

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

Cigna Health and Life Insurance Company

**NAIC #67369
900 Cottage Grove Road
Bloomfield, CT 06152-5026**

As of

April 30, 2018

TRINIDAD NAVARRO
COMMISSIONER



STATE OF DELAWARE
DEPARTMENT OF INSURANCE

I, Trinidad Navarro, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of April 30, 2018 on

Cigna Health and Life Insurance Company

is a true and correct copy of the document filed with this Department.

Attest By: 

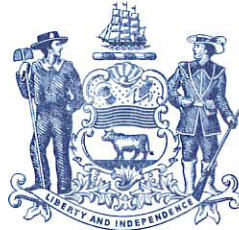


In Witness Whereof, I have hereunto set my hand
and affixed the official seal of this Department at the
City of Dover, this 1st day of October, 2019.



Trinidad Navarro
Insurance Commissioner

TRINIDAD NAVARRO
COMMISSIONER



STATE OF DELAWARE
DEPARTMENT OF INSURANCE

REPORT ON EXAMINATION

OF THE

Cigna Health and Life Insurance Company

AS OF

April 30, 2018

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.



In Witness Whereof, I have hereunto set my hand
and affixed the official seal of this Department at the
City of Dover, this 1st. day of October, 2019.

Trinidad Navarro
Insurance Commissioner

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Honorable Trinidad Navarro
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Navarro:

In compliance with the instructions contained in Exam Authority Number 67369-18-712, and pursuant to statutory provisions including 18 *Del. C.* §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

Cigna Health and Life Insurance Company #67369

The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

900 Cottage Grove Road
Bloomfield, CT 06152-5026

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the Department or DDOI, or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

The Company's main administrative offices are located in Bloomfield, CT.

The examination was announced as part of a series of examinations on companies in the health insurance marketplace in Delaware. The examination focused on Cigna Health and Life Insurance Company's (Company or CHLIC) practices and procedures relating to the following lines of business, written in Delaware: group accident and health, individual accident and health, preauthorization, complaint handling, appeals, grievances and claims. The purpose of the examination is to determine compliance by the Company with Delaware insurance laws and regulations related to the Company's consumer complaints, appeals and grievances and claims handling.

According to the Schedule T of their 2017 annual statement for the State of Delaware, the Company reported accident and health insurance premiums, including policy, membership and other fees of \$40,884,103.

There were no exceptions in the Company Operation and Management, Forms, and Underwriting and Rating, and eviCore Paid Claims sections. Producer Licensing and Policyholder Services were not requested, thus not reviewed.

The following exceptions were noted:

- **2 Exceptions**

- **18 Del. Admin. C. 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation**

- *1.2.1.2. Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.*

- The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

- **8 Exceptions**

- **18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation**

- *1.2.1.5. Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.*

- The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

- **10 Exceptions**

- **18 Del. Admin. C. 1310 § 6.1.3 Processing of Clean Claim**

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6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;

6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;

6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

- **6 Exceptions**

- **18 Del. C. § 332(c)(4) Prompt Response to Written Grievances**

- *(c)(4). The IRP shall provide that within 5 business days of receipt of a written grievance, the carrier shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance.*

The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

- **1 Exception**

- **18 Del. C. § 332(c)(5) Speedy Review of Grievances**

- *(c)(5). The IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than (i) 72 hours after the receipt of all necessary information relating to an emergency review, (ii) 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract, and (iii) 45 days after the receipt of all necessary information in all other instances. A grievance shall be considered decided when the carrier has made its final decision on the subject of the review and has deposited written notice of that decision in the mail, in accordance with paragraphs (7) and (8) of this subsection.*

The Company failed to specifically render a decision of a written grievance within 30 days.

- **4 Exceptions**

- **18 Del. C. § 332(c)(7) Written Notice of Decisions**

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(c)(7). The IRP shall provide that within 5 days after a grievance is decided in the manner described above, the insured shall be provided with written notice of the disposition of that grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance, but shall clearly inform the insured in layman's terms that mediation does not change the deadlines imposed by § 6416 of this title or this section. The Department of Insurance shall inform any person with rights under § 6416 of this title or this section of those rights.

The Company specifically failed to inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. C. § 318-322 and covered the experience period of January 1, 2016, through April 30, 2018, unless otherwise noted. The scope of the examination included, but was not limited to, the Company's practices and procedures relating to the following lines of business, written in Delaware: group accident and health, individual accident and health, preauthorization, complaint handling, appeals, grievances and claims to determine compliance by the Company with Delaware insurance laws and regulations related to the Company's consumer complaints, appeals and grievances and claims handling.

METHODOLOGY

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC. While examiners report on the errors found in individual files, the examiners also focus on general business practices of the Company.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

Delaware Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. Generally, practices,

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procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of exceptions identified during the examination and to review written summaries provided on the exceptions found.

COMPANY OPERATIONS AND MANAGEMENT

Company History

The Company was originally incorporated in the state of Florida as Orange State Life Insurance Company on May 2, 1963. In 1994, the Company re-domesticated to Ohio. In 1995, the Company became a wholly owned subsidiary of Anthem Insurance Companies, Inc., a subsidiary of Anthem Companies, Inc. In 1996, the Company re-domesticated to Indiana and changed its name to Anthem Health & Life Insurance Company.

On July 8, 1998, the Company became a wholly owned subsidiary of Great-West Life & Annuity Insurance Company, a Colorado-domiciled life insurance company. Power Corporation of Canada, a publicly traded, Montréal-based financial service company was the Company's ultimate parent. On June 15, 1999, the Company changed its name to Alta Health & Life Insurance Company (AHL).

On April 1, 2008, Connecticut General Life Insurance Company (CGLIC), an indirect, wholly owned subsidiary of Cigna Corporation (Cigna), acquired the healthcare division of Great-West Life & Annuity Insurance Company through a fully assumed indemnity reinsurance agreement. This acquisition included AHL, which became a direct, wholly owned subsidiary of CGLIC.

On March 3 and 5, 2010, respectively, AHL re-domesticated from Indiana to Connecticut and changed its name to Cigna Health and Life Insurance Company (CHLIC).

On August 31, 2012, CHLIC acquired the Great American Supplemental Benefits Group from American Financial Group. As part of this purchase agreement, CHLIC acquired Loyal American Holding Corporation, an Ohio corporation, and Ceres Sales, LLC, a Delaware limited liability company.

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CHLIC's principal products include group health benefit plans and professional services provided to employers and other groups. The Company is domiciled in the state of Connecticut and licensed in all 50 states, the District of Columbia, Puerto Rico, and the U.S Virgin Islands.

The company uses various Third-Party Administrators (TPAs) in the processing of their claims and appeals. The company employs EviCore to review and process radiology and nuclear cardiology appeals and claims. The company uses American Specialty Health (ASH) to review and process their chiropractic, physical therapy and occupational therapy claims. All other claims and appeals are handled internally by CHLIC through their National Appeals Organization (NAO).

According to the Schedule T of their 2017 annual statement for the State of Delaware, the Company reported accident and health insurance premiums, including policy, membership and other fees of \$40,884,103.

Internal Audit

The Company provided a list of 14 internal audits conducted within the last five (5) years. Internal audits include those audits completed by an internal audit function within the company or those conducted via a contracted vendor on behalf of the company. A review of all 14 audit reports covering underwriting and claim operations and functions reveal no irregularities.

COMPLAINTS HANDLING

The Company identified 18 consumer complaints received during the experience period. Of the 18 complaints identified 14 were forwarded from the Department. Upon further analysis, one complaint was for an affiliated company and one complaint was for Georgia and not Delaware as initially indicated. The remaining 16 complaint files were requested, received and reviewed. The company also provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files were reviewed for compliance with the Delaware statutes and regulations including but not limited to 18 *Del. C.* § 2304(17). This Section of the Code requires maintenance of a complete record of all complaints received since the date of its last examination. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint.

The following exceptions were noted:

2 Exceptions -18 *Del. Admin. C.* 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation.

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The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

2 Exceptions -18 Del. C. § 332(c)(7) Written notice of decisions.

The Company specifically failed to inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision.

Recommendation: It is recommended that the Company specifically inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision pursuant to 18 Del. Admin. C. § 332(c)(7).

GRIEVANCES AND APPEALS

A) eviCore Grievances and Appeals

The Company was requested to provide a list of all grievances and appeals during the experience period. The Company identified 60 grievances and appeals during the period. All 60 files were requested, received and reviewed. The Company then determined that four (4) files were duplicate listings and that five (5) were Administrative Service Only (ASO) files.

6 Exceptions – 18 Del. C. §332(c)(4) Prompt response to written grievances.

The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

Recommendation: It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. Admin. C. § 332(c)(4).

2 Exceptions -18 Del. C. § 332(c)(7) Written notice of decisions.

The Company specifically failed to inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision.

Recommendation: It is recommended that the Company specifically inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision pursuant to 18 Del. Admin. C. § 332(c)(7).

B) NAO Grievances and Appeals

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The Company was requested to provide a list of all grievances and appeals during the experience period. The Company identified 32 grievances and appeals during the period.

1 Exception – 18 Del. C. §332 (c)(5) Speedy review of grievances.

The Company failed to specifically render a decision of a written grievance within 30 days.

Recommendation: It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. Admin. C. § 332(c)(5).

UNDERWRITING AND RATING

A) ASH Paid Claims

The Company provided a universe of 1,468 paid claims processed during the examination period of January 1, 2016 through April 30, 2018. A random sample of 107 denied claims was requested, received and reviewed.

**2 Exceptions - 18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation;
Basis for Regulation.**

The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

Recommendation: It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5

2 Exceptions -18 Del. Admin. C. 1310 § 6.1.3 Processing of Clean Claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days pursuant to 18 Del. Admin. C. 1310 § 6.1.3.

B) ASH Denied Claims

The Company provided a list of 377 denied claims processed during the examination period of January 1, 2016 through April 30, 2018. A random sample, of 82 denied claims, was requested, received and reviewed.

The following exceptions were noted:

2 Exceptions -18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

Recommendation: It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5

2 Exceptions -18 Del. Admin. C. 1310 § 6.1.3 Processing of Clean Claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days pursuant to 18 Del. Admin. C. 1310 § 6.1.3.

C) CHLIC Denied Claims

The Company provided a list of 1,579 denied claims processed during the examination period of January 1, 2016 through April 30, 2018. A random sample, of 107 denied claims, was requested, received and reviewed.

3 Exceptions -18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

Recommendation: It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5

3 Exceptions -18 Del. Admin. C. 1310 § 6.1.3 Processing of Clean Claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days pursuant to 18 Del. Admin. C. 1310 § 6.1.3.

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D) eviCore Denied Claims

The Company provided a list of 103 denied claims processed during the examination period of January 1, 2016 through April 30, 2018. A random sample, of 76 denied claims, was requested, received and reviewed.

1 Exceptions -18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

Recommendation: It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5

3 Exceptions -18 Del. Admin. C. 1310 § 6.1.3 Processing of Clean Claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

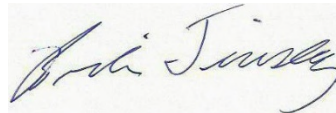
Recommendation: It is recommended that the Company specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days pursuant to 18 Del. Admin. C. 1310 § 6.1.3.

CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the Exceptions noted in the Report. Location in the Report is referenced in parenthesis.

1. *It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2. (Consumer Complaints).*
2. *It is recommended that the Company specifically inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision pursuant to 18 Del. C. § 332(c)(7). (Consumer Complaints; eviCore Grievances and Appeals)*
3. *It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. C. § 332(c)(4). (eviCore Grievances and Appeals).*
4. *It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. C. § 332(c)(5). (NAO Grievances and Appeals).*
5. *It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5 (Underwriting and Rating: ASH Paid Claims; ASH Denied Claims; CHLIC Denied Claims; eviCore Denied Claims).*
6. *It is recommended that the Company specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days pursuant to 18 Del. Admin. C. 1310 § 6.1.3. (Underwriting and Rating: ASH Paid Claims; ASH Denied Claims; CHLIC Denied Claims; eviCore Denied Claims).*

The examination conducted by Joseph Krug, Peter Salvatore, James Hartsfield and Brian Tinsley is respectfully submitted.



Brian Tinsley, AFE, MCM
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance