

STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

CIGNA HealthCare of Maine, Inc.

**900 Cottage Grove Road
Hartford, CT 06152-0001**

NAIC Number: 95447

October 20, 2011

**EXAMINATION REPORT PREPARED BY INDEPENDENT
CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE**

Pursuant to Title 24-A M.R.S.A. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of CIGNA Healthcare of Maine, Inc. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.



Honorable Eric A. Cioppa
Superintendent
Maine Bureau of Insurance

10/28/11
Date

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October, 24 2011

Mr. Eric A. Cioppa,
Superintendent of Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Cioppa:

Pursuant to Title 24-A MRSA§ 221(5), a targeted Market Conduct examination (the Examination) of selected focus areas including complaint handling, appeals, policyholder services, provider network, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

CIGNA Healthcare of Maine, Inc.

CIGNA Healthcare of Maine, Inc.'s (CIGNA or the Company)'s records were examined at the Company's offices located in Eden Prairie, Minnesota.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of Examination of CIGNA Healthcare of Maine, Inc. is, herewith, respectfully submitted.

A handwritten signature in cursive script, appearing to read "Barry Cukels".

RSM McGladrey, Inc.
Independent Market Conduct Examiner

SECTION I – EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) is conducting a targeted market conduct Examination of CIGNA to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those received by a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination includes but is not limited to the following:

1. Test the Company's processes to ensure that the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the insurer's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process, and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with the Company's representatives were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, workplan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the Agreement to Purchase Services (the Agreement). Rider A also establishes the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used statistically valid random samples where appropriate for the areas tested. Also, where applicable and consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted findings regarding the Company's claims, pre-authorizations, utilization review and appeals handling practices. The issues identified during the Examination are noted below in order of priority:

Finding #1

The Examiners identified ten (10) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A. § 2436-1A of the Maine Insurance Code concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. 24-A M.R.S.A. § 2436-1A stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. In four(4) of 10 possible violations noted above, the Company's failure to adjudicate the identified claims within the 30 day timeframe is the result of the Company's internal workflow, wherein claims are not timely or effectively transferred between Cigna Health Care (CHC) and Cigna Behavioral Health (CBH).

Finding # 2

The Examiners identified seven (7) of 130 denied and zero paid claims as possible violations of 24-A M.R.S.A. § 2436 (3) concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. This Code section stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. If the Company fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 ½% per month after the due date.

Finding # 3

The Examiners identified that the Company's Maine Administrative First Level Non-Medical Necessity appeal acknowledgement letter does not fully comply with Rule 850, § 9 C(1), which states in part that the aggrieved party must be advised that they have the right to submit written material to the reviewer. The Examiners noted that the letter does not include this disclosure. Follow up with the Company determined that this issue pertains to the Maine first level non-medical necessity appeal acknowledgement letter in use and as such this matter may be deemed as a general business practice.

Finding # 4

The Examiners identified six (6) of 41 First Level appeals as a possible violation of Rule 850, § 9 C (b) (vii), wherein the Company's First Level appeal decision letters were noncompliant regarding disclosure of Second Level appeals.

Finding # 5

The Examiners identified three (3) of 41 First Level appeals as a possible violation of 24-A M.R.S.A. § 4312 (3), wherein the Company's adverse decision letter does not contain the required disclosure regarding external review rights.

Finding # 6

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, Section 7 (D) (1), wherein the Company failed to make a determination regarding the authorization of services in a timely manner.

Finding # 7

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, Section 8 (A), wherein the Company did not demonstrate consistent oversight of their utilization review (UR) program.

Finding # 8

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of 24-A M.R.S.A. § 4304 (2), wherein the Company failed to notify the provider of the determination within two business days of the authorization request.

Finding # 9

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, § 8 (E) (2), wherein the Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information.

Finding # 10

The Examiners identified three (3) of five (5) Second Level appeals as a possible violation of Rule 850, § 9 D (3) (a), wherein the Company did not give the member the required 15 business days advance notice of the hearing.

Finding # 11

The Examiners identified two (2) of the five (5) Second Level appeals as a possible violation of Rule 850, § 9 D (3) (f), wherein the Company's second level appeal adverse determination notice did not state the reviewer's understanding of the issue.

Finding # 12

The Examiners identified eight (8) of 41 First Level appeals as a possible violation of Rule 850, § 9 C (1), which in part requires that the health carrier advise the covered person of their first level appeal rights and the name and phone number of the person handling the matter within 3 working days of receiving a grievance. In five (5) instances, the Company did not send the notice within three (3) business days; and in three (3) instances, the Company did not send the notice.

SECTION II – SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of the Maine Insurance Code, 24-A M.R.S.A. §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act and Bureau of Insurance Rule Chapters 191 and 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All

unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

RSM McGladrey, Inc. personnel participated in this Examination in their capacity as market conduct examiners. RSM McGladrey, Inc. provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III – COMPANY PROFILE

CIGNA, a wholly-owned subsidiary of CIGNA Health Corporation, domiciled in Maine, was purchased from Healthsource, Inc. in June 1997. During the period of the Examination, CIGNA was authorized to transact the business of a health maintenance organization (HMO) under 24-A M.R.S.A. Ch. 56.

CIGNA uses CBH for behavioral care management. CBH is a wholly-owned subsidiary of Connecticut General Corporation (CGC) and CGC is a wholly-owned subsidiary of CIGNA Corp. CBH was founded in 1974 and is based in Eden Prairie, Minnesota.

CBH arranges for the provision of behavioral health care services to individuals through its network of participating behavioral health care providers, offers behavioral health care management services, employee assistance programs and work/life programs to employer sponsored benefit plans. CBH contracts with mental health and substance abuse facilities and licensed, independent providers to complete its network. Providers include psychiatrists; psychologists; master's level social workers; marriage, family, and child counselors; and substance abuse specialists.

SECTION IV – EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed statistically valid samples, where applicable, to review and test specific attributes associated with policies that were marketed and sold to State of Maine residents. These populations included large group policies, small group policies with more than 20 covered employees, and State of Maine employee plan and city and local governmental plans. Also, where applicable, the samples included individual policies and groups with 20 or fewer employees for which the policyholders had elected mental health parity. Administrative services business, with the exception of the State of Maine employee plan, was excluded from the sample testing. The Examiner's sampling methodology was reviewed and approved by the Bureau.

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the Period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.
- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, pre-authorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- The population of denied and zero-paid claims which had a primary, secondary or tertiary behavioral health diagnosis.
- Claim related policies and procedures.

Additionally, the Examiners received training related to the Company's claim handling and processing systems.

In response to the Examiners' requests, the Company provided a population of 13,704 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a random sample of 130 denied and zero-paid claims using a 95% confidence level.

The Examiners also conducted interviews with Company representatives and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of utilization review (URs) and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed, as well as the disposition of the claim as a result of the UR.
- A listing of all UR requests that were denied during the Period. A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

In response to the Examiners' data requests, the Company provided the requested documentation and a population of fifty-four (54) URs performed during the Period. All fifty-four URs were for behavioral health services that had a partial or full denial of coverage. The Examiners tested each of the fifty-four (54) URs.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.
- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider relations specialists in the Company and their authorization levels for approving behavioral health-related services.

The Examiners identified twenty six (26) denied pre-authorization requests through a review of data provided by the Company. The Company provided the requested documentation for the denied pre-authorization requests, which the Examiners tested.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The Examiners also requested the related policies and procedures the Company had in place for the Period. Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the State of Maine.
- A listing of training to educate the specialists on the Company's policies and procedures.
- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.
- The Company's definition of a complaint as applied to complaints relating to residents of the State of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiners' data request, the Company provided the requested documentation and a listing of eight (8) behavioral health complaints received during the Period. The Examiners tested all eight complaints.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Examiners confirmed that the Company maintained a complaint log for the Period and identified 102 pharmacy-related complaints. Of the 102 pharmacy-related complaints, the Examiners tested forty three (43) pharmacy complaints for compliance with the State of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests.

Appeals and Grievances

- Written policy and procedures for processing First and Second Level appeals and grievances for residents of the State of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.
- The Company's definition of appeals and grievances as applied to those received in connection with residents of the State of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

The Examiners identified forty-six (46) appeals (including administrative and clinical levels I and II) through a review of information provided by the Company. The Company provided the requested documentation for the appeals, which the Examiners tested. The Examiners tested all forty-six appeals in the population.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, complaints and appeals relating to claims or requests for authorizations for services denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and State of Maine).
- Written policies and procedures provided to and used by the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges (the Charges).
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.

- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the State of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.
- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners reviewed a random sample of 43 claims from the 130 denied and zero-paid claim sample and compared the network status on the date of service to the Company listing of providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the State of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain CIGNA functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V – RESULTS OF THE EXAMINATION

The Examination identified one (1) potential business practice violation and fifty-one (51) potential individual violations of Maine insurance laws. In addition, other findings were noted regarding inconsistencies with the Company's policies and procedures or represent the Examiner's observations for possible improvements in the Company's practices. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The testing of a sample of 130 denied and zero-paid claims included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing. The Examiners determined that during the Period, the Company did not impose any more restrictive filing requirements on providers who filed behavioral health related claims when compared to medical claim submissions.

Testing identified potential violations regarding two (2) Maine statutes. The Maine statutes and the exceptions noted are as follows:

1. 24-A M.R.S.A. § 2436 (1-A) states:

1-A. Claimant, including a health care provider, may submit simultaneously a claim for payment with all carriers potentially liable for payment of the claim whether primary or secondary. Payment or denial of a claim by each carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim whether or not another carrier with which it is attempting to coordinate has acted on the claim.

Any payment made must be in accordance with rules adopted by the superintendent relative to coordination of benefits.

The Company failed to adjudicate ten (10) of the 130 denied and zero-paid claims, or 7.7%, within 30 days. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2436 (1-A)	The Company failed to adjudicate the claims within 30 days as required by Maine Statutes.	10	7.7%
TOTAL		10	7.7%

2. 24-A M.R.S.A. § 2436(3) states:

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 ½% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a healthcare provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, Chapter 375, subchapter 2-A.

The Company failed to pay late payment interest for seven (7) of the 130 denied and zero-paid claims, or 5.4%. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2436 (3)	The Company failed to pay late payment interest when the claims were not processed within 30 days.	7	5.4%
TOTAL		7	5.4%

Utilization Review and Pre-Authorization

Utilization Review

The Examiners tested the population of fifty-four (54) UR files the Company previously denied. Testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that UR denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified twenty eight (28) UR files that were denied by the Company due to not meeting the medical necessity criteria as defined by the Company. Further, the claims were not overturned through the Company's appeal process. The complete files as provided by the Company were reviewed and referred for peer-to-peer review.

In one (1) instance, the peer to peer review did not agree with the decision made by the Company.

Pre-Authorization

The Examiners tested the population of twenty-six (26) Pre-Authorization requests, which were denied by the Company. Also, the testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's policies and procedures.

Through the testing, the Examiners identified three (3) potential violations of four (4) Maine statutes. The Maine statutes and rules and the exceptions noted are as follows:

1. Rule 850, Section 7(D)(1) reads in part:

Section 7. Access To Services

In addition to the requirements of Title 24-A, Chapter 56 or otherwise required by rule a carrier offering a managed care plan is subject to the requirements of this Section.

D. Timely Access to Health Care Services

- 1) *Health care services shall be made accessible by carriers offering managed care plans to their enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.*

Three (3) of the twenty-six (26) pre-authorization, or 11.7%, involved requests wherein the Company failed to make a determination on a timely basis as required by the referenced statute. The errors are explained below:

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Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 7 (D) (1)	CHC received a pre-authorization request on April 1, 2005. CHC asked the PCP to contact CBH. CBH received the call from the PCP on 4/6/05. CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On April 15, 2005, CHC contacted the PCP and on April 18, 2005, the pre-authorization request to perform a neuropsychological evaluation of the patient was approved. The Company failed to make a determination regarding the authorization of services in a timely manner.	1	3.9%
Rule 850, § 7 (D) (1)	CBH received a pre-authorization request on May 6, 2005. On May 11, 2005, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On May 20, 2005, CBH authorized services. The Company failed to make a determination regarding the authorization of services in a timely manner.	1	3.9%
Rule 850, § 7 (D) (1)	CBH received a pre-authorization request on June 27, 2006. On July 5, 2006, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” The Company failed to make a determination regarding the authorization of services in a timely manner.	1	3.9%
TOTAL		3	11.5%

2. Rule 850, Section 8 (A) reads in part:

A. Corporate Oversight of Utilization Review Program

A health carrier shall be responsible for monitoring all utilization review activities carried out by or on its behalf, and for compliance with the requirements of this. The health carrier shall also ensure that, consistent with the requirements of Title 24-A M.R.S.A. §4304(1), appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

The Company did not demonstrate consistent oversight of their UR program as required by the referenced statute in three (3) of the twenty six (26) pre-authorizations, or 11.7%. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 8 (A)	CHC received a pre-authorization request on April 1, 2005. CHC asked the PCP to contact CBH. CBH received the call from the PCP on April 6, 2005. CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On April 15, 2005, CHC contacted the PCP and on 4/18/05, the pre-authorization request to perform a neuropsychological evaluation of the patient was approved. The Company did not demonstrate consistent oversight of their UR program.	1	3.9%
Rule 850, § 8 (A)	CBH received a pre-authorization request on 5/6/05. On May 11, 2005, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On May 20, 2005, CBH authorized the services. The Company did not demonstrate consistent oversight of their UR program.	1	3.9%

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Rule 850, § 8 (A)	CBH received a pre-authorization request on June 27, 2006. On July 5, 2006, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” The Company did not demonstrate consistent oversight of their UR program.	1	3.9%
TOTAL		3	11.7%

3. 24-A M.R.S.A § 4304 (2) reads in part:

2. Prior authorization of nonemergency services. Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

Three (3) of the twenty six (26) pre-authorizations, or 11.7%, involved requests wherein the Company did not respond within 2 business days of the authorization request, as required by the referenced statute. The errors are explained below:

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 CIGNA Healthcare of Maine, Inc.

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 4304 (2)	<p>CHC received a pre-authorization request on April 1, 2005. CHC asked the PCP to contact CBH. CBH received the call from the PCP on April 6, 2005. CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On April 15, 2005, CHC contacted the PCP and on April 18, 2005, the pre-authorization request to perform a neuropsychological evaluation of the patient was approved. The Company failed to notify the provider of the determination within two business days of the authorization request.</p>	1	3.9%
24-A M.R.S.A. § 4304 (2)	<p>CBH received a pre-authorization request on May 6, 2005. On May 11, 2005, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On May 20, 2005, CBH authorized the services. The Company failed to notify the provider of the determination within two business days of the authorization request.</p>	1	3.9%
24-A M.R.S.A. § 4304 (2)	<p>CBH received a pre-authorization request on June 27, 2006. On July 5, 2006, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” The Company failed to notify the provider of the determination within two business days of the authorization request.</p>	1	3.9%
TOTAL		3	11.7%

4. Rule 850, Section 8 (E) (2) read in part:

2. For initial determinations, a health carrier or the carrier's designated URE shall make the determination and so notify the covered person and their provider within 2 working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.

Three (3) of the twenty six (26) pre-authorization requests, or 11.7%, involved requests wherein the Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information, as required by the referenced statute. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 8 (E) (2)	CHC received a pre-authorization request on April 1, 2005. CHC asked the PCP to contact CBH. CBH received the call from the PCP on April 6, 2005. CBH issued a denial letter asking the member or provider to "contact the medical health plan for consideration." On April 15, 2005, CHC contacted the PCP and on April 18, 2005, the pre-authorization request to perform a neuropsychological evaluation of the patient was approved. The Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information.	1	3.9%

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Rule 850, § 8 (E) (2)	CBH received a pre-authorization request on May 6, 2005. On May 11, 2005 CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” On May 20, 2005, CBH authorized the services. The Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information.	1	3.9%
Rule 850, § 8 (E) (2)	CBH received a pre-authorization request on June 27, 2006. On July 5, 2006, CBH issued a denial letter asking the member or provider to “contact the medical health plan for consideration.” The Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information.	1	3.9%
TOTAL		3	11.7%

Additional Observations

The Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider’s discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g. M.D., D.O.).

As part of the Examiners’ review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners did not identify any pre-authorizations that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, not overturned through the Company’s appeal process. Therefore, no files were referred for peer-to-peer review.

No exceptions were noted in the Pre-Authorization Request referred for Peer Review.

Complaints, Appeals and Grievance Handling

Complaints

The Examiners tested the population of eight (8) complaints, which included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general complaint handling process. No exceptions were noted.

Pharmacy Complaints

No exceptions were noted.

Appeals

The Examiners tested the population of forty-six (46) appeals, which included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures.

Testing identified twenty two (22) potential violations of five (5) Maine statutes. The Maine statutes and rules and the exceptions noted are as follows:

1. Maine Rule Chapter 850 section 9 C (b) (vii) that states the following:

b) If a decision is adverse to the covered person, the written notice shall contain:

vii) A description of the process to obtain a Second Level grievance review of a decision, the procedures and time frames governing a Second Level grievance review, and the rights specified in subsection D(3)(c).

The Examiners reviewed forty one (41) First Level appeal files and identified six (6) instances, or 14.6%, in which the Company's First Level appeal decision letters were noncompliant regarding disclosure of Second Level appeal rights. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Maine Rule Chapter 850 section 9 C (b) (vii)	The Company's First Level Appeal decision letter does not contain necessary information pertaining to Second Level appeal rights.	6	14.6%
TOTAL		6	14.6%

2. Rule Chapter 850, Section 9 C (1) that states the following:

A grievance concerning any matter except an adverse utilization review determination may be submitted by a covered person or a covered person's representative. First Level appeals of adverse health care treatment decisions are subject to the requirements of section 8(G) of this rule. A covered person does not have the right to attend, or to have a representative in attendance, at the First Level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days of receiving a grievance.

Through the review of First Level Administrative appeals the Examiners identified a general business practice regarding the Company's First Level non-medical necessity appeal acknowledgement letter specific to the State of Maine. The letter does not include the required terminology indicating that the covered person or their representative has the right to submit written material to the reviewer of the appeal. As a result, all Maine residents that submitted a First Level non-medical necessity administrative appeal were not advised of this right.

3. 24-A M.R.S.A. § 4312 (3) states the following:

A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

- A. A description of the external review procedure and the requirements for making a request for external review; [1999, c. 742, §19 (NEW).]*
- B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; [1999, c. 742, §19 (NEW).]*
- C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and [1999, c. 742, §19 (NEW).]*
- D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. [1999, c. 742, §19 (NEW).]*

The Examiners reviewed forty one (41) First Level appeal files reviewed and identified three (3) instances, or 7.3%, involving an appeal wherein the Company's letter failed to include all necessary requirements. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 4312 (3)	The Company's adverse decision letter does not contain the required disclosure regarding external review rights.	3	7.3%
TOTAL		3	7.3%

4. Chapter 850, Section 9 D (3) (a) that states the following:

Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a Second Level panel review shall include the following:

- a) The review panel shall schedule and hold a review meeting within 45 working days of receiving a request from a covered person for a Second Level review. The review meeting*

shall be held during regular business hours at a location reasonably accessible to the covered person.

In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least 15 working days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

The Examiners reviewed five (5) Second Level appeal files reviewed and identified three (3) instances, or 60%, involving an appeal wherein the Company's letter failed to include all necessary requirements. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9 D (3) (a)	The Company's did not provide the member the required 15 business days advance notice of the hearing.	3	60.0%
TOTAL		3	60.0%

5. Chapter 850, Section 9 D (f)states the following:

The review panel shall issue a written decision to the covered person within 5 working days of completing the review meeting. A decision adverse to the covered person shall include the requirements set forth in subsection 9(C)(1)(b)(i-vi).

As a point of reference, Subsection 9(C)(1)(b)(i-vi) as noted above, states the following:

If the decision is adverse to the covered person, the written decision shall contain:

- i. The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).*
- ii. A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*
- iii. The reviewers' decision in clear terms and the basis for the decision.*
- iv. A reference to the evidence or documentation used as the basis for the decision.*

- v. *Notice of the covered person's right to contact the Superintendent's office.*
- vi. *The notice shall contain the toll free telephone number and address of the Bureau of Insurance.*
- vii. *Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S.A. §4312(3).*

The Examiners reviewed five (5) Second Level appeal files reviewed and identified two instances, or 40%, involving an appeal wherein the Company's letter failed to include all necessary requirements. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9 D (3) (f)	The Company's notice did not include a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.	2	40.0%
TOTAL		2	40.0%

6. Chapter 850, § 9 C (1) (also cited above under issue #2), states that a grievance concerning any matter except an adverse utilization review determination may be submitted by a covered person or a covered person's representative. First level appeals of adverse health care treatment decisions are subject to the requirements of section 8 (G) of this rule. A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days of receiving a grievance.

The Examiners identified 8 of 17 or 47% Administrative First Level appeals as a possible violation of Chapter 850, § 9 C (1), wherein the Company did not send the member an appeal

acknowledgement letter within three business days. The Company did not send an acknowledgement letter at all in three instances, in five instances the letter was not within three business days. The errors are stated below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9 C (1)	The Company did not send an appeal acknowledgement letter or the letter was not sent within 3 business days.	8	47%
TOTAL		8	47%

Additional Observations

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified twenty four (24) appeal files that were denied by the Company and not overturned by the Company for not meeting the medical necessity criteria as defined by the Company. The complete files provided by the Company were reviewed and referred for peer-to-peer review. No exceptions were noted in the appeal files referred for Peer Review.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine Statutes including Maine mental health parity requirements, which are mandated benefits and are administered pursuant to the Company's standard policies and procedures applicable to mandated benefit processing.

The following issues were identified:

1. The Company has two distinct business entities that are operated under the parent Company, CIGNA Insurance Company. CIGNA HealthCare is responsible for the processing of medical health related functions such as pre-authorizations, utilization review, claims, and appeals. Similarly, CIGNA Behavioral Health is responsible for processing behavioral health related functions, including; pre-authorizations, utilization review, claims, and appeals. The two entities are operated as individual and separate operations with information shared and transmitted between the two organizations.

During the course of the examination the Examiners have identified that this internal workflow is contributing to the incorrect processing of mental health related pre-authorizations, utilization review, claims, and appeals.

The Examiners identified four (4) instances, or 3.1%, of the 130 claim samples reviewed that involved medical and mental health diagnosis and procedure codes, which required joint handling by both CHC and CBH. The claims were transmitted back and forth between CHC and CBH and as a result, the files were not processed in a timely manner as mandated under 24-A M.R.S.A. § 2436 (See Claims Finding 1 above). The Company's internal workflow contributed to the claims processing delays as noted above, and has impacted the accurate claims adjudication in compliance with Maine's Mental Health Parity Laws.

Additionally, the Examiners identified that in two (2) of four (4) instances; the claims were not adjudicated by the Company. The Examiners called this matter to the Company's attention, which the Company confirmed and has since processed with late payment interest.

Provider Network

The accuracy of a provider's network status on the date of service was tested through a random sample review of 43 of the 130 denied and zero paid claim files. No exceptions were noted.

ADDENDUM – COMPANY’S RESPONSE

BUREAU’S REVIEW OF COMPANY RESPONSE

The Bureau has reviewed the Company’s response to the draft report and has attached it as an addendum to our report. As a result of our review of the Company’s response, comment three was revised to reference non-medical necessity appeals, the original finding # 5 was removed, and finding # 11 (originally, finding number 12) was revised. The reference to the Company’s infrastructure in Finding # 2, Finding # 3 and on page 27 was changed to reference the Company’s internal workflow. No further changes were deemed necessary based on the information provided in the response.

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December 30, 2010

RSM McGladrey, Inc.
1954 Greenspring Drive
Suite 400
Attn: Barry Wells, Examiner in Charge
Timonium, Maryland 21093

Re: Response to State of Maine Bureau of Insurance Market Conduct Examination Report
(Period January 1, 2005 - December 31, 2008)
CIGNA HealthCare of Maine, Inc. NAIC: 95447

Mr. Wells,

Thank you for your continued assistance with this examination. To the report received via email November 12, 2010 (confirmed as the final report December 16, 2010), we respond as follows:

Finding #1

The Examiners identified ten (10) of 130 denied and zero-paid claims as possible violations of Title 24-A §2436-1A of the Maine Insurance Rule concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine Rule stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. In four(4) of 10 possible violations noted above, the Company's failure to adjudicate the identified claims within the 30 day timeframe is the result of the Company's infrastructure, wherein claims are not timely or effectively transferred between Cigna Health Care (CHC) and Cigna Behavioral Health (CBH).

Company Response:

The Company agrees with this finding regarding the process timing of Samples 17, 69, 77, 86, 90, 93, 98, 107, 118, and 124.

However, with respect to the four claims, Sample 77, 90, 118 and 124, the Company continues to respectfully disagree that there is an issue with its infrastructure. Both Connecticut General Life Insurance Company and CIGNA HealthCare of Maine, Inc. delegate the utilization review and claims administration of behavioral health benefits to CIGNA Behavioral Health, Inc.

The issues identified during the examination were not indicative of an issue with the Companies' infrastructure but rather with the handling of a very specific classification of claims. The Company concedes that it had experienced issues with ensuring that some of the mixed services claims (i.e. those claims that involve both medical and behavioral health benefits appearing on the same claim form) were consistently adjudicated on a timely and efficient basis. This issue appears to be due to instances where CIGNA's internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. CIGNA is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

Finding # 2

The Examiners identified seven (7) of 130 denied and zero paid claims as possible violations of Title 24-A §2436-3 of the Maine Insurance Rule concerning Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine Rule stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. If the Company fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 ½% per month after the due date.

Company Response:

The Company agrees with this finding regarding the processing of Samples 17, 69, 77, 86, 90, 93, 98, 107, 118, and 124 and submits that during the examination it provided evidence that late payment interest (LPI) was paid where appropriate. However, please note that no LPI was due on Sample 93 as the entire payment was applied to the deductible or for Sample 98 because that claim was ultimately denied and no payment was made.

Finding # 3

The Examiners identified that the Company's Maine Administrative First Level appeal acknowledgement letter does not fully comply with Rule 850, § 9 C(1) of the Maine Insurance Rule, which states in part that the aggrieved party must be advised that they have the right to submit written material to the reviewer. The Examiners noted that the letter does not include this disclosure. Follow up with the Company determined that this issue pertains to the Maine first level appeal acknowledgement letter in use. Consequently, because the acknowledgement letter is utilized for all of the Company's first level administrative appeals involving Maine members, this matter is deemed to be a general business practice that is non-compliant with Maine statutes.

Company Response:

The Company respectfully disagrees that all of the Level One appeal acknowledgement letters reviewed during the examination would be subject to the requirements of Chapter 850, Section 9 and therefore disagrees that all would be out of compliance with the requirements therein. Please see the following clarifications below:

The Company agrees that the level one appeal acknowledgement letters for samples: 1, 2, 4, 5, 7, 9, 19, 21, 22, 23, 31, 34, 35, 37, 39, and 40 do not fully comply with Section 9 (C)(1) in that they do not inform the member of their right to submit written material to the reviewer.

However, the Company disagrees with regard to samples: 3, 6, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 24, 25, 26, 27, 28, 29, 30, 32, 33, 36, and 38. These samples were medical necessity appeals and therefore subject to the requirements of section 8(G) of Chapter 850 rather than section 9. Section 8 does not mandate the acknowledgement of a medical necessity appeal. Although Section 8 does not require an acknowledgement letter, for administrative ease and consistency, the Company has made an internal business decision to issue acknowledgement letters on both medical necessity and administrative appeals. However, as Maine's requirement regarding acknowledgement letters does not extend to medical necessity denials, the Company respectfully submits that these letters should not be viewed as being non-compliant.

Finding # 4

The Examiners identified six (6) of 41 First Level appeals as a possible violation of Rule 850, § 9 C(b) (vii) of the Maine Insurance Rule, wherein the Company's First Level appeal decision letters were noncompliant regarding disclosure of Second Level appeals.

Company Response:

The Company agrees with this finding.

Finding # 5

The Examiners identified six (6) of 130 denied and zero-paid claims as possible violations of Title 24-A, §2707 Rule 191, Section 10B of the Maine Insurance Statutes, wherein the Company did not retain the Explanation of Benefit Notices (EOB) when member liability existed.

Company Response:

The Company respectfully disagrees that it is in violation of Title 24-A, §2707; Rule 191, Section 10B. Even though the six claim file samples: 31, 51, 52, 88, 98, and 117 did not contain copies of the original member EOBs, the Company was able to provide the Examiners with system generated duplicates. As required by Section 10B, the duplicate EOBs provided would be evidence of the Company's "affairs and transactions" sufficient to identify all aspects of the claims adjudication and the notices that were provided.

Finding # 6

The Examiners identified three (3) of 41 First Level appeals as a possible violation of Title 24-A § 4312 (3) of the Maine Insurance Statutes, wherein the Company's adverse decision letter does not contain the required disclosure regarding external review rights.

Company Response:

Maine Insurance Rule, Title 24-A, 4312(3) only applies to adverse health care treatment determinations (i.e. medical necessity determinations). Pursuant to the definitions section of Title 24-A, 4301-A(6): a health care treatment decision is defined as "a decision regarding the diagnosis, care or treatment when medical services are provided by a health plan, or a benefit decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services." Of the samples reviewed during the examination, only two (Samples 14 and 17) were medical necessity appeals. With regard to those two appeal letters, they contained notice of the right to external review however the Company agrees that the notice did not contain the level of specificity required by Title 24-A, 4312(3).

Finding # 7

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, Section 7(D)(1) of the Maine Insurance Rule, wherein the Company failed to make a determination regarding the authorization of services in a timely manner.

Company Response:

The Company agrees with this finding as it relates to Samples 6, 8 and 18.

Finding # 8

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, Section 8(A) of the Maine Insurance Rule, wherein the Company did not demonstrate consistent oversight of their utilization review (UR) program.

Company Response:

The Company respectfully disagrees that it did not demonstrate consistent oversight over its UR program. As noted during the examination, CIGNA HealthCare conducts annual internal oversight audits of CIGNA Behavioral Health, Inc. to ensure that all delegated functions are in compliance with applicable federal and state laws.

In addition, CIGNA Behavioral Health is certified by the State of Maine and other states as a Utilization Review agent. One of its many requirements as a Utilization Review agent is to ensure that appropriate clinical personnel have operational responsibility for the delegated utilization review functions pursuant to the Company's policy and procedures (as provided during the examination).

The Company respectfully submits that the three errors identified would not be sufficient to constitute inconsistent oversight.

Finding # 9

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Title 24-A § 4304 (2) of the Maine Insurance Rule, wherein the Company failed to notify the provider of the determination within two business days of the authorization request.

Company Response:

The Company agrees that with regard to Samples 6, 8 and 18, it did not notify the member or provider of the determination within two working days of obtaining all necessary information.

Finding # 10

The Examiners identified three (3) of 26 pre-authorization denials as a possible violation of Rule 850, Section 8(E)(2) of the Maine Insurance Rule, wherein the Company failed to notify the member or provider of the determination within two working days of obtaining all necessary information.

Company Response:

The Company agrees that with regard to Samples 6, 8 and 18, it did not notify the member or provider of the determination within two working days of obtaining all necessary information.

Finding # 11

The Examiners identified three (3) of five (5) Second Level appeals as a possible violation of Rule 850, § 9 D(3)(a) of the Maine Insurance Rule, wherein the Company did not give the member the required 15 business days advance notice of the hearing.

Company Response:

The Company agrees with this finding with regard to the Samples 41, 42 and 45.

Finding # 12

The Examiners identified two (2) of the five (5) Second Level appeals as a possible violation of Rule 850, § 9 D(3)(f) of the Maine Insurance Rule, wherein the Company's second level appeal adverse determination notice did not state the reviewer's understanding of the issue; additionally, one (1) of the two (2) notices did not state the names of the reviewers. When this matter was discussed with CIGNA it was learned that through a prior examination conducted by the Bureau, one (1) of the two (2) instances regarding the failure of the Company to note the names of the reviewers on the appeal notices had been identified. The examination resulted in a corrective action plan as mandated by the Bureau.

Company Response:

The Company agrees with the finding that the decision notice letters for appeal Samples 42 and 43 did not contain a statement of the reviewer's understanding of the appeal.

With respect to the additional finding that the appeal notice letter for sample 43 lacked the names and credentials of the Reviewer, the Company also agrees. However, the letter in the file was produced prior to the corrective action plan that was put in place pursuant to a prior Maine audit. As this issue was already addressed and corrected pursuant to that previous audit, the Company respectfully asks that this part of the finding be withdrawn from this examination.

Finding # 13

The Examiners identified eight (8) of 41 First Level appeals as a possible violation of Rule 850, § 9 C (1) of the Maine Insurance Rule, which in part requires that the health carrier advise the covered person of their first level appeal rights and the name and phone number of the person handling the matter within 3 working days of receiving a grievance. In five (5) instances, the Company did not send the notice within three (3) business days; and in three (3) instances, the Company did not send the notice.

Company Response:

The Company respectfully disagrees with this finding.

Chapter 850, Section 9 C(1) requires health carriers to apprise participants of their right to request a grievance review, and the right to submit written information for the review, within three (3) working days of receipt of a request for an appeal however it is silent as to the form of such notice.

With regard to Samples 2, 4, 34, 35, 37, 39 and 40, while it is true that the Company did not submit an acknowledgement letter apprising the participant of these rights within three (3) working days, the Company submits that it did provide sufficient written notice as required. This notice of the appeal rights was provided via the initial denial notifications in the form of the Explanation of

Benefits (EOB). In addition to advising of the administrative denial via CIGNA's claims system, the EOB also advised, on the back, of the participant's right to request an appeal:

"Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan."

(Please see the copy of the ERISA appeal rights language that is printed on the backside of all EOBs).



With regards to Sample 22, the participant's services were administratively reviewed and denied as opposed to being denied by the claims adjudication system. In this case, the Company provided written notification of the initial administrative denial and apprised the participant of her right to request an appeal as well as her right to submit written information for that appeal:

"Upon receipt of all necessary information, one of our staff who was not involved in the original decision will review your appeal...."

As a result, while the Company agrees that separate acknowledgement letters were not sent to the above-referenced participants within three (3) business days it submits that it was still in substantial compliance with the notice requirements by virtue of the initial denial notifications that were sent to participants.

Additional Observations:

1. The Company has two distinct business entities that are operated under the parent Company, CIGNA Insurance Company. CIGNA HealthCare is responsible for the processing of medical health related functions such as pre-authorizations, utilization review, claims, and appeals. Similarly, CIGNA Behavioral Health is responsible for processing behavioral health related functions, including; pre-authorizations, utilization review, claims, and appeals. The two entities are operated as individual and separate operations with information shared and transmitted between the two organizations.

During the course of the examination the Examiners have identified that this infrastructure is contributing to the incorrect processing of mental health related pre-authorizations, utilization review, claims, and appeals.

Company Response:

The Company continues to respectfully disagree that there is an issue with its infrastructure and also wishes to clarify the corporate relationship that was noted above (as taken from the Draft Report). Connecticut General Life Insurance Company (CGLIC), CIGNA HealthCare of Maine, Inc. (Company or CHC/ME) and CIGNA Behavioral Health, Inc. (CBH) are all affiliates under Connecticut General Corporation which is a wholly owned subsidiary of CIGNA Corporation; "CIGNA Insurance Company" as noted should be changed to reflect the correct relationships.

The Company respectfully disagrees that having different internal administrators of the medical benefits versus the behavioral benefits causes any undue delay in the delivery of health care services. CHC/ME serves as the medical benefits administrator and CBH serves as the behavioral health benefits administrator. Participants and providers are on notice of this distinction by virtue of the member's ID card which has separate telephone numbers for each type of service as well as via documentation in the member's plan document. Requests for benefit authorization pertaining to medical benefits should be directed to the medical benefits administrator, CHC/ME, and requests for behavioral health benefit authorization should be directed to the behavioral health benefits administrator, CBH.

During the examination the Company agrees that there were misdirected pre-authorization requests which resulted in the need for redirects to the appropriate administrator however this should not be construed as a problem with the Companies' infrastructure or source of delay. These redirects were necessary in order to ensure that requests for services were being reviewed by the appropriate clinical peer (i.e. physician with same or similar specialty as the provider requesting services).

Similarly as noted in more detail below, any delays with claim adjudication were related to a specific type of claim which contained both medical and behavioral health services. Issues with these types of claims appears to be due to instances where internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. The Company is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

2. The Examiners identified four (4) instances, or 3.1%, of the 130 claim samples reviewed that involved medical and mental health diagnosis and procedure codes, which required joint handling by both CHC and CBH. The claims were transmitted back and forth between CHC and CBH and as a result, the files were not processed in a timely manner as mandated under Maine Insurance Rule, Title 24-A, Section 2436 (See Claims Finding 1 above). The Company's infrastructure contributed to the claims processing delays as noted above, and has impacted the accurate claims adjudication in compliance with Maine's Mental Health Parity Laws.

Company Response:

The Company respectfully disagrees with this finding.

CIGNA HealthCare of Maine, Inc. (Company or CHC/ME) delegates the utilization review and claims administration of the behavioral health benefits to CIGNA Behavioral Health, Inc. (CBH). CBH submits that its utilization review (including pre-authorization and appeals) policies and procedures as well as CIGNA's (i.e. CGLIC's, CHC-ME's and CBH's) claims SOPs, all comply with the various Maine insurance mandates including Maine's mental health parity mandates.

The issues identified during the exam were not indicative of an issue with the Company's infrastructure but rather with the handling of a very specific classification of claims. The Company concedes that it had experienced issues with ensuring that some of the mixed services claims (i.e. those claims that involve both medical and behavioral health benefits appearing on the same claim form) were consistently adjudicated on a timely and efficient basis. This issue appears to be due to instances where CIGNA's internal workflows were not consistent in directing these mixed services claims to the appropriate internal claims engine for adjudication. CIGNA is currently working on remediating these issues including the implementation of an internal auditing process to ensure that these issues do not recur.

Additionally, the Examiners identified that in two (2) of four (4) instances; the claims were not adjudicated by the Company. The Examiners called this matter to the Company's attention, which the Company confirmed and has since processed with late payment interest.

Company Response:

The Company agrees with this finding and confirms that the claims were adjudicated during the examination.

Again, thank you for the continued assistance. If you should have any concerns or questions, please do not hesitate to contact me by phone at 954.514.6642 or by email at jeremy.murphy@cigna.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Murphy', with a stylized flourish at the end.

Jeremy L. Murphy
Regulatory Affairs Manager
Legal & Public Affairs

STATE OF MAINE

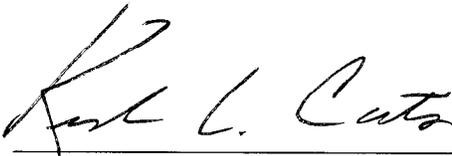
COUNTY OF KENNEBEC, SS

Kendra L. Coates, CPA, CFE, CIE, Director of Financial Analysis, being duly sworn according to law, deposes and says that in accordance with the authority vested in her by Eric A. Cioppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, she has overseen an examination on the condition and affairs of the

CIGNA HealthCare of Maine, Inc.

For the time period of January 1, 2005 to December 31, 2008, and that the foregoing report of examination, subscribed to by her, is true to the best of her knowledge and belief.

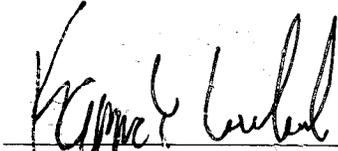
The examination was performed by RSM McGladrey, Inc. on behalf of the State of Maine, Bureau of Insurance.



Kendra L. Coates, CPA, CFE, CIE
Director of Financial Analysis

Subscribed and sworn to before me

This 28th day of October, 2011



Notary Public

My commission expires:

KARMA Y. LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2016