NEW HAMPSHIRE INSURANCE DEPARTMENT

MARKET CONDUCT

AND MANAGED CARE EXAMINATION

REPORT

OF

CIGNA HEALTHCARE OF NEW HAMPSHIRE, INC

A NEW HAMPSHIRE LICENSED
HEALTH MAINTENANCE ORGANIZATION

JUNE 1, 2000

STATE OF NEW HAMPSHIRE)
)
COUNTY OF MERRIMACK)

John M. Talley, Esq., being first duly sworn, upon his oath deposes and says:
That he is an examiner employed by the Insurance Department of the State of New Hampshire;
That an examination was made of the affairs of

CIGNA HealthCare of New Hampshire, Inc.

of Concord and Hooksett, New Hampshire, a stock company authorized under the laws of the State of New Hampshire pursuant to authority vested by Paula T. Rogers, Esq., Commissioner of Insurance of the State of New Hampshire;
That he was an Examiner on said examination and that the attached report of Examination is a true and complete report of the condition of the above named stock Company on June 1, 2000 _____ as determined by the examiners.

_____
John M. Talley, Esq., Examiner

Subscribed and sworn to before me this
_____ Day of _____, AD _____.

_____
Notary Public

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NEW HAMPSHIRE INSURANCE DEPARTMENT
MARKET CONDUCT EXAMINATION OF
CIGNA HEALTHCARE OF NEW HAMPSHIRE, INC
EXAMINATION REPORT

June 1, 2000

Paula T. Rogers, Esq.
Insurance Commissioner
State of New Hampshire
56 Old Suncook Road
Concord, New Hampshire 03301-5151

Commissioner:

Pursuant to your instructions and authorization, a market conduct examination was performed on:

CIGNA Healthcare of New Hampshire, Inc., a CIGNA corporation

hereinafter referred to as "CHC-NH" or the "Plan". A New Hampshire corporation, CHC-NH has principle offices at 54 Regional Drive, Concord, New Hampshire and Two College Park Drive, Hooksett, New Hampshire. The examination was conducted at CHC-NH's offices located on Two College Park Drive, Hooksett, New Hampshire 03106. The following report is herewith respectfully submitted.

I. DESCRIPTION OF THE COMPANY

CHC-NH was incorporated on March 14, 1985 as Healthsource New Hampshire, Inc. (HSNH) and licensed as a health maintenance organization under RSA 420-B, effective June 21, 1985. The Plan became federally qualified in July 1986. CIGNA HealthCare Inc. purchased HSNH in 1997 and changed the name of the company to CIGNA HealthCare of New Hampshire, Inc in the first quarter of 2000. Through an internal, regional sales force, the Plan marketed several health maintenance organization (HMO) and point of service (POS) products during the examination period, as well as a Medicare product for seniors.

II. PAST EXAMINATION

While still HSNH, the company was previously examined for a three-year period ending December 31, 1996. The market conduct report dated December 1, 1997 cited several areas of concern and made recommendations for remedial action to be taken in those areas. During the present examination, the examiners gave special attention to the Plan's response to the recommendations made. Any findings regarding those recommendations are reported herein.

III. SCOPE OF EXAMINATION

As a health maintenance organization under RSA 420-B, the Plan was examined under the authority of RSA 400-A:37. The examination period covered from January 1, 1997 through December 31, 1999. The general areas reviewed were:

* Company Operations/Management
* Complaint Procedures
* Grievance Procedures
* Marketing and Sales
* Network Adequacy
* Provider Credentialing
* Provider Contracts
* Producer Licensing
* Member Services
* Quality Assessment and Improvement
* Underwriting and Rating
* Utilization Review
* Claims Processing
* Delegated Services

The examiners reviewed documentation and interviewed personnel to determine market conduct practices and other activities that were departures from applicable law and regulations. Other matters of special interest were also reviewed. In general, if no improprieties were found, comments on documentation reviewed during the examination were omitted from the report. Attention is directed to the Summary of Recommendations, included as Appendix I to this report.

IV. PROVIDER CREDENTIALING

The credentialing policies of the Plan for providers and facilities were reviewed without any findings made. Additionally, the examiners randomly selected 98 credentialing files to review the application of those procedures. There were no findings made. However, in 22 files, the examiners could not locate necessary credentialing documentation in the Macess system. Macess is a computer imaging document storage system that is designed to warehouse all of the paper previously held in files. The examiners determined that there was not a systematic method of cataloging documents in the system. This made finding documents difficult and cumbersome. The examiners believe that it would be helpful to establish a method of cataloguing that would aid in locating documents. The credentialing documents sought were subsequently obtained from the Plan's Credentialing system.

Under the Dartmouth Hitchcock Medical Center (DHMC) contract, the Plan delegated credentialing of the hospital and clinic physicians in the northern sector of the state to DHMC.[1] In accordance with NCQA procedures, CHC-NH audited the delegated

[1] CHC-NH credentialed the DHMC clinic physicians in the southern sector of New Hampshire.

credentialing function for 1998. A report was issued February 10, 1999, citing several "action items" to be implemented by DHMC. The examiners found the report precise and thorough. The examiners were informed that CHC-NH is targeting the action items for its 1999 audit of DHMC's delegated credentialing function.

Administrative Recommendation:

The Plan establish procedures that would allow a better audit trail of credentialing documentation in the Macess system.

V. MEMBER SERVICES - COMPLAINT AND GRIEVANCE PROCESS

Policies and Procedures

CHC-NH has designated its Member Services department as the contact point for all member complaints and grievances. All complaints and concerns pertaining to claims and medical determinations are channeled through the member services representatives for distribution to the designated review personnel. The examiners reviewed the policies and procedures pertaining to this and made the following findings:

a. Claims Review Committee
This process addresses member requests for exceptions regarding denied claim or benefit coverage. Claims Review Committee is responsive to member's problems and concerns about Plan policies, procedures, benefits and services. Members or Providers can request an exception/appeal, written or verbal. The Overview states that the claims review process is to be completed within 30 business days. RSA 420-J:5 III(a) states that the first level grievance review decision shall be made within 20 business days after receipt of the grievance and all relevant information.

b. Appeals Coordinator Responsibilities
Step 3 states that "A decision will be rendered within 30 days of receipt of the Request for appeal." Step 5 states that the appeal is presented to the Claims Review Committee within 30 business days from receipt of the member's or provider's written appeal request. Again, RSA 420-J:5 III(a) states that the first level grievance review decision shall be made within 20 business days after receipt of the grievance and all relevant information.

c. Member Rights – Non-Federal Qualified
On Page 2 of the Member Rights pamphlet it states that the "Member's request for review will be forwarded to the Claims Review Committee with written response sent to the member within 30 days of receipt of all necessary information." As stated above, RSA 420-J:5 III (a) states that a written decision shall be issued within 20 business days after receipt of the grievance and all relevant information.

First and Second Level Appeal Sample

The examiners reviewed a random selection of 172 first and 71 second level member appeal files from a universe of 2427 first level and 249 second level appeals. The sample included claims denials and medical necessity denials (adverse determinations). It was found that the Plan's review committees rendered their decisions within 11.5 days for level one appeals and 31.1 days for level two appeals. This is within the time frames delineated in RSA 420-J:5. The examiners further determined that the Plan's decision letters were also in compliance in form, content and issuance time from the date of decision.

New Hampshire Insurance Department Complaints

NHCAR Part Ins 1001.01(c) requires that an insurer must return a written response to a consumer inquiry or complaint through the New Hampshire Insurance Department (NHID) within 10 working days. The examiners reviewed all of the consumer complaints or inquiries sent by the NHID. Excluding complaints that were in the appeals track and mental health appeals, the examiners determined that CHC-NH answered 49 out of 116 inquiries within 10 working days – 42.24%, or a 56.76% error ratio. Hence, CHC-NH is in violation of this regulation. It should be noted that the previous market conduct examination report also cited HSNH for violating this regulation.

In reviewing the above files, the examiners noted that in many instances CHC-NH contacted NHID when the response was going to be late. The examiners viewed contact as giving a response within the 10 working day time period. However, there were many instances where the examiners determined that a similar contact was possibly made but no notation was made in the file. The examiners informed the responsible CHC-NH personnel that the practice of making notation in the file should be consistently performed in every situation when CHC-NH will be late in its response to NHID.

Recommendations:

1. **CHC-NH change the above stated procedures to comply with RSA 420-J:5 III(a) as stated. However, since the actual appeal hearings and decisions complied with RSA 420-J:5, the examiners do not recommend that sanctions be imposed for the procedural violations.**

2. **CHC-NH should amend its procedure to comply with NHCAR Part Ins 1001.01(c). This recommendation was made in the last examination report. Subject to the Commissioner's discretion, the company may be penalized under NHCAR Part Ins 1001.16 for continued non-compliance with NHCAR Part Ins 1001.01(c).**

Administrative Recommendation:

Telephonic contact with the NHID requesting an extension of time to answer should be documented in the member file. The examiners noted that there was evidence in some files that this had been done.

VI. MARKETING AND SALES

The examiners reviewed the policies and procedures of the Sales Department and other material including 91 employer group files and 31 broker files for compliance with applicable statute and regulations. The following findings were made:

a. A form letter transmits small group renewal rates to the broker of record for the applicable group. Among other things, these letters remind the broker that "the Open Enrollment period will be in effect for the 30 days prior to the renewal date." All of the letters in the sample contained this language. RSA 420-G:8,1 mandates that "Each small employer shall have an annual open enrollment period 60 days in length." The letter does not properly state this statutory requirement.

b. Beginning in 1999, CHC-NH uses a Re-Certification Form that is sent to each group prior to the renewal date to be completed, signed and returned. Completed forms show the current number of employees, the number of eligible employees, the number of employees covered by CHC-NH and the number covered elsewhere or by other plans. The data collected enables CHC-NH to measure the group's level of participation. The form is placed in the employer group file and held as historical data. The examiner noted that there was no place on the form to record the date on which the information was given. Without a date on the form, it is not possible to identify the time when the data shown on the form was applicable to the group. CHC-NH has yet to determine if they will make this form a permanent part of their procedures. Whether the form will continue to be used or not is uncertain. If it does, adding a space for recording the date on the form will aid CHC-NH in determining when the information was applicable to the employer group.

c. The examiners requested and received photocopies of the licenses held by CHC-NH Sales Department staff as required by RSA 420-B:18. The examiners further inquired into the policies and procedures of CHC-NH relative to pre-licensing training for newly hired Sales Department staff. CHC-NH does not have its own pre-licensing training program for new Sales Department staff. CHC-NH relies on the New Hampshire Association of Life Underwriters (NHALU) Pre-Licensing Training Program which consists of 20 hours of self-study and one day of classroom study. From November through June, the one day of classroom study is presented each month, or 8 times a year. The course does not meet in July, August, September or October. New sales personnel are given copies of the NHALU course brochure. It is the sales personnel's responsibility to schedule taking the course. It is expected that the license examination will be taken within 6 months of their employment. James Scammon, CHC-NH Sales Director, stated that during this training period and prior to the successful completion of the examination, new sales personnel are to be accompanied by a supervisor or licensed agent when meeting with customers. The examiners determined that this training procedure is not effective and there have been violations of RSA 420-B:18. The review as of 11/16/99 revealed 2 staff

members who were unlicensed at that time and one staff member was employed for 8 months before passing the licensing examination:

Name	Job Title	Hired	Passed Exam	Duration
Dana Bolduc	Cust. Service Spec.	1/21/99	No	10 Months
Rene Lafleur	Client Manager	1/21/99	No	10 Months
Sara Maley	Small Grp. Client Mgr.	3/1/99	11/29/99*	8 Months

*Passed exam on the second attempt.

Per James Scammon, Sales Director, Dana Bolduc, who usually is accompanied by a supervisor or licensed representative, has met with clients on her own a few times. A supervisor or licensed representative accompanies Sara Maley about 90% of the time. And, Rene Lafleur has been out on his own to visit clients.

Recommendations:

1. **CHC-NH revise its renewal procedures to ensure that each small employer group be provided an annual open enrollment period that is 60 days in length as required by RSA 420-G: 8.I.**

2. **CHC-NH revise it procedures to require new CHC-NH sales representatives to pass the examination and become licensed prior the representative actively soliciting or enrolling participants in accordance with RSA 420-B:18. For the admitted activity in violation of this statute, the Insurance Commissioner may, at her discretion, impose penalties on CHC-NH under RSA 420-B:13.**

Administrative Recommendations:

1. **CHC-NH should require new sales representatives to enter a pre-licensing training program immediately after their date of hire. For this to be possible, pre-licensing training programs should be available year round. As this is not presently the case, CHC-NH should address this problem either by developing its own pre-licensing training program or by sending new sales representatives to more than one external pre-licensing training program. Should CHC-NH establish its own pre-licensing training program, it would be necessary for this program to be listed with the Insurance Commissioner as an approved pre-licensing course pursuant to NHCAR Part Ins 1301.02(b).** [2]

2. **CHC-NH should adopt a policy that all new sales representatives must be accompanied by a licensed sales representative whenever they are, or may be,**

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[2] CIGNA does offer a New Hire Core Program, an 11-week training program for new hires. This program prepares the participant for the state licensing examination in the very first week. It is offered only twice a year and not all new hires attend. Attendance is at the discretion of the Sales Manager. Generally, new hires with prior industry experience do not attend the program.

involved in a solicitation or enrollment situation until he or she becomes licensed by the NHID.

VII. UNDERWRITING AND RATING

Small Group Rates

CHC-NH uses two pricing models, the Large Group (101+) Pricing Model and the Small Group (1-100) Pricing Model. Groups with less than 10 employees are list-billed. The examiners' major objective was to verify that the rates approved by the NHID were the rates that were being used by CHC-NH. The secondary objective was to confirm that the rate calculations done were accurate. Toward this end, new business or renewal rate calculations were tested for five large groups and five small groups.

It was discovered that an inadvertent error was made when the Small Group Pricing Model was revised to reflect a newly approved rate filing, effective April 1, 1999. Specifically, the package adjustment factor, which functions as a credit against the base rate, was increased by nine percent twice when only one increase was to have been made. It was determined that the Small Group Pricing Model reflecting this rate filing was used with all new and renewal rate calculations for a period of five months, April through August 1999. The error was minor. The impact on rates for these groups was an undercharge of less than 1 percent.

The examiner's reviewed the rate calculations for five small groups using the Small Group Pricing Model and five large groups using the Large Group Pricing Model. It was determined that the rates used in the pricing models were the rates approved by the NHID for the period to which the rates applied and that the calculations were accurate.

Group Subscriber Agreements

In reviewing the Group Subscriber Agreements (GSA), it was noted that GSA # MKCGSA196, included language allowing a member's PCP to refer a member to an in-network mental health provider. By contrast, GSA # MKCGSA199 made no mention of access to mental health benefits through the referral of the primary care physician (PCP). As RSA 420-B: 8-b, 1(b) states, "The policy shall also include a statement that a primary care physician may refer an enrolled participant to a psychiatrist or other mental health care provider within the organization's network." CHC-NH indicated that a PCP referral is not required for this service. Hence, requiring members to contact their PCP to access mental health benefits (or even suggesting it) is a barrier to access and is unnecessary. The examiners acknowledge that PCP referral should not be a requirement. However, the statute should be read as allowing a PCP referral as an additional and optional means of accessing in-network mental health providers. CHC-NH is statutorily required to include a statement in the GSA that will allow PCP referral as a means of accessing mental health benefits.

Under section 6.A(6) of GSA MKCGSA196 and MKCGSA199 (e.g. the eligibility section), it states, "Any employee or dependent who has met their lifetime benefit maximum through any other medical plan or policy is not eligible for coverage under HEALTHSOURCE." GSA MKCPOSGSA197 included the same statement under Section 5.A(3). NHID considers the use of this statement as an eligibility rule to be a violation of RSA 420-G:6, I. NHID personnel stated that they had informed CHC-NH that the following language, or similar language in meaning, will be acceptable: "Any employee or dependent who has met their lifetime maximum through any other HEALTHSOURCE plan is not eligible for coverage under this HEALTHSOURCE plan."

GSA MKCPOSGSA197 excludes from coverage "nutritional supplements, formulas and therapies", but provides for a cross-reference to the benefit that provides coverage for enteral formulas and food modified to be low-protein. GSA's MKCGSA196, MKCGSA199 and MKCPOSGSA193 do specify the "nutritional supplements, formulas and therapies" exclusion, but do not include a cross-reference to the enteral formulas benefit. The examiners suggest that the exclusion, wherever found, include the same cross-reference in all GSA's.

When the above issues were communicated to CHC-NH personnel, they indicated that these issues would be addressed in the next revision of the GSA. It was also stated that CHC-NH has not enforced the previous use of lifetime maximums as an eligibility issue.

Recommendations:

1. **To comply with RSA 420-B, 8-b, I(b), CHC-NH include a statement in all present and future GSA's to the effect that a primary care physician may refer an enrolled participant or member to any mental health provider within the CHC-NH mental health provider network.**

2. **CHC-NH revise all GSA's in use to change the language of the eligibility section in order to incorporate the above substitute language (or similar language) suggested by the Insurance Department to comply with RSA 420-G: 6, I.**

Administrative Recommendation:

A cross-referencing statement be added to the exclusion for "nutritional supplements, formulas and therapies" to reference the benefit that provides coverage for enteral formula and food modified to be low protein.

CIGNA/CHC-NH Internet Web Sites

Web sites maintained by companies are increasingly becoming a central source of member information relative to companies, their operations, products, policies and procedures. Accordingly, the examiners reviewed the information maintained on the CIGNA Web Site for CHC-NH.

Upon reviewing the New Hampshire Policy and Procedure Manual under the home page for the New England Regional Operations Center, a sub-division of the CIGNA Healthcare National Service Organization home page, the examiners found five (5) statements in the Manual that are inconsistent with or misrepresentative of New Hampshire law, as follows:

a. Under the subject Eligibility-COBRA, the Manual states, "State of New Hampshire Continuation of Coverage applies to all employers with 20 or less eligible employees." This statement is incorrect. Pursuant to RSA 415:18, VII (g)(1), the New Hampshire Continuation of Coverage law applies to all fully insured groups regardless of size.

b. Again, under Eligibility-COBRA, it states, with respect to surviving spouses and divorced spouses, that " Coverage may continue up to 36 months." Under RSA 415:18, VII (g)(1)(D), when the surviving spouse, divorced spouse or legally separated spouse is 55 years of age or older, then, "the extension period shall continue until the surviving spouse, divorced spouse, or legally separated spouse becomes eligible for participation in another employer-based group plan or becomes eligible for Medicare." The web site Manual statement is correct with respect to such spouses under 55 years of age, but incorrect if these spouses are 55 years of age or older.

c. In discussing the 39-Week Extension, the following two statements are made that reflect previous but not current New Hampshire law:

   "(a) An employee must be employed for six months prior to effective date of 39 Week if eligibility was based on employment", and
   "(b) If eligibility was not based on employment, member must be covered under plan for six months prior to effective date of 39 Weeks."

   The limitations expressed in these statements were removed from RSA 415:18, VII (g)(1).

d. Under Eligibility-COBRA, it states that coverage under COBRA will continue until "the individual(s) becomes eligible for other group health insurance coverage." RSA 415: 18, VII (g)(1)(E) states that "Extension coverage need not be provided beyond: …the first day of the month following the date the individual becomes eligible for benefits under another group plan." The phrase "eligible for benefits" in the New Hampshire law means actually insured by another group plan, not just eligible to participate or enroll in another group plan. Accordingly, the web site Manual discussion is inconsistent with New Hampshire law.

e. Under the subject of Mental Health-Outpatient visits, the web site Manual states, "All outpatient treatment for psychiatric or substance abuse problems require pre-approval from the MHA." This statement does not comply with RSA 420-B: 8-b, I(b) which requires HMOs to allow its members up to 5 visits each contract year that are not subject to utilization review. The requirement of approval for all outpatient visits,

including the first five, implies that the HMO may disapprove such visits. This implies a process that would involve utilization review.

Recommendation:

To correct the specific findings stated above, the CIGNA HealthCare New Hampshire Policy and Procedure Manual on the CIGNA Web Site be revised to comply with New Hampshire law.

VIII. UTILIZATION REVIEW

The examiners reviewed the Case Management Training Manual and the Utilization Management policies and procedures for compliance with New Hampshire law. The following findings were made:

a. Insufficient Clinical information policy and procedure
This policy and procedure establishes the procedure for obtaining necessary clinical information to make a utilization determination. It does not state, but should state, that pursuant to NCAR Part Ins. 2001.11(g), the company must notify the patient or physician within 24 hours of the need for additional clinical information.[3]

b. Health Services Specialist duties
During 1997 and 1998, the Health Services Specialist were allowed to approve a medical procedure that was on a list. The listed procedures did not need pre-certification. This violated NHCAR Part Ins. 2001.16(a). In 1999, this procedure was changed by CHC-NH wherein the Health Services Specialist is not allowed to make any decisions, only to transmit information to the licensed Case Managers.

c. Post-standard member template appeal decision letters
The examiners made no findings concerning the content of the template appeal decision letters. However, it was noted that the NHID address was not correctly stated in the denial letters (e.g. wrong street address, no street address).[4]

Recommendation:

CHC-NH revise its Utilization Management policies and procedures regarding Insufficient Clinical Information to include the requirements of NHCAR Part Ins. 2001.11(g) to notify the patient or physician within 24 hours of the need for additional clinical information.

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[3] From the review of a sample of the case management decisions, the examiners determined that the Plan personnel did, in fact, request additional clinical or medical information within 24 hours.
[4] However, it was noted that, in the case management and appeals decision files reviewed by the examiners, the denial letters did state the correct address for the New Hampshire Insurance Department.

IX. QUALITY ASSESSMENT AND IMPROVEMENT

CHC-NH's Quality Management program was reviewed for compliance with RSA 420-J:9. The examiners noted that the Plan received the highest accreditation given by National Committee for Quality Assurance (NCQA) in 1999. No findings were made concerning the compliance of the program. The examiners did find that the confidentiality statements for the Plan's Clinical Quality Committee members had not been updated since 1997 and that one committee member had not signed a statement. As part of its numerous functions, the committee has access to member medical information when reviewing the Plan's utilization review activities.

NHCAR Part Ins. 2001.14(a) requires that an HMO "shall have written procedures for assuring that patient-specific information obtained during the process of utilization review shall be:

> (1) Kept confidential in accordance with applicable laws and rules;
> (2) Used solely for the purposes of utilization review, quality management…."

CHC-NH's procedures require that the Clinical Quality Committee members sign a confidentiality statement. The statements should be periodically reviewed for updating and determining that all members have signed a statement.

Recommendation:

In order to comply with NHCAR Part Ins. 2001.14 (a)(1) and (2), CHC-NH should periodically review the confidentiality statements for updating and completeness.

X. CLAIMS

CHC-NH's claims processing procedures and system were reviewed for compliance with applicable New Hampshire law and accuracy of payment. The denied claims and the member-submitted claims were areas reviewed in detail.

Denied Claims

The examiners obtained a random selection of 100 denied claims from a universe of 160,259 denials processed from 1/1/97 through 9/30/99 to review for compliance with NHCAR Part Ins.1001.02 (a), 1001.02 (f) and 1001.06. The following findings were made:

a. NHCAR Part Ins. 1001.02(a), in part, states "…[If] a complete coverage decision is not made within 30 days, the insurer provide a written explanation to the member claimant justifying such delay." The examiners found that 17 out of the 100 denied claims (17%) did not send a notice to the member within the 30-day period.

b. NHCAR Part Ins. 1001.02(f) states "Whenever the insurer denies a claim on the basis of no coverage…, the insurer shall inform the insured in writing the reason for the denial and include the department's [NHID] toll free telephone number." The examiners found that the following messages printed on numerous Explanation of Benefits (EOB's) were confusing.

(1) When a participating provider claim is denied a message is printed on the member's EOB indicating that the member is not responsible for amount in excess of Usual & Customary. However, the charges are then reflected as the patient responsibility. A total of 68 of the 100 claims reviewed used that message on the EOB regardless of patient responsibility.

(2) When the denial code 237 (Resubmit to Mental Health Administrator) is used, the EOB instructs the member to re-submit the claim to the Mental Health Administrator. However, since the Mental Health Administrator, MCC [now CIGNA Behavioral Care, Inc.], is a CIGNA company, CHC-NH should be referring the claims, automatically. This would expedite the process and minimize the potential for duplicate claim submissions. The examiners believe that this would be the appropriate process for these sensitive claims.

c. NHCAR Part Ins. 1001.06 states that any denied claim shall contain a statement that informs the member of his/her right to contact the New Hampshire Insurance Department to file a complaint against the insurer. The statement must contain the address and toll free telephone of the department. The examiners found that the statements contained the wrong address for the department.

Recommendation:

CHC-NH develop and implement procedures to fully comply with NHCAR Part Ins. 1001.02(a).

Administrative Recommendations:

1. **CHC-NH investigate the use of the participating provider message, and the notation that the charges are the patient's responsibility, relating to denied claims.**

2. **The denial letters sent to members be revised to include the current address of the New Hampshire Insurance Department.**

3. **If a New Hampshire provider submits a mental health claim to CHC-NH in error, CHC-NH should forward the claim to CIGNA Behavioral Care, Inc. Upon forwarding the claim, CHC-NH should generate an EOB with a message stating that the claim has been forwarded to the Mental Health Administrator.**

4. **If the Member submits the claim, the claim should likewise be forwarded to CIGNA Behavioral Care, Inc. and the same message should be transmitted to the member by letter or through the processing system generating an Explanation of Benefit.**

Member-submitted claims

The examiners randomly selected 102 member-submitted claims to review for compliance with NHCAR Part Ins. 1001.02(a).[5] The selection also included Working Wonders claims that are processed under a different system. It was determined that 100 out of 102 member-submitted claims were processed within 30 days -- 98%.[6] 80 out of 102 member-submitted claims were either processed of paid within 10 working days. Of the remaining 22 claims, 11 claims were submitted and paid prior to the 5/24/99 amendment.[7]

Since the Working Wonders claims made up 44.8% of the member-submitted claims, the examiners reviewed the entire processing system. The Working Wonders Program is three separate programs:

* The Prize program (members submit activity cards for specific prizes earned through recorded exercise activity) rewards members who establish a regular exercise regimen. It is a total honor system. This program was not tested since there was not an effective method of ascertaining the accuracy or timeliness of the award transmittal.

* The Health Club Membership and Incentive Bonus program gives the enrolled participant a discounted membership with contracted health clubs and a periodic monetary payment to those members who regularly use the health club. In 1999, this program had approximately 59,000 member-participants with 100 contracted health clubs and over 100 participating providers and vendors. The total amount paid for 1999 was more than $3,000,000.

* The Health Education program reimburses the member's costs for attending various health education classes offered in New Hampshire's communities. The examiners reviewed member materials describing the benefits for each part of the Working Wonders Program. In discussions of the program materials with CHC-NH personnel, the examiners determined that the company receives numerous phone calls from members regarding reimbursement for Health Education classes. The examiners

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[5] It should be noted that NHCAR Part Ins. 1001.02(a) was amended effective 5/24/99. The prior section required that payment, denial or notice of delay of processing of the claim be made within 10 working days. The present regulation requires payment, denial or notice within 30 days. The examiners took this change into consideration when reviewing the member-submitted claims and reporting their findings.

[6] The examiners noted that CHC-NH projected a goal of 99% of claims being processed within a 30-day period.

[7] The time of payment of these claims did violate the requirements of the prior regulation. However, due to the change in the regulation and the low percentage of error in the total sample, the examiners did not make any findings or recommendations.

suggest that the Health Informational brochures and reimbursement forms be included in the new subscriber packets to increase program awareness.

The Working Wonders claims reviewed in the member-submitted sample were either Incentive Bonus payments or Health Education reimbursement. The Incentive Bonus process creates a pending electronic record for a check to be paid to the eligible member. This record is sent to MHC (claims processing system) for auto adjudication through the standard claims process. The examiners traced 6 electronic claims (selected from the original member-submitted sample) through the above process. Of the six claims, one claim was determined to have been paid in error. This error led the examiners to make the following determinations:

* The process for payment to a qualifying member should be standardized. When a member qualifies for an incentive check after 6 months of consecutive membership in a health club with the required minimal amount of visits, the qualifying month should not be the date of service for the claim. Example – if June qualifies a member, then when the June workout sheets are received (within 15 days of the next month) the check would be authorized no sooner than the middle of July. Then, when the claim is forwarded to claim processing via electronic claim and is paid, the claims date of service would be July, not June. The examiners found dates of service on claims both ways (dated in the qualifying month or the month after). This causes inconsistencies in the payment process and possible errors in payment.[8]

* The Incentive Check (electronic claim generating) System does not have the capability of identifying a break in membership coverage (less than minimum visits are recorded in the club membership history file). The processing system takes the electronic claim date of service and checks eligibility for coverage on that date. This would allow a payment to be made to a member that did not qualify under the terms of the program.

Administrative Recommendation:

1. **The Date of Service assigned manually for Incentive check claim generation is consistent with qualifying policies to eliminate potential inaccuracies in history data and eliminate potential overpayment.**

2. **The incentive check electronic claims generating system be enhanced to identify a break in coverage and/or the claims processing system enhance coverage criteria to suspend and question these claims.**

XI. DELEGATED SERVICES

Excluding mental health, which was the subject of a recent target examination, CHC-NH delegates the processing of pharmaceutical claims. During the examination period, CHC-NH contracted with Pharmacy Data Management, Inc. (PDM) from April 1, 1991

[8] The examiners did not, however, find any overpayments in the sample.

through March 1, 1999. Effective 3/1/99 ARGUS Health Systems, Inc. (ARGUS) became the contracted processor for CIGNA.

To determine the economic effect of CHC-NH's pharmaceutical benefit during the examination period, the examiner requested and received the following data:

* Total claims paid from 1-1-97 through 2-29-00 were 3,412,861 - Totaling $87,509,369.71

* Total claims denied from 1-1-97 through 2-29-00 were 604,913 - Totaling $20,634,230.46

* Total processed by ARGUS for New Hampshire members:
  - Total provider submitted claims processed from 3-1-99 through 12-31-99 - 2,160,945
  - Total Direct Member Reimbursement (DMR) claims processed from 3-1-99 through 12-31-99 - 10,947
  - Total Dollars paid from 3-1 through 12-31-99 - $59,775,937.77
  - Total Dollars paid for DMR claims from 3-1 through 12-31-99 - $328,417.90

Contract and Audit reports review

To determine the quality management oversight activity of CIGNA and CHC-NH, the examiners reviewed the contracts and corresponding amendments in force during the examination period.

PDM Contract

Section 3.3 of the PDM contract states "Where PDI (a Healthsource pharmaceutical subsidiary) requests access for the purpose of conducting an audit, such Audit may be conducted at PDM during regular business hours upon receipt by PDM at least ten days in advance have written notice from PDI of its intent to initiate such Audit." From the examiner's discussion with the CIGNA Corporate Coordinator who handled the transition from PDM to ARGUS, it was determined that CIGNA Healthcare did not conduct oversight audits of the PDM contract for 1997 and 1998.
Additionally, Exhibit B of the PDM contract contains performance standards to measure performance levels of PDM on a monthly basis. The examiners noted that these monitoring measures were not offered to verify oversight of PDM's performance.

ARGUS Contract

CIGNA did perform corporate wide audits of ARGUS's contractual performance in August and December 1999. The examiners reviewed both reports and made the following determinations:

* CHC-NH Quality Management does not have any established QM oversight of ARGUS claims processing accuracy (member or provider) to date. Per the Director of Quality Management, the delegated functions performed by ARGUS are not within the scope of the QM Program.

* The August CIGNA Healthcare Corporate Audit report lacked any evidence of claims processing accuracy testing by ARGUS or CIGNA. The examiners' inquiries determined that ARGUS did not feel it was their responsibility to review processed claims for accuracy.

* Exhibit B of the existing contract with ARGUS was developed as a direct result of the CIGNA Healthcare Corporate Audit teams findings in August of 1999. The Exhibit was added as an amendment to the contract in September of 1999 (EXHIBIT B - PERFORMANCE GUARANTEES). The exhibit established claims accuracy standards and direct inquiry standards.

* The December audit report published the results of CIGNA's examining ARGUS's performance under those new standards. The report had findings of untimely input of contractual, group benefit structures, rate and eligibility information. These deficiencies have a direct impact on the DMR claims generated for process. However, the claims review performed by CIGNA encompassed provider claims, only. Hence, the report had no impact on DMR claims that are inputted for processing by CHC-NH personnel.

* Since the same claims processing system is used to pay both provider and member claims, ARGUS generates all Explanations of Benefit Forms for claims processed.

Based upon the above determinations, the examiners made the following findings:

a. During the examination period, CHC-NH did not conduct a quality management oversight review of the delegated claims processing services conducted by PDM.

b. CHC-NH Quality Management department does not encompass pharmacy claims and/or member and provider inquiries directed to its delegated processor, ARGUS, within its' standard reporting of processing claims quality.

Administrative Recommendation:

The Quality Management or Claims department established procedures, standards and quality level monitoring of member submitted pharmacy claims, to be included in the standard quality management reporting.

Claims Testing

To determined compliance with NHCAR Part 1001, the examiners requested a random sampling of member-submitted claims or DMR's and the attending Explanation of

Benefits (EOB). CHC-NH personnel stated that all of the PDM claims were in storage and would be time consuming to retrieve. They suggested that the examiners concentrate their efforts on the ARGUS claims. From a universe of 6400 DMR claims, a random sample of 50 claims and EOB's was selected for testing.

Timeliness of payment:

The examiners tested the 50 claims in its sample for timeliness of payment in accordance with NHCAR Part 1001.02 (a). The following results and findings were documented from the study:

a. 76% of the selection could not be used for timeliness measure, as the receipt date was not available. Documentation of the ARGUS claims processing information revealed that the date received was actually the entry date by the claim processor, not the date that CHC-NH originally received the claim.

b. The EOB date and the check date reflect the same origination date. However, it was found that the paid date was not reflective of the actual claim payment. An additional 5 calendar days elapsed from the paid date recorded in the system until the date the check is issued and released.

c. Ten (10) claims (or 20% of the sample) could not be located within the Macess System. The present method of retaining member submitted claim image is to process within unit and forward to be scanned into the Macess correspondence folder for that member. The examiners determined that inconsistencies exist in the scanning of this claims documentation. Some claims could not be found; some were found in the individual's correspondence file and others were filed in the wrong member folders. These imaging problems could cause a duplication of processing efforts and potential duplicate payment.

d. The remaining 24% of the sample (12 claims) took an average of 20 days to process (from entry date of claim to date of EOB). Due to the deficiencies in the sample, these results may not represent the processing system as a whole. However, the examiners did determine that ARGUS is processing claims within the contractual 30-day limit.

e. Five of the claims within the member submitted claims sample identified the lack of timeliness in the update of their Eligibility and/or Benefit record. Two claims related to the lack of receipt of an ID card prior to effective date of coverage (an enrollment issue). Three claims related to a change in existing eligibility/benefit (an ARGUS updating of records issue). Each of these situations caused the member to pre-pay the prescription and submit receipted bills for reimbursement. This result is not in compliance with the GSA (General Services Agreement) which outlines the methods of pharmacy benefit utilization.

Recommendation:

CHC-NH initiate procedures to capture the data necessary to measure the timeliness of process for member submitted pharmacy claims for compliance to NHCAR Part Ins. 1001.02 (a).

Administrative Recommendations:

1. **All pharmacy claims received are scanned into Macess prior to processing (consistent with other claim types) to assure control of claim receipts, increasing efficiencies and secure a reference date for claims processing corporate, NCQA and regulatory compliance.**

2. **CHC-NH establish procedures and quality measures to remedy the inconsistencies found in Macess and provide consistent imaging of the pharmacy claims.**

3. **CHC-NH review its enrollment timeliness procedures for compliance with internal policy and procedure standards.**

Accuracy of Payment

A sample of 50 member submitted claims were reviewed for accuracy of process. The review encompassed the entire process to include CIGNA personnel and the Argus intervention for claims adjudication and check issuance. The following items were determined:

a. Incomplete Records
   Two (2) claims (4%) within the sample could not be located within CIGNA Healthcare Inc. record retention files. Verification of payment could not be determined. The audit trail for these member-submitted claims was incomplete.

b. Social Security number
   Three (3) claims (6%) within the sample related to South Carolina using the member SSN as the ID number and ARGUS processor requiring a 9 digit ID number with a suffix in the ID number field. New Hampshire ID numbers filled with a suffix created matching Social Security numbers with some of the South Carolina members. This problem was identified and in June 1999 a system enhancement was made to assure proper payment designation (added DOB to eligibility criteria). Discussion with the pharmacy operations director and documentation of enhancement verified awareness of potential errors.

c. New Hampshire and Vermont membership update
   This sample identified 3 claims (6%) with unmatched name and ID numbers for New Hampshire and Vermont members. Two claims had a New Hampshire address on the Explanation of Benefits and the checks. These same two claims had a Client # 47,

which represents a Vermont member. All three claims had a similar concern relating to payment error resulting from an 8/6/99 eligibility file update.

d. Explanation of Benefits
The Explanation of Benefits (EOB) found within the samples are not in compliance with NHCAR Part Ins. 1001 in it's entirety (specifically 1001.01, 1001.02 (f), 1001.04 and 1001.06). The EOB's were also found to be non-compliant with NHCAR Part Ins. 1001 in the prior Market Conduct Examination Report for the year ending 12/31/96. In that report, the examiners made similar findings and recommended implementation of procedures to comply with NHCAR Part Ins. 1001. Those findings and recommendations did not reference any specific claim type. Neither did they exclude delegated claims processing. Pharmacy claims should have been considered in the revisions implemented to achieve compliance with the 1996 examination recommendations.

Recommendation:

All Explanation of Benefits, acknowledgements, denials, and delay letter procedures be implemented for pharmacy claims to establish proper notification to members as required within NHCAR Part Ins. 1001. Subject to the Commissioners discretion, the company may be penalized under NHCAR Part Ins 1001.16 for continued non-compliance with NHCAR Part Ins 1001.

Administrative Recommendation:

CIGNA implement a quality claim review for pharmacy claims submitted by members to improve the accuracy of claims paid. The examiners specifically recommend that:

a. **A follow-up review of the June 1999 system enhancement be completed to determine its effectiveness in solving the Social Security/ID number situation.**

b. **Verification of the 8/6/99 eligibility impact between NH and VT be quantified and safeguards be established to prevent future occurrences.**

The following errors were also identified within this sample. These errors could effect future claims payments:

* Audit trail – 30% of claims reviewed did not properly reflect a complete and accurate record of the claims processed.

* Incomplete or improperly filed claims data that could increase company exposure to duplicate payments

* Claims processing policies and procedures were not consistent. A receipted bill was not always required and the patient and/or pharmacist's signature was not always obtained.

* Explanation of Benefits for member submitted claims were not reflective of the actual claim payment reasoning. Limited pay codes are available for member submitted claims processing within ARGUS systems.

Administrative recommendation:

1. **CIGNA or CHC-NH corporate audit activity be shared with the Claims Department quality testing (being established) which would eliminate future errors and could ultimately decrease member submitted claims.**

2. **The quality measures established for pharmacy claims processing address the errors relating to adequacy of audit trail for members submitted claims.**

XII. CONCLUSION

The examiners would like to acknowledge that during the exit conference CHC-NH submitted documentation of remedial action taken in response to several of the findings and recommendations contained in this report.

The examiners would like to thank CIGNA HealthCare of New Hampshire, Inc. for their cooperation during this target examination. Special recognition must be given to Gena Moses for her aid in coordinating our requests. In addition to the undersigned, John M. Tailey, Esq. and Joelien Atwater, examiners for the New Hampshire Insurance Department, participated in the work and preparation of this report.

Respectfully submitted,

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Robert C. Warren, Jr., Examiner-in-Charge

APPENDIX I

Summary of Recommendations

PROVIDER CREDENTIALING

Administrative Recommendation:

The Plan establish procedures that would allow a better audit trail of credentialing documentation in the Macess system.

MEMBER SERVICES – COMPLAINT AND GRIEVANCE PROCESS

Recommendations:

1. CHC-NH change the above stated procedures to comply with RSA 420-J:5, III(a) as stated. However, since the actual appeal hearings and decisions complied with RSA 420-J:5, the examiners do not recommend that sanctions be imposed for the procedural violations.

2. CHC-NH amend its procedure to comply with NHCAR Part Ins 1001.01(c). This recommendation was made in the last examination report. Subject to the commissioner's discretion, the company may be penalized under NHCAR Part Ins 1001.16 for continued non-compliance with NHCAR Part Ins 1001.01(c).

Administrative recommendation:

Telephonic contact with the NHID requesting an extension of time to answer should be documented in the member file. The examiners noted that there was evidence in some files that these had been done.

MARKETING AND SALES

Recommendations:

1. CHC-NH revise its renewal procedures to ensure that each small employer group be provided an annual open enrollment period that is 60 days in length as required by RSA 420-G: 8, I.

2. CHC-NH revise its procedures to require new CHC-NH sales representatives to pass the licensing examination and become licensed prior to the representative actively soliciting or enrolling participants in accordance with

RSA 420-B:18. For the admitted Activity in violation of this statute, the Insurance Commissioner may, at her discretion, impose penalties on HSNH under RSA 420-B:19.

Administrative recommendations:

1. CHC-NH should require new sales representatives to enter a pre-licensing training program immediately after their date of hire. For this to be possible, pre-licensing training programs should be available year round. As this is presently not the case, CHC-NH should address this problem either by developing its own pre-licensing training program or by sending new sales representatives to more than one pre-licensing training program. Should CHC-NH establish its own pre-licensing training program, it would be necessary for this program to be listed with the Insurance Commissioner as an approved pre-licensing course pursuant to NHCAR Part Ins 1301.02(b)[1]

2. CHC-NH should adopt a policy that all new sales representatives must be accompanied by a licensed sales representative whenever they are, or may be, involved in a solicitation or enrollment situation until he or she becomes licensed by the NHID.

UNDERWRITING AND RATING

Group Subscriber Agreements

1. To comply with RSA 420-B, 8-b, I (b), CHC-NH include a statement in all present and future GSA's to the effect that a primary care physician may refer an enrolled participant or member to any mental health provider within the CHC-NH mental health provider network.

2. CHC-NH revise all GSA's in use to change the language of the eligibility section in order to incorporate the above substitute language (or similar language) suggested by the Insurance Department to comply with RSA 420-G:6, I.

Administrative recommendation:

A cross-referencing statement be added to the exclusion for "nutritional supplements, formulas and therapies" to reference the benefit that provides coverage for enteral formula and food modified to be low protein.

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[1] CIGNA does offer a New Hire Core Program, an 11 week training program for new hires. This program prepares the participant for the state licensing examination in the very first week. However, it is offered only twice a year and not all new hires attend. Attendance is at the discretion of the Sales Manager. Generally, new hires with prior industry experience do not attend the program.

CIGNA/Healthsource Internet Web Sites

Recommendation:

To correct the specific findings stated above, The CIGNA Healthcare New Hampshire Policy and Procedure Manual on the CIGNA Web Site be revised to comply with New Hampshire law.

UTILIZATION REVIEW

Recommendations:

1. CHC-NH revise its Utilization Management policies and procedures regarding Insufficient Clinical Information to include the requirements of NHCAR Part Ins 2001.11(g) to notify the patient or physician within 24 hours of the need for additional clinical information.

2. CHC-NH revise its Utilization Management policies and procedures regarding Secondary Surgical Opinions to include the requirements of NHCAR Part Ins 2001.11(a)(1) which requires that a secondary opinion be given within 2 days after all of the required information is obtained.

QUALITY ASSESSMENT AND IMPROVEMENT

Recommendation:

In order to comply with NHCAR Part Ins 2001.14 (a)(1) and (2), CHC-NH should periodically review the confidentiality statements for updating and completeness.

CLAIMS

Denied Claims

Recommendations:

CHC-NH develop and implement procedures to fully comply with NHCAR Part Ins 1001.02(a).

Administrative Recommendations:

1. CHC-NH investigate the use of the participating provider message and the notation that the charges are the patient's responsibility, relating to denied charges.

1. The denial letters sent to members be revised to include the current address of the New Hampshire Insurance Department.

2. If a New Hampshire provider submits a mental health claim to CHC-NH in error, CHC-NH should forward the claim to CIGNA Behavioral Care, Inc. Upon forwarding the claim, CHC-NH should generate an EOB with a message stating that the claim has been forwarded to the Mental Health Administrator.

3. If the member submits the claim, the claim should likewise be forwarded to CIGNA Behavioral Care, Inc. and the same message should be transmitted to the member by letter or through the processing system generating an Explanation of Benefit.

Member-submitted claims

Administrative recommendations:

1. The date of service assigned manually for incentive check claim generation is consistent with qualifying policies to eliminate potential inaccuracies in history data and eliminate potential overpayment.

2. The incentive check electronic claims generating system be enhanced to identify a break in coverage and/or the claims processing system enhance coverage criteria to suspend and question these claims.

DELEGATED SERVICES

Contract and Audit reports review

Administrative Recommendation:

The Quality Management or Claims department establish procedures, standards and quality level monitoring of member submitted pharmacy claims. Data relevant to such claims should be included as part of the standard quality management reporting.

Claims Testing

Recommendation:

1. CHC-NH initiate procedures to capture the data necessary to measure the timeliness of process for member submitted pharmacy claims and to use such data to monitor compliance with NHCAR Part Ins 1001.02(a).

Administrative Recommendations:

1. All pharmacy claims received should be scanned into Macess prior to processing (consistent with other claim types) in order to assure control of claim receipts, increase efficiencies and secure a reference date to use in measuring compliance with corporate, NCQA and regulatory claim processing standards.

2. CHC-NH establish procedures and quality measures to remedy the inconsistencies found in Macess and provide consistent imaging of pharmacy claims.

3. CHC-NH review its enrollment timeliness procedures for compliance with internal policy and procedure standards.

Accuracy of Payment

Recommendation:

1. All explanation of benefits, acknowledgements, denials and delay letter procedures be implemented for pharmacy claims to establish proper notification to members as required within NHCAR Part Ins 1001. Subject to the Commissioner's discretion, the company may be penalized under NHCAR Part Ins 1001.16 for continued non-compliance with NHCAR Part Ins 1001.

Administrative recommendations:

1. CIGNA or CHC-NH corporate audit activity be shared with the Claims Department quality testing (being established) which would eliminate future errors and could ultimately decrease member submitted claims.

2. The quality measures established for pharmacy claims processing should address the errors relating to adequacy of audit trail for member submitted claims.

3. CIGNA implement a quality claim review for pharmacy claims submitted by members to improve the accuracy of claims paid. The examiners specifically recommend that:

a. A follow-up review of the June 1999 system enhancement be completed to determine its effectiveness in solving the Social Security/ID number situation.
b. Verification of the 9/6/99 eligibility impact between NH and Vermont be quantified and safeguards be established to prevent future occurrences.