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STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

In Re: Cigna HealthCare of New Hampshire, Inc.

AMENDED ADMINISTRATIVE ORDER

Docket No.: INS No. 07-007-EP

Cigna HealthCare of New Hampshire, Inc. ("Cigna")
Analysis on Compliance with New Hampshire RSA 400-A:37, RSA 420-B:10 II, RSA 420-J:5 V, Ins 1001.04 (a), (b), Ins 3005.01

Background

1. Cigna Healthcare of New Hampshire, Inc. (hereinafter "Cigna") is a domestic stock insurance company licensed to conduct business in the state of New Hampshire. Under RSA 400-A:37, the New Hampshire Insurance Commissioner (hereinafter "Commissioner") may perform an examination of any domestic company licensed in New Hampshire.

2. On July 21, 2006, the Commissioner, under RSA 400-A:37, initiated a desk review examination of Cigna for the purpose of determining Cigna's compliance with a previously issued Consent Order and Agreement issued in June 2005 in Docket No. Ins. 05-032-MC. The purpose of the examination was to determine whether Cigna had achieved compliance with the requirements of that order and with New Hampshire insurance laws and rules.

3. The scope of the examination was to evaluate Cigna's compliance with the statutory and regulatory requirements of RSA 420-J:V and Ins 1001 for grievance and appeals procedures for the period of July 1, 2005 through December 31, 2005.

4. The desk review examination was conducted from July 21, 2006 until December 2006.

Facts and Findings

5. In December 2006, the examiners terminated the examination due to Cigna's failure to produce documentation that the examiners believed was required to

determine compliance with the grievance procedures. During the examination, Cigna stated that when it denied a post-service administrative claim that it did not provide an initial claim denial notification that stated the basis for denial.

6. Cigna's practice of not providing the member with either a claim denial notification or an explanation of benefits prevented the examiners from determining whether Cigna complied with the requirements of the previous Consent Order and Agreement relative to grievance procedures. As a result of Cigna's failure to provide initial claim determinations, the examiners terminated the examination without making any specific findings relative to Cigna's compliance with the terms of the 2005 Consent Order and Agreement.

7. Although the examination was terminated without findings as to Cigna's compliance with the terms of the 2005 Consent Order and Agreement, the examination revealed that Cigna's practices violated other New Hampshire insurance law and rules.

8. Specifically, the examiners determined that Cigna's practice of not providing a claim denial letter or an explanation of benefits form for a post-service administrative claim violated RSA 400-A:37 and RSA 420-B:10 II, which require that a carrier maintain records that are sufficient to allow the state to conduct an examination of its business.

9. Cigna's failure to issue an initial claim denial letter or provide an explanation of benefits form for a denial of a post-service administrative claims prevented the examiners from determining whether the grievance appeals process complied with the terms and conditions of the 2005 Consent Order and Agreement. For example, Cigna's failure to provide an initial claim determination letter prevented the examiners from testing Cigna's compliance with the statutory requirement and confirming that the policyholder received adequate explanation of denial and the right to appeal.

10. Cigna's failure to issue an initial claim denial letter or an explanation of benefits form for claim denials also violated Ins 1001.04, which requires that, "If a claim is denied in whole or in part the insured, claimant or authorized representative of either shall be given the reason for the denial. In any case where coverage is denied the insurer shall notify the insured, claimant or authorized representative of either of the applicable policy provision upon which denial is based." In addition, Ins 1001.04 provides that, " Statements setting forth benefits included within claim payments shall be in writing and in sufficient detail so that the insured, claimant or authorized representative of either can reasonably understand the benefits included within the claim payment."

11. During their review, the examiners also found violations of RSA 420-J:5 V that had not previously been documented in the 2005 Consent Order and Agreement. RSA 420-J:5 V (a)(1) requires that the claimant be provided with the specific reason or reasons for the determination. Over thirty percent (30%) of the written communications that the examiners reviewed were misleading and inaccurate and failed to fully inform the member as to the basis for the denial of the claim. The written determinations issued by Cigna failed to meet the standard required by RSA 420-J:5 V (a)(1) for the following reasons:
    a. The letters were poorly written, contained multiple phrases separated by colons, and did not identify the specific reason why the particular subscriber's claim had been denied.
    b. The letters contained contradictory statements such as, "After review of the information submitted and the terms of your benefit plan, I am pleased to inform you that we have authorized the reprocessing of the claim submitted…" followed by, "Please note that services which require prior authorization must have that authorization placed on file with the health plan prior to the services being rendered."
    c. The letters contained incomplete sentences that failed to communicate the basis for decision, such as, "Our records indicate that Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition; orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism and maxillary constriction."
    d. The letters contained typographical errors that changed the meaning of the decision such as, "There are no benefits on your plan to covered Non-Participating Providers."
    e. The letters contained "stock paragraphs" that were inaccurate and misleading such as, "According to your benefit booklet rendered in an in-network outpatient hospital facility…"

12. The examiners also reviewed explanation of payment documents during the examination. The reason for the review of these payment documents was to determine the basis for the initial denial of certain claims. The explanation of payment documents included information on a number of claims and policyholders in addition to the claims that were the subject of the examination. Before providing these documents to the examiners, Cigna should have redacted the confidential information included in the documents that was beyond the scope of the examination. Cigna failure to do this resulted in the disclosure of confidential protected health information that was outside of the scope of the examination.

Findings

13. Cigna violated RSA 400-A:37, RSA 420-B:10 II, Ins 1001.04, RSA 420-J:5 V by failing to provide initial determination letters or explanation of benefits for its claim denials and by failing to provide written determinations on appeal that informed claimants of the specific reason or reasons for denial of the claim.

14. Cigna also violated RSA 420-J:5 V and Ins 1001 by failing to maintain its documents and files in such a manner as to allow the Commissioner to conduct an examination and determine compliance with the insurance laws and the 2005 Consent Order and Agreement.

Order

1. Cigna shall immediately prepare a formal written Corrective Action Plan ("Plan") incorporating all elements necessary to achieve full compliance with RSA 420-J:5 and Ins 1001.04. Cigna shall submit a copy of the plan, which shall include a contact name, telephone number and e-mail address of the individual responsible for implementing the Plan to the Commissioner for approval within 30 days from the date of this Initial Order issued on 2/27/07. Upon approval by the Commissioner, Cigna shall implement the requirements of the Plan in a timely manner.

2. The Corrective Action Plan shall meet the following standards:

   - The Plan shall describe in detail proposed enhancements or system changes that will ensure compliance with RSA 420-J:5 V and Ins 1001.04, and shall specify the dates for the completion of each phase. The Plan shall also include the full implementation and completion deadline date, which shall be no later than 120 days from the date of the Initial Order.
   - The Plan shall include specific operational steps that will be developed and implemented to achieve compliance with RSA 420-J:5 V and Ins 1001.04. The Plan shall provide a description of each step and include a full and detailed explanation that supports the Company's expectation that the operational changes will be achieved.
   - The Plan shall immediately implement a quality oversight process for all Level 1 and Level 2 grievance determination letters and provide copies of the documented process to the Commissioner, within 30 days of the Initial Order. The Plan must include the requirement that Cigna provide the department with copies of all Level 1 and Level 2 Appeal letters issued in

the previous month by the last business day of each month for a six-month period following the date of this order.

- The examiners will review, document and communicate their findings with regard to Cigna's compliance with the Corrective Action Plan no later than ten business days after receipt of the material. Violations shall subject Cigna to additional fines and penalties.

3. An administrative fine of $35,000 is assessed against Cigna. The department agrees that Cigna shall make a payment in the amount of $30,000 within 10 days of the date of the Amended Order. The remaining $5,000 of the administrative fine shall be suspended pending Cigna's compliance with the terms of the Initial Order issued on February 27, 2007. Should the department determine that Cigna has failed to comply with the terms of the Initial Order, it shall issue a further order with findings and Cigna shall have the right to appeal that order and the findings of the department therein.

4. If deemed necessary by the Commissioner, Cigna, upon reasonable advance notice, shall submit to a follow-up market conduct examination to be conducted within 24 months to determine compliance with the Initial Order.

5. If Cigna fails to comply with the terms of the Initial Order, either in whole or in part, the Commissioner may, at his option institute an action to enforce compliance with this Order in the Merrimack County Superior Court.

6. This Amended Order is issued by Consent with Cigna as indicated by its signature.

NEW HAMPSHIRE INSURANCE DEPARTMENT

Alexander K. Feldvebel — 4/30/07

Alexander K. Feldvebel
Deputy Commissioner

Date

Cigna Healthcare of New Hampshire, Inc.

5/14/07

Company Officer

Date