

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

CIGNA HEALTH AND LIFE INSURANCE COMPANY

NAIC #67369

**3111 W DR MLK JR DRIVE
TAMPA, FL, USA 33607**

As of

March 31, 2024

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 March 31, 2024 on

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

Attest By:

A handwritten signature in blue ink, appearing to read "A. Smith", written over a horizontal line.



In Witness Whereof, I have hereunto set my hand
and affixed the official seal of this Department at the
City of Dover, this 6 day of November, 2025.

A handwritten signature in blue ink, appearing to read "Trinidad Navarro", written over a horizontal line.

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
March 31, 2024

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 6 day of November, 2025.

A handwritten signature in blue ink that reads "Trinidad Navarro".

Trinidad Navarro
Insurance Commissioner

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Honorable Trinidad Navarro
Insurance Commissioner
State of Delaware
1351 West North Street
Suite 101
Dover, Delaware 19904

Dear Commissioner Navarro:

In compliance with the instructions contained in Certificate of Examination Authority Number: 67369-24-515 and pursuant to statutory provisions including 18 Delaware Code §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

Cigna Health and Life Insurance Company
NAIC #67369

This examination was performed as of March 31, 2024.

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

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

The examination was called as a follow-up to the Mental Health Parity examination that was conducted as of June 30, 2019. This examination focused on Cigna Health and Life Insurance Company (Cigna or the Company) healthcare lines in the following areas of operation: Complaint and Grievance Handling, Policyholder Services, Claims, Utilization Review, Mental Health Parity, Pharmacy Review, and the Company's relationships and oversight of contracted Pharmacy Benefit Managers (PBMs). Those exceptions that were cited in the previous exam will be indicated below. The following exceptions were noted and the details for the cited code references are included below:

- **4 Exceptions**

- **18 Del. C. § 320(c) Conduct of examination; access to records; correction.**

- *(c) Every person being examined, the person's officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination.*

Cigna failed to make documents related to the subject of the examination available for review.

- **1 Exception**

- **18 Del. C. § 2304(17) Failure to maintain complaint handling procedures.**

- *Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.*

Cigna failed to maintain a complete record of the complaint and the time it took to process the complaint as there is no indication it was completed.

- **67 Exceptions**

- **18 Del. C. § 332(c)(4) Arbitration of disputes involving health insurance coverage.**

- *(c) The Insurance Commissioner shall approve those IRPs that meet the following minimum criteria:*

- *(4) Prompt response to written grievances. — 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.*

Cigna failed to acknowledge receipt of the appeals within five business days of receipt.

- **42 Exceptions**

- **18 Del. C. § 332(c)(5)b Arbitration of disputes involving health insurance coverage.**

- That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:*

- a. 72 hours after the receipt of all necessary information relating to an emergency review;*
 - b. 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*
 - c. 45 days after the receipt of all necessary information in all other instances.*

Cigna failed to decide grievances within 30 days after receipt of all necessary information.

- **1 Exception**

- **18 Del. C. § 332(c)(8) Arbitration of disputes involving health insurance coverage.**

- (8) Manner of notice of decisions. — Written notice of the review decision shall be deposited in the mail, addressed to the last known address of the covered person. In the case of emergency reviews, the carrier shall also make reasonable efforts to notify the covered person immediately following the determination of the grievance and the written notice of determination shall be deposited in the mail, addressed to the last known address of the claimant, within 48 hours after the receipt of all information necessary to complete the review. For cases involving a denial, reduction or termination of benefits where the external review may be conducted pursuant to this section, written notice shall be mailed requesting delivery confirmation by the United State Postal Service.*

Cigna failed to deposit the expedited decision in the mail within 48 hours after the receipt of all the information necessary to complete the review.

- **6 Exceptions**

- **18 Del. Admin. C. § 1301-4.0 Notice Requirements for Appeal of a Carrier's Final Coverage Decision.**

- At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if the final coverage decision does not authorize payment of the claim in its entirety, the carrier shall provide the covered person with a written notice of the process by which a covered person may appeal the carrier's final coverage decision. The notice shall include a statement that mediation services are offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision. The notice provided to a covered person shall, at a minimum, contain the following language:*

- “You have the right to seek a review of a claim reduction or denial through the Delaware Insurance Department. The Delaware Insurance Department provides free informal mediation services which are in addition to, but do not replace, your right to a review of this decision through an external review or through the Department's*

arbitration program, as applicable. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 800-282-8611 or 302-674-7310.

Your decision to pursue mediation with the Department does not change the deadlines imposed for filing a request for an external review (set by Section 5.0 of this regulation) or arbitration (set by Regulation 1315 of Delaware Administrative Code Chapter 18, 18 DE Admin. Code 1315).

All requests for review through the Department's arbitration program must be filed with the Department within 60 days from the date you receive this carrier's notice, otherwise, this decision will be final. All requests for external review must be filed with this carrier within four months of your receipt of this final coverage decision."

Cigna failed to provide a written notice of the process for appeal by which a covered person may appeal the carrier's coverage decision.

- **6 Exceptions**

- **18 Del. Admin. C. § 1301-5.2 IHCAP Procedure.**

- *5.2 Upon receipt of an appeal, the carrier shall transmit the appeal electronically to the Department as soon as possible, but within no more than 3 business days.*

Cigna failed to transmit the appeals to the Department within 3 business days.

- **7 Exceptions**

- **18 Del. Admin. C. § 18 Del. C. § 3556A(f) Primary care coverage.**

- *(f) Coverage for chronic care management must not be subject to patient deductibles, copayments, or fees.*

Cigna subjected members to patient deductibles, copayments, or fees for the coverage of chronic care management.

- **34 Exceptions**

- **18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.**

- *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.*

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

- **3 Exceptions**

- **18 Del. Admin. C. § 1310-6.1.2 Processing of Clean Claim.**

- *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.*

Cigna failed to pay the allowable portion of claims that were deemed payable within 30 days after receipt of the claim. This was cited in the previous examination.

- **34 Exceptions**

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

- *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.*

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

- **1 Exception**

- **18 Del. C. § 3570A(b) Autism spectrum disorders coverage.**

- *(b) Coverage for applied behavior analysis services under this section by an insurer shall be subject to a maximum benefit of \$36,000 per 12-month period per person, but shall not be subject to any limits on the number of visits an individual may make to an autism services provider, or that a provider may make to an individual, regardless of the locations in which services are provided. After December 31, 2012, the Insurance*

Commissioner shall, on or before April 1 of each calendar year, publish in the Delaware Register of Regulations an adjustment to the maximum benefit equal to the change in the United States Department of Labor Consumer Price Index for all Urban Consumers (CPI-U) in the preceding year and the published adjusted maximum benefit shall be applicable to all health insurance policies issued or renewed thereafter. Payments made by an insurer on behalf of a covered individual for treatment unrelated to applied behavior analysis shall not be applied toward any maximum benefit established under this subsection.

Cigna imposed limits on the number of visits an individual may make to an autism services provider.

- **10 Exceptions**

- **18 Del. C. § 2304(16)f Unfair claim settlement practices.**

- *(16) No person shall commit or perform with such frequency as to include a general business practice any of the following:*

- *(f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.*

Cigna failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

- **12 Exceptions**

- **18 Del. C. § 2304(16)h Unfair claim settlement practices.**

- *(16) No person shall commit or perform with such frequency as to include a general business practice any of the following:*

- *h. Attempting to settle a claim for less than the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application;*

Cigna failed to correctly settle claims after deductibles had been met.

- **2 Exceptions**

- **18 Del. C. § 3571V(b) Time of submitting claim for reimbursement.**

- *(b) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.*

Cigna failed to permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement.

- **5 Exceptions**

- **18 Del. C. § 2304(16)a Unfair methods of competition and unfair or deceptive acts or practices defined.**

(16) Unfair claim settlement practices. — No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

Cigna misrepresented pertinent facts or insurance policy provisions relating to coverage(s) at issue in the Certificate(s) of Coverage.

- **7 Exceptions**

18 Del. C. § 3583(b) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

Cigna failed to issue an adverse determination and notify the covered person's health-care provider within 8 business days.

- **1 Exception**

18 Del. C. § 3583(c) Utilization Review Entity's Obligations with Respect To Pre-Authorizations In Non-Emergency Circumstances.

(c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a preauthorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

Cigna failed to issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization.

- **2 Exceptions**

18 Del. C. § 332(c)(7) Arbitration of disputes involving health insurance coverage.

(c) The Insurance Commissioner shall approve those IRPs that meet the following minimum criteria:

(7) Written notice of decisions. — 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.

Cigna failed to provide a written notice of a grievance decision within 5 days.

- **2 Exceptions**

- **18 Del. C. § 3565(d) Emergency care.**

- (d) Plans described in subsections (a) and (b) of this section shall cover:*

- (1) Any medical screening examination or other evaluation medically required to determine whether an emergency medical condition exists;*

- (2) Necessary emergency care services, including treatment and stabilization of an emergency medical condition; and*

- (3) Services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition as approved by the insurer with respect to services performed by non-network providers, provided that the insurer is required to approve or disapprove coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no case to exceed 1 hour from the time of the request.*

Cigna failed to cover the necessary emergency care services where an emergency medical condition exists.

- **9 Exceptions**

- **18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

- (a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3377 of this title.*

Cigna failed to notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization.

- **45 Exceptions***

- **18 Del. C. § 3586(a) Length of pre-authorization.**

- (a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of*

continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title and except as otherwise set by evidence-based treatment protocol.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

- **36 Exceptions**

- **18 Del. C. § 3591(a) Step therapy exception process.**

- *(a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:*

- *(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.*

- *(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.*

- *(3) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.*

- *(4) The required prescription drug is not in the best interest of the patient, based on medical necessity.*

- *(5) The patient is stable, for the medical condition under consideration, on a prescription drug selected by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.*

Cigna failed to expeditiously grant step therapy exceptions.

- **2 Exceptions**

- **18 Del. C. § 3556(i)(2) Obstetrical and gynecological coverage.**

- *(i)(2) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such*

benefits must be provided to covered individuals, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy-related benefits and include the following:

- a. Intrauterine insemination.*
- l. Medications.*

Cigna failed to provide coverage for fertility care services including medications.

- **11 Exceptions**

- **18 Del. C. § 7303 Access and prohibitions.**

- (a) Any person in the State may select the pharmacy of the person's choice as long as the pharmacy has agreed to participate in the plan according to the terms offered by the insurer.*

- (b) Any pharmacy or pharmacist has the right to participate as a contract provider under a plan or policy if the pharmacy or pharmacist agrees to accept the terms and reimbursement set forth by the insurer.*

- (f) At least 60 days prior to the effective date of any health benefit plan or renewal of any pharmacy contract network which provides for coverage of pharmacy services, including prescription drug coverage, to Delaware residents, and restricts pharmacy participation, the entity providing the health benefit plan shall provide notice to all pharmacies within the State and shall offer to the pharmacies the opportunity to participate in the health benefit plan. Such notice and offer shall be considered given upon delivery of written notice to the Delaware Pharmaceutical Society, Inc. or its successor, and upon publication of such notice in a newspaper of general circulation throughout the State. All pharmacies within the State shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The health benefit insurer shall inform the plan beneficiaries of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services.*

Cigna's Focused 90 CVS (Cigna 90 Now) network failed to permit members to use the pharmacy of the person's choice and permitted members to use only certain in-network retail pharmacies which is not in compliance with the Pharmacy Access Act. The Company confirmed that 14 plans were enrolled in Focused 90 CVS (Cigna 90 Now) during the 2022-2023 time period.

- **72 Exceptions**

- **18 Del. C. § 3578(b)(1)b Insurance coverage for serious mental illness.**

- (b) Coverage of serious mental illness and drug and alcohol dependency. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide:*

- 1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*

2. *Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all of the following:*

A. Treatment provided in residential setting.

B. Intensive outpatient programs.

C. Inpatient withdrawal management.

b. Subject to subsections (a) and (c) through (g) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan. By way of example, such terms include deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits or limits in the coverage of prescription medicines.

Cigna imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications.

Pharmacy Summaries	Exceptions
Off-Label Age Limitation on Various ADHD Formulations	8
Spravato Prior Authorization Requirements	3
Preferred brand Strategy Vyvanse IP0477	23
Preferred brand Strategy Vyvanse 1801	26
Preferred brand Strategy Vyvanse 1803	12
Total	72

- **72 Exceptions**

26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Cigna imposed more stringent terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications.

Pharmacy Summaries	Exceptions
Off-Label Age Limitation on Various ADHD Formulations	8
Spravato Prior Authorization Requirements	3
Preferred brand Strategy Vyvanse IP0477	23
Preferred brand Strategy Vyvanse 1801	26
Preferred brand Strategy Vyvanse 1803	12
Total	72

- **1 Exception**

18 Del. C. § 3578(b)(2)a Insurance coverage for serious mental illness.

(2)a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3565(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

Cigna imposed a 192 tablet per 30-day lock-out on Lucemyra, which did not allow a member to have access to an additional 5-day emergency supply of the prescribed medication, without prior authorization, due to a 30-day lockout.

- **5 Exceptions**

18 Del. C. § 3571X Medication assisted treatment for drug and alcohol dependencies.

(a) For purposes of this section, “medication-assisted treatment” means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.

(d) A health insurer shall provide benefits under this section as follows:

(1) Not impose a prior authorization requirement.

Cigna imposed a prior authorization requirement on naloxone products (naloxone, Narcan, Zimhi, Kloxxado, and Evzio) which required a physician to submit a quantity limit override (prior authorization) when a member seeks additional units of naloxone within the Company’s imposed 30-day lock-out period.

- **1 Exception**

18 Del. C. § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. — No person shall make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which:

a. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

Cigna has misrepresented the benefits, advantages, conditions, or terms of the insurance policy by asserting that “*prior authorization is not required if you have an emergency and need medication*”, while simultaneously requiring a physician to “*request a quantity limit override when an emergency supply is appropriate*” in order to circumvent the Company-imposed limit of two (2) units per 30 days on naloxone products.

- **5 Exceptions**

- **18 Del. C. § 3578(2)a Insurance coverage for serious mental illness.**

- *(2)a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3565(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.*

Cigna imposed a quantity limit of 2 units per 30-day lock out period, which did not allow members to have immediate access, without prior authorization, to an additional 5-day emergency supply of the prescribed medications (naloxone, Narcan, Zimhi, Kloxxado, or Evzio) used in drug dependencies.

- **3 Exceptions***

- **18 Del. C. § 3586(a) Length of pre-authorization.**

- *(a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title and except as otherwise set by evidence-based treatment protocol.*

Cigna limited the initial prior authorization approval to 2 months and the reauthorization approval to 6 months on Spravato based on a Treatment Resistant Depression diagnosis. This impacted one member with one approval on Spravato (IP0220 versions 1/1/22 to 8/31/22, 9/1/22 to 9/30/23 and 10/1/23 to 10/1/24), during the exam period.

- **9 Exceptions**

- **18 Del. C. § 3559 Contraceptive coverage.**

- *(a) For purposes of this section:*

- *(4) “Therapeutic equivalent” means a contraceptive drug, device, or product that is all of the following:*

- *a. Approved as safe and effective.*

- *b. Pharmaceutically equivalent to another contraceptive drug, device, or product in that it contains an identical amount of the same active drug ingredient in the same*

dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity, and identity.

c. Assigned, by the FDA, the same therapeutic equivalence code as another contraceptive drug, device, or product.

(b) Carriers shall provide coverage for contraceptive methods in all health benefit plans delivered or issued for delivery in this State. Coverage for contraceptive methods must include all of the following:

(1) All FDA-approved contraceptive drugs, devices, and other products as follows:

a. If the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section.

b. If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the health benefit plan may provide coverage for more than 1 drug, device, or other product and may impose cost-sharing requirements as long as at least 1 drug, device, or other product for that method is available without cost-sharing. If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.

(c) (1) Coverage provided under this section is not subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement, except under paragraph (b)(1) of this section or as otherwise required under federal law. Coverage offered under this section may not impose unreasonable restrictions or delays in the coverage, except that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

Cigna did not include and cover Lo Loestrin fe, Annovera, Depo sub-q Provera 104mg, Natazia, Nextstellis, Phexxi, Slynd, Twirla, and Tyblume on its formularies without cost sharing during the exam period.

- **3 Exceptions**

- **18 Del. C. § 3559(b) Contraceptive coverage.**

- *(b) Carriers shall provide coverage for contraceptive methods in all health benefit plans delivered or issued for delivery in this State. Coverage for contraceptive methods must include all of the following:*

- *(1) All FDA-approved contraceptive drugs, devices, and other products as follows:*

- *a. If the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section.*

- *b. If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the health benefit plan may provide coverage for more than 1 drug, device, or other product and may impose cost-sharing requirements as*

long as at least 1 drug, device, or other product for that method is available without cost-sharing. If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.

Cigna imposed a cost-share (deductible), when an individual's attending provider recommended a particular FDA-approved contraceptive based on a medical determination with respect to that individual.

- **199 Exceptions**

- **18 Del. C. § 3591(a) Step therapy exception process.**

(a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.

(3) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(4) The required prescription drug is not in the best interest of the patient, based on medical necessity.

(5) The patient is stable, for the medical condition under consideration, on a prescription drug selected by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.

Cigna imposed a restrictive step therapy process in their policies by failing to allow step therapy exceptions, in requiring insureds to fail an AB rated generic due to a formulation difference between the Brand and generic medication. The Company indicated there were 199 policy version(s) accounting for 401 utilization review approvals and 370 utilization review denials affecting 300 unique members that required a physician to provide evidence of an adverse event due to formulation differences.

- **1 Exception**

18 Del. C. § 3580(a)(7) Specialty tier prescription coverage.

(a) Unless otherwise specifically provided, the definitions herein apply throughout this section. (7) “Specialty drug” means a prescription drug that:

a. Is prescribed for a person with:

1. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis; or

2. A rare medical condition, defined as any disease or condition that affects fewer than 200,000 persons in the United States, or about 1 in 1,500 people, such as cystic fibrosis, hemophilia, and multiple myeloma; and

b. The total monthly cost of the prescription is \$600 or more; and

c. The drug is not stocked at a majority of retail pharmacies; and

d. The drug has 1 or more of the following characteristics:

1. It is an oral, injectable, or infusible drug product.

2. It has unique storage or shipment requirements, such as refrigeration.

3. Patients receiving the drug require education and support beyond traditional dispensing activities.

Cigna at the time the specialty designation was made, did not take steps to determine if these medications were stocked at the majority of retail pharmacies and cost less than \$600 per month.

- **17 Exceptions**

18 Del. C. § 3580(a)(7) Specialty tier prescription coverage.

(a) Unless otherwise specifically provided, the definitions herein apply throughout this section. (7) “Specialty drug” means a prescription drug that:

a. Is prescribed for a person with:

1. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis; or

2. A rare medical condition, defined as any disease or condition that affects fewer than 200,000 persons in the United States, or about 1 in 1,500 people, such as cystic fibrosis, hemophilia, and multiple myeloma; and

b. The total monthly cost of the prescription is \$600 or more; and

c. The drug is not stocked at a majority of retail pharmacies; and

d. The drug has 1 or more of the following characteristics:

1. It is an oral, injectable, or infusible drug product.

2. It has unique storage or shipment requirements, such as refrigeration.

3. Patients receiving the drug require education and support beyond traditional dispensing activities.

Cigna designated medications (Novarel, Ovidrel, Pregnyl, Profasi, Bravelle, Fertinex, Follistim, Gonal-F, Menopur, Metrodin, Pergonal, Repronex, Lupron, Synarel,

Zoladex, Antagon and Cetrotide) as specialty drugs which do not meet the definition as set forth in 18 *Del. C.* § 3580(a)(7).

- **35 Exceptions**

- **18 *Del. C.* § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.**

- *The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:*

- *(1) Misrepresentations and false advertising of insurance policies. — No person shall make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which:*

- *a. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;*

Cigna misrepresented the benefits, advantages, conditions or terms of an insurance policy by designating certain medications as specialty medications on its Preferred Drug Lists (PDLs), that do not meet the definition of specialty medications as set forth in 18 *Del. C.* § 3580(a)(7). The Company's Preferred Drug Lists state, "*Specialty medications are used to treat complex medical conditions. Some plans may limit coverage to a 30-day supply and/or require you to use a preferred specialty pharmacy to receive coverage. In this drug list, specialty medications have an asterisk (*) next to them.*"

- **122 Exceptions***

- **18 *Del. C.* § 3586(a) Length of pre-authorization.**

- *(a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title and except as otherwise set by evidence-based treatment protocol.*

Cigna's policies did not allow pre-authorizations for pharmaceuticals to be valid for 1 year from the date the health-care provider receives the pre-authorization except as otherwise set by evidence-based treatment protocol(s). There were 92 unique policies including 30 versions (122).

*During the course of the examination, the Company was made aware of all exceptions related to 18 *Del. C.* § 3586(a) Length of pre-authorization. The Company's response indicated that the errors were human errors and that there is a system override program that should have been utilized to prevent these errors. The Company, however, did not provide access to the examiners to said override program or to the instructions available to the company personnel in charge of reviewing these pre-authorizations, citing the program was protected under attorney client privilege and was therefore confidential. It is noted that instructions to reviewers and the related program are not considered attorney/client privilege without a full legal analysis and review, and failure to provide the documents requested in future exams will likely result in enhanced penalties.

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, 2022, through March 31, 2024, unless otherwise noted. The focus of the examination was to re-examine the areas where issues were identified on the previous examination dated June 30, 2019, Chapters 33 and 35, and compliance with any related, updated Delaware Code requirements.

METHODOLOGY

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

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. General practices, 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, Cigna's 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 Cigna's officials to discuss the various types of exceptions identified during the examination and review written summaries provided on the exceptions found.

COMPLAINT, GRIEVANCES, AND APPEALS HANDLING

A. Complaint Policies and Procedures

The Company was requested to provide a copy of the Consumer/Provider Complaint Handling guidelines and/or procedures during the exam period of January 1, 2022, through March 31, 2024. The Company's complaints consisted of administrative/benefit complaints, quality of care complaints, quality of service complaints, and case

management complaints through both Cigna and Evernorth Behavioral Health (a subsidiary). The Company's policies and procedures related to the handling and processing of complaints were provided and reviewed. The policies and procedures were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

B. Grievance and Appeals Policies and Procedures

The Company was requested to provide a copy of the Company's Appeals and Grievances policies and procedures during the exam period of January 1, 2022, through March 31, 2024. The Company's policies and procedures related to the handling and processing of appeals and grievances were provided and reviewed. The policies and procedures were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

C. Complaints

The Company was requested to provide a listing of all complaints filed with the Company during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 14 complaints. There were ten (10) DOI complaints and four (4) non-regulatory complaints. All 14 complaints were reviewed for compliance with the applicable Statutes and Regulations.

The Delaware Department of Insurance provided a list of complaints that were received during the examination period. The listing was reconciled with the Company's complaint listing for any discrepancies.

The following exceptions were noted:

1 Exception – 18 Del. C. § 320(c) Conduct of examination; access to records; correction.

Cigna failed to provide a copy of the resolution letter of the complaint.

Recommendation: It is recommended that the Company make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, and information relating to the subject of the examination and shall facilitate the examination as required by 18 Del. C. § 320(c).

1 Exception - 18 Del. C. § 2304(17) Failure to maintain complaint handling procedures.

Cigna failed to maintain a complete record of the complaint and the time it took to process the complaint as there is no indication it was completed.

Recommendation: It is recommended that the Company maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint as required by 18 *Del. C.* § 2304(17).

D. First Level Appeals

The Company was asked to provide a listing of all First Level Appeals during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 750 first-level appeals. A random sample of 86 first-level appeals were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

36 Exceptions – 18 *Del. C.* § 332(c)(4) Arbitration of disputes involving health insurance coverage.

Cigna failed to acknowledge receipt of the appeals within five business days of receipt.

Recommendation: It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. C.* § 332(c)(4).

25 Exceptions – 18 *Del. C.* § 332(c)(5)b Arbitration of disputes involving health insurance coverage.

Cigna failed to decide grievances within 30 days after receipt of all necessary information.

Recommendation: It is recommended that the Company decide grievances in an expeditious manner, and in any event, no more than 30 days after the receipt of all necessary information as required by 18 *Del. C.* § 332(c)(5)b.

1 Exception – 18 *Del. C.* § 332(c)(8) Arbitration of disputes involving health insurance coverage.

Cigna failed to deposit the expedited decision in the mail within 48 hours after the receipt of all the information necessary to complete the review.

Recommendation: It is recommended that the Company mail expedited decisions within 48 hours after the receipt of all information necessary to complete the review as required by 18 *Del. C.* § 332(c)(8).

1 Exception – 18 *Del. Admin. C.* § 1301-4.0 Notice Requirements for Appeal of a Carrier’s Final Coverage Decision.

Cigna failed to provide a written notice of the process for appeal by which a covered person may appeal the carrier's coverage decision.

Recommendation: It is recommended that the Company provide the covered person with a written notice of the process by which a covered person may appeal the carrier's final coverage decision as required by 18 *Del. Admin. C.* § 1301-4.0.

E. Second Level Appeals

The Company was asked to provide a listing of all Second Level Appeals during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 62 second-level appeals. All 62 second level appeals were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

25 Exceptions – 18 *Del. C.* § 332(c)(4) Arbitration of disputes involving health insurance coverage.

Cigna failed to acknowledge receipt of the appeals within five business days of receipt.

Recommendation: It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. C.* § 332(c)(4).

11 Exceptions – 18 *Del. C.* § 332(c)(5)b Arbitration of disputes involving health insurance coverage

Cigna failed to decide grievances within 30 days after receipt of all necessary information.

Recommendation: It is recommended that the Company decide grievances in an expeditious manner, and in any event, no more than 30 days after the receipt of all necessary information as required by 18 *Del. C.* § 332(c)(5)b.

H. Independent Utilization Review Organization

The Company was requested to provide a listing of all Independent Utilization Review Organizations (IUROs) filed with the Delaware Department of Insurance during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of

13 IUROs. All 13 IUROs were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

6 Exceptions - 18 Del. Admin. C. § 1301-5.2 IHCAP Procedure

Cigna failed to transmit the appeals to the Department within 3 business days.

Recommendation: It is recommended that the Company transmit appeals electronically to the Department within 3 business days as required by 18 Del. Admin. C. § 1301-5.2.

POLICYHOLDER SERVICES

The Company was asked to provide policies and procedures related to the handling and reimbursement of chronic care management, and to provide documentation related to the applicability and use of Procedure-to-Diagnosis Process (PXDX). The Company provided the time frame from how long it takes the PXDX to make a decision before it is sent to a reviewer, what the reviewer is required to review, and the length of time a reviewer spends reviewing each PXDX decision. The Company indicated they send the PXDX claims to medical directors for review within two business days. The Company was unable to provide on average how long the medical director spends reviewing the PXDX cases. The Company stated that they stopped using PXDX in December of 2023. The Company was requested to identify any other automated systems that were used in place of the PXDX for Delaware situs policies during the examination period, to which they indicated there were none. The Company provided a listing of 19 first-level appeals of PXDX claim decisions as part of the review. The policies, procedures and all 19 first level appeals were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

6 Exceptions – 18 Del. C. § 332(c)(4) Arbitration of disputes involving health insurance coverage.

Cigna failed to acknowledge receipt of the appeals within five business days of receipt.

Recommendation: It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 Del. C. § 332(c)(4).

6 Exceptions – 18 Del. C. § 332(c)(5)b Arbitration of disputes involving health insurance coverage

Cigna failed to decide grievances within 30 days after receipt of all necessary information.

Recommendation: It is recommended that the Company decide grievances in an expeditious manner, and in any event, no more than 30 days after the receipt of all necessary information as required by 18 *Del. C.* § 332(c)(5)b.

CLAIMS

A. Claims Policies and Procedures

The Company was requested to provide the policies and procedures related to the acceptance of electronic claims and procedures related to the issuance of electronic remittance advice. The Company provided a list of procedures used for the period of January 1, 2022, through March 31, 2024. The Company provided a list of 1206 procedures that were used. A random sample of 53 procedures was reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

B. Chronic Care Management Paid Claims

The Company was asked to provide a listing of all Chronic Care Management Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 120 claims paid. A random sample of 76 claims paid was reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

7 Exceptions – 18 *Del. C.* § 3556A(f) Primary care coverage.

Cigna subjected members to patient deductibles, copayments, or fees for the coverage of chronic care management.

Recommendation: It is recommended that the Company not subject members to patient deductibles, co-payments, or fees for the coverage for chronic care management as required by 18 *Del. C.* § 3556A(f)

2 Exceptions – 18 *Del. Admin. C.* § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.1.

C. Chronic Care Management Denied Claims

The Company was asked to provide a listing of all Chronic Care Management Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 16 claims denied. All 16 claims denied were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

D. Insulin Pump Paid Claims

The Company was asked to provide a listing of all Insulin Pump Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 264 claims paid. A random sample of 76 claims paid was reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

4 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

E. Insulin Pump Denied Claim

The Company was asked to provide a listing of all Insulin Pump Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 18 claims denied. All 18 claims denied were reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

3 Exceptions – 18 Del. Admin. C. § 1310-6.1.2 Processing of Clean Claim.

Cigna failed to pay the allowable portion of claims that were deemed payable within 30 days after receipt of the claim. This was cited in the previous examination.

Recommendation: It is recommended that the Company 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 within 30 days as required by 18 Del. Admin. C. § 1310-6.1.2.

1 Exception – 18 Del. Admin. C. § 1310-6.1.3 Processing of Clean Claim.

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

F. Autism Spectrum Disorder Paid Claims

The Company was asked to provide a listing of all Autism Spectrum Disorder Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 14,216 claims paid. A random sample of 109 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

7 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

1 Exception – 18 Del. C. § 3570A(b) Autism spectrum disorders coverage.

Cigna imposed limits on the number of visits an individual may make to an autism services provider.

Recommendation: It is recommended that the Company not subject the maximum benefit to any limits on the number of visits an individual may make to an autism services provider as required by 18 Del. C. § 3570A(b).

G. Autism Spectrum Disorder Denied Claims

The Company was asked to provide a listing of all Autism Spectrum Disorder Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 662 claims denied. A random sample of 83 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

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

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

7 Exceptions – 18 Del. C. § 2304(16)f Unfair claim settlement practices.

Cigna failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

H. Infertility Paid Claims

The Company was asked to provide a listing of all Infertility Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 5,315 claims paid. A random sample of 108 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

I. Infertility Denied Claims

The Company was asked to provide a listing of all Infertility Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 130 claims denied. A random sample of 76 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

6 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

J. Medical Paid Claims

The Company was asked to provide a listing of all Medical Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 996,612 claims paid. A random sample of 109 paid claims was reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

1 Exception – 18 Del. Admin. C. § 1310-6.1.3 Processing of Clean Claim.

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

1 Exception – 18 Del. C. § 2304(16)f Unfair claim settlement practices.

Cigna failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

K. Medical Denied Claims

The Company was asked to provide a listing of all Medical Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 5,315 denied claims. A random sample of 111 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

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

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

L. Mental Health Paid Claims

The Company was asked to provide a listing of all Mental Health Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 189,286 claims paid. A random sample of 109 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 2304(16)h Unfair claim settlement practices.

Cigna failed to correctly settle claims after deductibles had been met.

Recommendation: It is recommended that the Company settle claims for the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application as required by 18 Del. C. § 2304(16)h.

1 Exception – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

M. Mental Health Denied Claims

The Company was asked to provide a listing of all Mental Health Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 1,633 claims denied. A random sample of 105 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3571V(b) Time of submitting claim for reimbursement.

Cigna failed to permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement.

Recommendation: It is recommended that the Company permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement as required by 18 Del. C. § 3571V(b)

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

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

N. Substance Use Disorder Paid Claims

The Company was asked to provide a listing of all Substance Use Disorder Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 11,721 claims paid. A random sample of 108 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

10 Exceptions – 18 Del. C. § 2304(16)h Unfair claim settlement practices.

Cigna failed to correctly settle claims after deductibles had been met.

Recommendation: It is recommended that the Company settle claims for the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application as required by 18 Del. C. § 2304(16)h.

1 Exception – 18 Del. C. § 3571V(b) Time of submitting claim for reimbursement.

Cigna failed to permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement.

Recommendation: It is recommended that the Company permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement as required by 18 Del. C. § 3571V(b)

9 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

Cigna failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of clean claims. This was cited in the previous examination.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

1 Exception – 18 Del. Admin. C. § 1310-6.1.3 Processing of Clean Claim.

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

O. Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all Substance Use Disorder Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 412 claims denied. A random sample of 76 claims denied was reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

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

Cigna failed to notify a provider or policyholder in writing why claims would not be paid within 30 days. This was cited in the previous examination.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

P. Pharmacy Medical Surgical Paid Claims

The Company was asked to provide a listing of all Pharmacy Medical Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 16,567 claims paid. A random sample of 109 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

Q. Pharmacy Medical Surgical Denied Claims

The Company was asked to provide a listing of all Pharmacy Medical Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 48,951 claims denied. A random sample of 109 claims denied was reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

R. Pharmacy Mental Health Paid Claims

The Company was asked to provide a listing of all Pharmacy Mental Health Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 28,870 claims paid. A random sample of 109 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

S. Pharmacy Mental Health Denied Claims

The Company was asked to provide a listing of all Pharmacy Mental Health Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 7,898 claims denied. A random sample of 108 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

T. Pharmacy Substance Use Disorder Paid Claims

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 857 claims paid. A random sample of 86 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

U. Pharmacy Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 200 claims denied. A random sample of 76 claims denied was reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

V. Pharmacy Specialty Medication Paid Claims

The Company was asked to provide a listing of all Pharmacy Specialty Medication Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 3,803 claims paid. A random sample of 108 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

W. Pharmacy Specialty Medication Denied Claims

The Company was asked to provide a listing of all Special Medication Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 2,966 claims denied. A random sample of 108 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

5 Exceptions – 18 Del. C. § 2304(16)a Unfair methods of competition and unfair or deceptive acts or practices defined.

Cigna misrepresented pertinent facts or insurance policy provisions relating to coverage(s) at issue in the Certificate(s) of Coverage.

Recommendation: It is recommended that the Company does not misrepresent pertinent facts or insurance policy provisions relating to coverage at issue as required by 18 Del. C. § 2304(16)a.

X. Pharmacy Insulin Paid Claims

The Company was asked to provide a listing of all Pharmacy Insulin Claims Paid during the exam period of January 1, 2022, to March 31, 2024. The Company provided 1,074 claims paid. A random sample of 105 claims paid was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

Y. Pharmacy Insulin Denied Claims

The Company was asked to provide a listing of all Pharmacy Insulin Claims Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 1,493 claims denied. A random sample of 105 claims denied was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

UTILIZATION REVIEW

A. Utilization Review Policies and Procedures

The Company was requested to provide a copy of the Utilization Review Policies and Procedures that were in effect during the exam period of January 1, 2022, through March 31, 2024. The policies and procedures were related to medical necessity criteria, state and federal legislation, decision making policy, guidelines for criteria policy, timeliness of health services decisions, emergency services, prudent layperson emergency services, and peer-to-peer review. The policies and procedures were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

B. Prior Authorization Medical Surgical Approved Utilization Review

The Company was asked to provide a listing of all Medical Prior Authorization Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 591 Approved Medical Surgical Prior Authorization URs. A random sample of 116 approved URs were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

C. Prior Authorization Medical Surgical Denied Utilization Review

The Company was asked to provide a listing of all Prior Authorization Medical Denied Utilization Reviews (URs) during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 635 Denied Medical Surgical Prior Authorization URs.

A random sample of 115 denied URs was reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3583(b) Utilization review entity’s obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to issue an adverse determination and notify the covered person’s health-care provider within 8 business days.

Recommendation: It is recommended that the Company grant a pre-authorization or issue an adverse determination and notify the covered person’s health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization as required by 18 Del. C. § 3583(b).

D. Prior Authorization Mental Health Approved Utilization Review

The Company was asked to provide a listing of all Mental Health Prior Authorization Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 16 Approved Mental Health Prior Authorization URs. All 16 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

E. Prior Authorization Substance Use Disorder Approved Utilization Review

The Company was asked to provide a listing of all Substance Use Disorder Prior Authorization Utilization Reviews (URs) Approved during the exam period of January 1, 2022 to March 31, 2024. The Company provided a listing of 7 Approved SUD Prior Authorization URs. All 7 approved URs were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

F. Prior Authorization Autism Approved Utilization Review

The Company was asked to provide a listing of all Autism Prior Authorization Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 56 Approved Autism Prior Authorization URs. All 56 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

G. Prior Authorization Autism Denied Utilization Review

The Company was requested to provide a listing of all Autism Prior Authorization Utilization Reviews (URs) Denied during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 40 Denied Autism Prior Authorization URs. All 40 denied URs were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

5 Exceptions – 18 Del. C. § 3583(b) Utilization review entity’s obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to issue an adverse determination and notify the covered person’s health-care provider within 8 business days.

Recommendation: It is recommended that the Company grant a pre-authorization or issue an adverse determination and notify the covered person’s health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization as required by 18 Del. C. § 3583(b).

H. Concurrent Medical Surgical Approved Utilization Review

The Company was requested to provide a listing of all Medical Concurrent Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 2556 Approved Concurrent Medical Surgical URs. A random sample of 114 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

1 Exception – 18 Del. C. § 320(c) Conduct of examination; access to records; correction.

Cigna failed to provide a copy of the decision notification letter.

Recommendation: It is recommended that the Company make freely available to the Commissioner, or the Commissioner’s examiners, the accounts, records, documents, files, and information relating to the subject of the examination and shall facilitate the examination as required by 18 Del. C. § 320(c).

I. Concurrent Medical Surgical Denied Utilization Review

The Company was asked to provide a listing of all Medical Concurrent Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company

provided a listing of 40 Denied Concurrent Medical Surgical URs. All 40 denied URs were reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 320(c) Conduct of examination; access to records; correction.

Cigna failed to provide a copy of the decision notification letter.

Recommendation: It is recommended that the Company make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, and information relating to the subject of the examination and shall facilitate the examination as required by 18 Del. C. § 320(c).

J. Concurrent Mental Health Approved Utilization Review

The Company was requested to provide a listing of all Mental Health Concurrent Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 336 Approved Concurrent Mental Health URs. A random sample of 79 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

1 Exception – 18 Del. C. § 3583(c) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization.

Recommendation: It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization as required by 18 Del. C. § 3583(c).

K. Concurrent Mental Health Denied Utilization Review

The Company was asked to provide a listing of all Mental Health Concurrent Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 23 Denied Concurrent Mental Health URs. Three (3) URs were determined to be out-of-scope for the examination period. The remaining 20 denied URs were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

1 Exception – 18 Del. C. § 3583(b) Utilization review entity’s obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to issue an adverse determination and notify the covered person’s health-care provider within 8 business days.

Recommendation: It is recommended that the Company grant a pre-authorization or issue an adverse determination and notify the covered person’s health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization as required by 18 Del. C. § 3583(b).

L. Concurrent Substance Use Disorder Approved Utilization Review

The Company was requested to provide a listing of all Substance Use Disorder Concurrent Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 84 Approved Concurrent Substance Use Disorder URs. A random sample of 79 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

M. Concurrent Substance Used Disorder Denied Utilization Review

The Company was asked to provide a listing of all Substance Use Disorder Concurrent Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 6 Denied Concurrent Substance Use Disorder URs.. All 6 denied URs were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

N. Concurrent Autism Approved Utilization Review

The Company was asked to provide a listing of all Autism Concurrent Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 10 Approved Concurrent Autism URs. All 10 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

O. Concurrent Autism Denied Utilization Review

The Company was asked to provide a listing of all Autism Concurrent Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 5 Denied Concurrent Autism URs. All 5 denied URs were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

P. Retrospective Medical Surgical Approved Utilization Review

The Company was requested to provide a listing of all Medical Surgical Retrospective Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 1584 Approved Retrospective Medical Surgical URs. A random sample of 113 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 332(c)(7) Arbitration of disputes involving health insurance coverage.

Cigna failed to provide a written notice of a grievance decision within 5 days.

Recommendation: It is recommended that the Company provide the insured with written notice of the disposition of that grievance within 5 days after a grievance is decided as required by 18 Del. C. § 332(c)(7).

2 Exceptions – 18 Del. C. § 3565(d) Emergency care.

Cigna failed to cover the necessary emergency care services where an emergency medical condition exists.

Recommendation: It is recommended that the Company cover necessary emergency care services, including treatment and stabilization of an emergency medical condition as required by 18 Del. C. § 3565(d).

Q. Retrospective Medical Surgical Denied Utilization Review

The Company was asked to provide a listing of all Medical Surgical Retrospective Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided 1,089 Denied Retrospective Medical Surgical URs. A random sample of 113 denied URs was reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

R. Retrospective Mental Health Approved Utilization Review

The Company was requested to provide a listing of all Mental Health Retrospective Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 4 Approved Retrospective Mental

Health URs. All 4 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

S. Retrospective Mental Health Denied Utilization Review

The Company was requested to provide a listing of all Mental Health Retrospective Utilization Reviews (URs) Denied during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 1 Denied Retrospective Mental Health URs. The 1 denied UR was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

T. Retrospective Substance Use Disorder Approved Utilization Review

The Company was requested to provide a listing of all Substance Use Disorder Retrospective Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 1 Approved Retrospective Substance Use Disorder UR. The 1 approved UR was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

U. Retrospective Autism Approved Utilization Review

The Company was requested to provide a listing of all Autism Retrospective Utilization Reviews (URs) Approved during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 11 Approved Retrospective Autism URs. All 11 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

V. Retrospective Autism Denied Utilization Review

The Company was requested to provide a listing of all Autism Retrospective Utilization Reviews (URs) Denied during the exam period of January 1, 2022, through March 31, 2024. The Company provided a listing of 5 Denied Retrospective Autism URs. All 5 denied URs were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

W. Pharmacy Medical Surgical Approved Utilization Review

The Company was asked to provide a listing of all Pharmacy Medical Surgical Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 1233 Approved Pharmacy Medical Surgical URs. A random sample of 86 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3583(a) Utilization review entity’s obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to notify the covered person’s health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person’s health-care provider within 2 business days of obtaining a clean pre-authorization required by 18 Del. C. § 3583(a).

4 Exceptions – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 Del. C. § 3586(a).

X. Pharmacy Medical Surgical Denied Utilization Review

The Company was asked to provide a listing of all Pharmacy Medical Surgical Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 453 Denied Pharmacy Medical Surgical URs. A random sample of 84 denied URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

4 Exceptions – 18 Del. C. § 3583(a) Utilization review entity’s obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to notify the covered person’s health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization required by 18 *Del. C.* § 3583(a).

2 Exceptions – 18 *Del. C.* § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

22 Exceptions – 18 *Del. C.* § 3591(a) Step therapy exception process.

Cigna failed to expeditiously grant step therapy exceptions.

Recommendation: It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 *Del. C.* § 3591(a).

2 Exceptions – 18 *Del. C.* § 2304(16)f Unfair methods of competition and unfair or deceptive acts or practices defined

Cigna failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)f.

2 Exceptions – 18 *Del. Admin. C.* § 1301-4.0 Notice Requirements for Appeal of a Carrier's Final Coverage Decision.

Cigna failed to provide a written notice of the process for appeal by which a covered person may appeal the carrier's coverage decision.

Recommendation: It is recommended that the Company provide the covered person with a written notice of the process by which a covered person may appeal the carrier's final coverage decision as required by 18 *Del. Admin. C.* § 1301-4.0.

Y. Pharmacy Mental Health Approved Utilization Review

The Company was asked to provide a listing of all Pharmacy Mental Health Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024.

The Company provided a listing of 12 Approved Pharmacy Mental Health URs. All 12 approved URs were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 Del. C. § 3586(a).

Z. Pharmacy Mental Health Denied Utilization Review

The Company was asked to provide a listing of all Pharmacy Mental Health Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 4 Denied Pharmacy Mental Health URs. All 4 denied URs were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3591(a) Step therapy exception process.

Cigna failed to expeditiously grant step therapy exceptions.

Recommendation: It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 Del. C. § 3591(a).

1 Exception – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 Del. C. § 3586(a).

AA. Pharmacy Insulin Approved Utilization Review

The Company was asked to provide a listing of all Pharmacy Insulin Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The

Company provided a listing of 5 Pharmacy Approved Insulin utilization reviews. All 5 approved URs were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

BB. Pharmacy Insulin Denied Utilization Review

The Company was asked to provide a listing of all Pharmacy Insulin Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 5 Denied Pharmacy Insulin URs. All 5 denied URs were reviewed for compliance with applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 3591(a) Step therapy exception process.

Cigna failed to expeditiously grant step therapy exceptions.

Recommendation: It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 Del. C. § 3591(a).

CC. Pharmacy Specialty Approved Utilization Review

The Company was asked to provide a listing of all Specialty Pharmacy Utilization Reviews (URs) Approved during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 1,233 Approved Specialty Pharmacy URs. A random sample of 79 approved URs was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization required by 18 Del. C. § 3583(a).

34 Exceptions – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 Del. C. § 3586(a).

DD. Pharmacy Specialty Denied Utilization Review

The Company was asked to provide a listing of all Specialty Pharmacy Utilization Reviews (URs) Denied during the exam period of January 1, 2022, to March 31, 2024. The Company provided a listing of 46 Denied Specialty Pharmacy URs. All 46 denied URs were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 3556(i)(2) Obstetrical and gynecological coverage.

Cigna failed to provide coverage for fertility care services including medications.

Recommendation: It is recommended that the Company provide medical or hospital expenses related to coverage for fertility care services, including in vitro fertilization services as required by 18 Del. C. § 3556(i)(2).

2 Exceptions – 18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

Cigna failed to notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization required by 18 Del. C. § 3583(a).

3 Exceptions – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. This was cited in the previous examination.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

11 Exception – 18 *Del. C.* § 3591(a) Step therapy exception process.

Cigna failed to expeditiously grant step therapy exceptions.

Recommendation: It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 *Del. C.* § 3591(a).

3 Exceptions – 18 *Del. Admin. C.* § 1301-4.0 Notice Requirements for Appeal of a Carrier’s Final Coverage Decision.

Cigna failed to provide a written notice of the process for appeal by which a covered person may appeal the carrier's coverage decision.

Recommendation: It is recommended that the Company provide the covered person with a written notice of the process by which a covered person may appeal the carrier's final coverage decision as required by 18 *Del. Admin. C.* § 1301-4.0.

MENTAL HEALTH PARITY

The Company was requested to provide a copy of the current, up to date Mental Health Parity and Addiction Equity Act report during the exam period of January 1, 2022, through March 31, 2024. The report was to include a description of the process used to develop or select the medical necessity criteria for mental illness and drug and alcohol dependencies benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

A. Non-Pharmacy Non-Quantitative Treatment Limitations Review

The report identified all non-quantitative treatment limitations (NQTLs) that are applied to mental illness, and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits. The Company identified the following NQTLs, Medical Necessity, Prior Authorization, Concurrent Review, Retrospective Review, and Emergency Services. The Company provided a copy of the results of the analysis that demonstrates that the medical necessity criteria and NQTLs identified, as written and in operation were comparable.

The MHPAEA Report and NQTL analyses were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

B. Pharmacy Non-Quantitative Treatment Limitations Review

The report identified all non-quantitative treatment limitations (NQTLs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits. The report consisted of Prior Authorization, Step Therapy, Quantity Limits, Non-Formulary, and Formulary Design. The NQTL analyses were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

PHARMACY REVIEW

The Company was requested to provide the written utilization management (UM) and/or drug utilization review (DUR) policies including all versions, Pharmacy and Therapeutics (P&T) Committee meeting minutes, formularies, formulary changes, step therapy protocols, and included multiple information requests. The Company's documentation was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

11 Exceptions - 18 Del. C. § 7303 Access and prohibitions.

Cigna's Focused 90 CVS (Cigna 90 Now) network failed to permit members to use the pharmacy of the person's choice and permitted members to use only certain in-network retail pharmacies which is not in compliance with the Pharmacy Access Act. The Company confirmed that 14 plans were enrolled in Focused 90 CVS (Cigna 90 Now) during the 2022-2023 time period.

Recommendation: It is recommended that the Company allow members to select the pharmacy of the person's choice and allow any pharmacy or pharmacist the right to participate as a contract provider as required by 18 Del. C. § 7303.

8 Exceptions - 18 Del. C. § 3578(b)(1)b Insurance coverage for serious mental illness

Cigna more stringently applied prior authorization approval criteria on ADHD medications (chewable tablets, suspensions, and orally disintegrating tablets) such as an off-label age limitation (i.e. Individual is less than age 13) from 1/1/2022 to 1/1/2023 compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

8 Exceptions – 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

Cigna more stringently applied prior authorization approval criteria on ADHD medications (chewable tablets, suspensions, and orally disintegrating tablets) such as an off-label age limitation (i.e. Individual is less than age 13) from 1/1/2022 to 1/1/2023 compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i).

1 Exception - 18 Del. C. § 3578(b)(2)a Insurance coverage for serious mental illness

Cigna imposed a 192 tablet per 30-day lock-out on Lucemyra, which did not allow a member to have access to an additional 5-day emergency supply of the prescribed medication, without prior authorization, due to a 30-day lockout.

Recommendation: It is recommended that the Company provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications as required by 18 Del. C. § 3578(b)(2)a.

5 Exceptions – 18 Del. C. § 3571X Medication assisted treatment for drug and alcohol dependencies.

Cigna imposed a prior authorization requirement on naloxone products (naloxone, Narcan, Zimhi, Kloxxado, and Evzio) which required a physician to submit a quantity limit override (prior authorization) when a member seeks additional units of naloxone within the Company's imposed 30-day lock-out period.

Recommendation: It is recommended that the Company do not impose prior authorization requirements on medication-assisted treatments as required by 18 Del. C. § 3571X.

1 Exception – 18 Del. C. § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.

Cigna has misrepresented the benefits, advantages, conditions, or terms of the insurance policy by asserting that “*prior authorization is not required if you have an emergency and need medication*”, while simultaneously requiring a physician to “*request a quantity limit override when an emergency supply is appropriate*” in order to circumvent the Company-imposed limit of two (2) units per 30 days on naloxone products.

Recommendation: It is recommended that the Company not issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which misrepresents the benefits, advantages, conditions or terms of any insurance as required by 18 Del. C. § 2304(1)a.

5 Exceptions – 18 Del. C. § 3578(2)a Insurance coverage for serious mental illness.

Cigna imposed a quantity limit of 2 units per 30-day lock out period, which did not allow members to have immediate access, without prior authorization, to an additional 5-day emergency supply of the prescribed medications (naloxone, Narcan, Zimhi, Kloxxado, or Evzio) used in drug dependencies.

Recommendation: It is recommended that the Company provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications as required by 18 Del. C. § 3578(2)a.

3 Exceptions - 18 Del. C. § 3578(b)(1)b Insurance coverage for serious mental illness

Cigna had more stringently applied prior authorization approval duration requirements on Spravato (IP0220 versions 1/1/22 to 8/31/22, 9/1/22 to 9/30/23 and 10/1/23 to 10/1/24), which is a mental health medication, compared to MED/SURG medications. This impacted one member with one approval on Spravato during the exam period.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

3 Exceptions – 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company had more stringently applied prior authorization approval duration requirements on Spravato (IP0220 versions 1/1/22 to 8/31/22, 9/1/22 to 9/30/23 and 10/1/23 to 10/1/24), which is a mental health medication, compared to MED/SURG medications. This impacted one member with one approval on Spravato during the exam period.

Recommendation: It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i).

3 Exceptions – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna limited the initial prior authorization approval to 2 months and the reauthorization approval to 6 months on Spravato based on a Treatment Resistant Depression diagnosis. This impacted one member with one approval on Spravato (IP0220 versions 1/1/22 to 8/31/22, 9/1/22 to 9/30/23 and 10/1/23 to 10/1/24), during the exam period.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

9 Exceptions – 18 *Del. C.* § 3559 Contraceptive coverage.

Cigna did not include and cover Lo Loestrin fe, Annovera, Depo sub-q Provera 104mg, Natazia, Nextstellis, Phexxi, Slynd, Twirla, and Tyblume on its formularies without cost sharing during the exam period.

Recommendation: It is recommended that the Company include at least 1 contraceptive drug, device, or product in its formulary without cost-sharing as required by 18 *Del. C.* § 3559.

3 Exceptions – 18 *Del. C.* § 3559(b) Contraceptive coverage.

Cigna imposed a cost-share (deductible), when an individual's attending provider recommended a particular FDA-approved contraceptive based on a medical determination with respect to that individual.

Recommendation: It is recommended that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing as required by 18 *Del. C.* § 3559(b).

199 Exceptions – 18 *Del. C.* § 3591(a) Step therapy exception process.

Cigna imposed a restrictive step therapy process in their policies by failing to allow step therapy exceptions, in requiring insureds to fail an AB rated generic due to a formulation difference between the Brand and generic medication. The Company indicated there were 199 policy version(s) accounting for 401 utilization review approvals and 370 utilization review denials affecting 300 unique members that required a physician to provide evidence of an adverse event due to formulation differences.

Recommendation: It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 *Del. C.* § 3591(a).

23 Exceptions - 18 *Del. C.* § 3578(b)(1)b Insurance coverage for serious mental illness

Cigna more stringently applied a preferred brand strategy on Vyvanse as part of the step therapy process before approval of a target medication based on The Drug and Biologic Coverage Policy Attention Deficit Hyperactivity Disorder (ADHD) Stimulants IP0477 policy from 1/1/2023 to 9/14/2023 compared to MED/SURG medication step therapy strategies.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b.

23 Exceptions – 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

Cigna more stringently applied a preferred brand strategy on Vyvanse as part of the step therapy process before approval of a target medication based on The Drug and Biologic Coverage Policy Attention Deficit Hyperactivity Disorder (ADHD) Stimulants IP0477 policy from 1/1/2023 to 9/14/2023 compared to MED/SURG medication step therapy strategies.

Recommendation: It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

26 Exceptions - 18 *Del. C.* § 3578(b)(1)b Insurance coverage for serious mental illness

Cigna more stringently applied a preferred brand strategy on Vyvanse and Mydayis as part of the step therapy process before approval of a target medication based on the Drug and Biologic Coverage Policy Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) Coverage Policy Number 1801 from 2/20/2023 to 3/31/2024 compared to MED/SURG medication step therapy strategies.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b.

26 Exceptions – 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

Cigna more stringently applied a preferred brand strategy on Vyvanse and Mydayis as part of the step therapy process before approval of a target medication based on the Drug and Biologic Coverage Policy Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) Coverage Policy Number 1801 from 2/20/2023 to 3/31/2024 compared to MED/SURG medication step therapy strategies.

Recommendation: It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

12 Exceptions - 18 Del. C. § 3578(b)(1)b Insurance coverage for serious mental illness

Cigna more stringently applied a preferred brand strategy on Vyvanse and Mydayis as part of the step therapy process before approval of a target medication based on the Drug and Biologic Coverage Policy Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) Coverage Policy Number 1803 from 2/20/2023 to 3/31/2024 when compared to MED/SURG medication preferred brand step therapy strategies.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

12 Exceptions – 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

Cigna more stringently applied a preferred brand strategy on Vyvanse and Mydayis as part of the step therapy process before approval of a target medication based on the Drug and Biologic Coverage Policy Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) Coverage Policy Number 1803 from 2/20/2023 to 3/31/2024 when compared to MED/SURG medication preferred brand step therapy strategies.

Recommendation: It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 C.F.R. § 54.9812-1(c)(4)(i), 29 C.F.R. § 2590.712(c)(4)(i), 45 C.F.R. § 146.136(c)(4)(i).

1 Exception – 18 Del. C. § 3580(a)(7) Specialty tier prescription coverage.

Cigna at the time the specialty designation was made, did not take steps to determine if these medications were stocked at the majority of retail pharmacies and cost less than \$600 per month.

Recommendation: It is recommended that the Company does not designate medications as specialty drugs which do not meet the definition of a specialty drug pursuant to 18 Del. C. § 3580(a)(7).

17 Exception – 18 Del. C. § 3580(a)(7) Specialty tier prescription coverage.

Cigna designated medications (Novarel, Ovidrel, Pregnyl, Profasi, Bravelle, Fertilinex, Follistim, Gonal-F, Menopur, Metrodin, Pergonal, Repronex, Lupron, Synarel, Zoladex, Antagon and Cetrotide) as specialty drugs which do not meet the definition as set forth in 18 Del. C. § 3580(a)(7).

Recommendation: It is recommended that the Company does not designate medications as specialty drugs which do not meet the definition of a specialty drug pursuant to 18 Del. C. § 3580(a)(7).

35 Exceptions – 18 Del. C. § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.

Cigna misrepresented the benefits, advantages, conditions or terms of an insurance policy by designating certain medications as specialty medications on its Preferred Drug Lists (PDLs), that do not meet the definition of specialty medications as set forth in 18 Del. C. § 3580(a)(7). The Company’s Preferred Drug Lists state, “*Specialty medications are used to treat complex medical conditions. Some plans may limit coverage to a 30-day supply and/or require you to use a preferred specialty pharmacy to receive coverage. In this drug list, specialty medications have an asterisk (*) next to them.*”

Recommendation: It is recommended that the Company not issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which misrepresents the benefits, advantages, conditions or terms of any insurance as required by 18 Del. C. § 2304(1)a.

122 Exceptions – 18 Del. C. § 3586(a) Length of Pre-Authorization.

Cigna’s policies did not allow pre-authorizations for pharmaceuticals to be valid for 1 year from the date the health-care provider receives the pre-authorization except as otherwise set by evidence-based treatment protocol(s). There were 92 unique policies including 30 versions (122).

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 Del. C. § 3586(a).

PHARMACY REBATES

The Company was asked to provide a Pharmacy Rebates received in 2022 and 2023. The Company received \$2,428,582 in 2022 and \$3,871,291 in 2024 for the state of Delaware. The Company also provided the annual statements for 2022 and 2023 and supplemental pages regarding Healthcare. The Company does not pay the rebate back to the policyholders. The Company stated that 100% of the expected rebates are used to reduce net pharmacy claims reported on the annual statement. The Examiners were able to verify the reporting in the annual statements. The rebates and how the rebates were used were reviewed to applicable Statutes and Regulations.

There were no exceptions noted.

CONCLUSION

As stated in the Scope of Examination section, the purpose of the examination was to determine compliance by Cigna Health and Life Insurance Company with applicable insurance laws and regulations related to the healthcare lines.

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 make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, and information relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c). (Complaint, Grievances and Appeals Handling)(Utilization Review).
2. It is recommended that the Company maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint as required by 18 *Del. C.* § 2304(17). (Complaint, Grievances and Appeals Handling).
3. It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. C.* § 332(c)(4). (Complaint, Grievances and Appeals Handling)(Policyholder Services).
4. It is recommended that the Company decide grievances in an expeditious manner, and in any event, no more than 30 days after the receipt of all necessary information as required by 18 *Del. C.* § 332(c)(5)b. (Complaint, Grievances and Appeals Handling)(Policyholder Services).
5. It is recommended that the Company mail expedited decisions within 48 hours after the receipt of all the information necessary to complete the review as required by 18 *Del. C.* § 332(c)(8). (Complaint, Grievances and Appeals Handling).
6. It is recommended that the Company provide the covered person with a written notice of the process by which a covered person may appeal the carrier's final coverage decision as required by 18 *Del. Admin. C.* § 1301-4.0. (Complaint, Grievances and Appeals Handling)(Utilization Review).
7. It is recommended that the Company transmit appeals electronically to the Department within 3 business days as required by 18 *Del. Admin. C.* § 1301-5.2. (Complaint, Grievances and Appeals Handling).

8. It is recommended that the Company not subject members to patient deductibles, co-payments, or fees for the coverage for chronic care management as required by 18 *Del. C.* § 3556A(f). (Claims).
9. It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.1. (Claims).
10. It is recommended that the Company 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 within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.2. (Claims).
11. It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.3. (Claims).
12. It is recommended that the Company not subject the maximum benefit to any limits on the number of visits an individual may make to an autism services provider as required by 18 *Del. C.* § 3570A(b). (Claims).
13. It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)f. (Claims)(Utilization Review).
14. It is recommended that the Company settle claims for the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application as required by 18 *Del. C.* § 2304(16)h. (Claims).
15. It is recommended that the Company permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement as required by 18 *Del. C.* § 3571V(b). (Claims).
16. It is recommended that the Company does not misrepresent pertinent facts or insurance policy provisions relating to coverage at issue as required by 18 *Del. C.* § 2304(16)a. (Claims).
17. It is recommended that the Company grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization as required by 18 *Del. C.* § 3583(b). (Utilization Review).

18. It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization as required by 18 *Del. C.* § 3583(c). (Utilization Review).
19. It is recommended that the Company provide the insured with written notice of the disposition of that grievance within 5 days after a grievance is decided as required by 18 *Del. C.* § 332(c)(7). (Utilization Review).
20. It is recommended that the Company cover necessary emergency care services, including treatment and stabilization of an emergency medical condition as required by 18 *Del. C.* § 3565(d). (Utilization Review).
21. It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization required by 18 *Del. C.* § 3583(a). (Utilization Review).
22. It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a). (Utilization Review)(Pharmacy Review).
23. It is recommended that the Company expeditiously grant step therapy exception determinations as required by 18 *Del. C.* § 3591(a). (Utilization Review) (Pharmacy Review).
24. It is recommended that the Company provide medical or hospital expenses related to coverage for fertility care services, including in vitro fertilization services as required by 18 *Del. C.* § 3556(i)(2). (Utilization Review).
25. It is recommended that the Company allow members to select the pharmacy of the person's choice and allow any pharmacy or pharmacist the right to participate as a contract provider as required by 18 *Del. C.* § 7303. (Pharmacy Review).
26. It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b. (Pharmacy Review).
27. It is recommended that the Company not impose more stringent terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i). (Pharmacy Review).

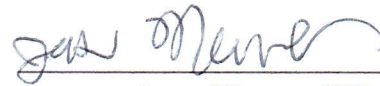
28. It is recommended that the Company provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications as required by 18 *Del. C.* § 3578(b)(2)a. (Pharmacy Review).
29. It is recommended that the Company not impose prior authorization requirements on medication-assisted treatments as required by 18 *Del. C.* § 3571X. (Pharmacy Review).
30. It is recommended that the Company not issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which misrepresents the benefits, advantages, conditions or terms of any insurance as required by 18 *Del. C.* § 2304(1)a. (Pharmacy Review).
31. It is recommended that the Company provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that include immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications as required by 18 *Del. C.* § 3578(2)a. (Pharmacy Review).
32. It is recommended that the Company include at least 1 contraceptive drug, device, or product in its formulary without cost-sharing as required by 18 *Del. C.* § 3559. (Pharmacy Review).
33. It is recommended that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing as required by 18 *Del. C.* § 3559(b). (Pharmacy Review).
34. It is recommended that the Company does not designate medications as specialty drugs which do not meet the definition of a specialty drug pursuant to 18 *Del. C.* § 3580(a)(7). (Pharmacy Review).

The examination conducted by Joseph Krug, Jason Nemes, Peter Salvatore, Gwendolyn Douglas, Michael Vogel, Kirk Stephan, and Jeffrey Smith is respectfully submitted.



Jason Nemes, CIE, MCM
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance

I, Jason Nemes, hereby verify and attest, under penalty of perjury, that the above is a true and correct copy of the examination report and findings submitted to the Delaware Department of Insurance pursuant to examination authority 67369-24-515.



Jason Nemes, CIE, MCM