolina Department of Insurance (Department) offices located at 11 S. 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 September 19, 2016, and covered the period of January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through July 3, 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 provide timely determinations for utilization review requests, non-expedited appeals, and expedited appeals; failure to provide compliant decision letters to covered persons advising of rights and the process to request a second-level review; and failure to notify covered persons in writing of a hearing at least

15 days prior to the hearing date or advising of the right to submit supporting materials before and at the hearing.

Policyholder Grievances – Member Grievance Reviews – For subjecting the insured to out-of-network benefits when in-network providers were unable to meet health needs without delay; failure to effectuate prompt, fair and equitable settlements of claims; and failure to provide proper written acknowledgement, decision, and hearing letters to members.

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

Utilization Management (UM) is the evaluation of the appropriateness and medical need of health care services procedures and facilities according to evidence-based criteria or guidelines, under the provisions of an applicable health benefits plan. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting. UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification, and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews as well as appeals introduced by the provider, payer, or patient. A UM program is comprised of roles, policies, processes, and criteria.

The Company's Utilization Management Program (Program) and services 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, the Company has established a formal structure to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Program, which is integrated with other operational areas of the Company. The Company's policies and procedures were found to be in compliance with appropriate North Carolina statutes.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and other services, concurrent review of inpatient health services, retrospective review, referral and complex case management, and discharge planning.

The Company provided a listing of 560 medical necessity review files. One hundred thirty-one medical necessity review files were randomly selected for review to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. The Company did not adhere to the provisions of NCGS 58-50-61 as:

- Two utilization review files did not contain sufficient documentation to ascertain if notification was given to the provider within three business days.
- One file contained a noncertification decision letter that was not completed and communicated within 30 days after receiving all information.

Appeal Record Reviews

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/her appeal if a delay in the rendering of health care would be detrimental to his/her health.

The Company provided a listing of 15 first-level member appeals files and four second-level grievance files. The entire population of 19 files was reviewed to determine adherence to

Company guidelines and compliance with applicable North Carolina Statutes and rules. The Company did not adhere to the provisions of NCGS 58-50-61(k) as:

- One file indicated that the insurer failed to give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after receiving the request for an appeal.
- Three files evidenced that after receiving a request for a standard non-expedited appeal, no acknowledgement letter was sent at all.
- Six files revealed that the standard non-expedited appeal was not acknowledged within three business days after receipt.

The average service time to process a member appeal was 19 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	6	31.6
8 - 14	2	10.5
15 - 21	2	10.5
22 - 30	8	42.1
31 - 60	1	5.3
Total	**19**	**100.0**

The Company provided a total population of one expedited member appeal file. No adverse trends or unfair trade practices were observed during this review.

POLICYHOLDER GRIEVANCES

Member Grievance Reviews

The Company provided a listing of 118 member grievance files and 14 second level grievance files. The entire population of 132 member grievance files was reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules. The Company did not adhere to the provisions of NCGS 58-50-62 as:

- Forty-two files did not contain a copy of the member's acknowledgment letter sent within three business days.
- Ten files did not contain a copy of the member's acknowledgment letter.
- Ninety-three files contained a decision letter that did not include the professional qualifications and the licensure of the person or persons reviewing the grievance.

- Forty files contained a decision letter that did not include a statement of the reviewers understanding of the grievance.

- Six files contained a decision letter that did not advise the covered person of his/her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

- Eight files contained a hearing letter that did not notify the covered person in writing at least 15 days before the review meeting date.

- Eighteen files contained hearing letters that did not advise the covered person of his/her rights to submit their supporting materials before and at the review meeting.

The Company did not adhere to the provisions of NCGS 58-3-200(d) as 19 files contained evidence that the insurer penalized the insured by subjecting the insured to use out-of-network benefits although in-network health care providers were unable to meet the health needs of the insured without unreasonable delay. The Department asked the Company to readjust payment on the 19 incorrectly processed claims. After careful reconsideration, the Company paid benefits including interest totaling $36,446.96. The Company did not adhere to the provisions of NCGS 58-63-15(11)(d)(f)(h) by:

- Refusing to pay claims without conducting a reasonable investigation based upon all available information;

- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear; and

- Attempting to settle claims for less than the amount to which a reasonable man would have believed he was entitled.

The service time could not be calculated on two files as a member decision notification was not sent. The survey was based on the remaining 116 files. The average service time to process a member grievance was 14 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	48	41.4
8 - 14	24	20.7
15 - 21	16	13.8
22 - 30	25	21.6
31 - 60	2	1.7
Over 60	1	0.8
Total	**116**	**100.0**

Fourteen of the 118 member grievance files were escalated to second-level grievance requests. The Company did not adhere to the provisions of NCGS 58-50-62 as:

- One second level did not contain a copy of the member's acknowledgment letter.
- Twelve second level files contained a decision letter that did not include the professional qualifications and the licensure of the members of the review panel.
- Four second level files contained a decision letter that did not include a statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
- One second level file did not contain a copy of the hearing letter.
- Seven second level files contained a hearing letter that did not advise covered person of his/her rights to submit their supporting materials before and at the review meeting.

The average service time to process a second-level grievance was 1 calendar day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	14	100.0
Total	**14**	**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's goal is for performance results not to exceed five percent below the standard. The Company's performance results were within these parameters during the examination period. No adverse trends or unfair trade practices were revealed during this review.

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 timely determinations for utilization review requests, non-expedited and expedited appeals; and adherence to the insurer grievance procedures concerning written notification decisions, acknowledgement, and hearing letters. In addition, the Company must not subject insureds to out-of-network benefits when in-network providers are unable to meet health needs without delay and effectuate prompt, fair, and equitable settlements of claims

CONCLUSION

A target examination has been conducted on the market conduct affairs of Connecticut General Life Insurance Company for the period January 1, 2014, through December 31, 2014, with analyses of certain operations of the Company being conducted through July 3, 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, Shane E. Jordan, MHS, MCM, North Carolina Market Conduct Senior Examiner and Darla Wright, MCM, North Carolina Market Conduct Senior Examiner participated in this examination.

Respectfully submitted,

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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

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