ORDER

BY THE HONORABLE ROGER A. SEVIGNY
INSURANCE COMMISSIONER OF THE
STATE OF NEW HAMPSHIRE

IN THE MATTER OF:

Cigna Life and Health Insurance Company, NAIC #67369

TARGETED MARKET CONDUCT EXAMINATION REPORT – SUD BENEFITS
Docket No.: INS No. 15-074-MC

WHEREAS, the New Hampshire Insurance Department ("the Department") conducted a targeted market conduct examination of the above-referenced insurance company ("the Company") regarding its handling of substance use disorder ("SUD") benefits during the period January 1, 2015 through September 30, 2015, and the examination resulted in a Verified Market Conduct Examination Report ("Verified Report") as of November 1, 2016.

WHEREAS, the Verified Report contains the findings and recommendations of the Examiners.

WHEREAS, the Company received a copy of the Verified Report, and, by correspondence dated December 5, 2016, submitted a Rebuttal to the Verified Report to the Department but did not specifically request modification to the Verified Report.

WHEREAS, by an Order executed by the Commissioner on December 27, 2016, the Department adopted the Verified Report pursuant to RSA 400-A:37, IV (b) (1) with modifications as noted in that Order.

WHEREAS, the Company did not request a closed meeting with the Commissioner pursuant to RSA 400-A:37, IV (c) (2).

WHEREAS, the Adopted Report has been modified slightly at the request of examiners to clarify the examiners' explanation of market conditions with respect to network adequacy, a change which does not alter the examiners' findings with respect to the Company's practices.

NOW THEREFORE, in accordance with RSA 400-A:37, IV (c)(4), the Adopted Report, as modified, is hereby accepted and filed, and shall be deemed final.

It is **SO ORDERED**

New Hampshire Insurance Department

Date: February 7, 2017

Roger A. Sevigny, Commissioner

STATE OF NEW HAMPSHIRE

COUNTY OF MERRIMACK

Joelien J Atwater, being duly sworn, upon her oath deposes and says:

That she is an examiner employed by the Insurance Department of the State of New Hampshire;

That an examination was made of the affairs of the

Cigna Health and Life Insurance Company, Inc.

Organized and authorized under laws of the State of **New Hampshire,**

Vested by **Roger A. Sevigny**, Commissioner of Insurance of the State of New Hampshire;

That she was the examiner-in-charge of said examination and that the attached report of the examination is a true and complete report of the condition of the above named Company as of October 28, 2016 as determined by the examiners.

Examiner-In-Charge

Subscribed and sworn to before me this
1st Day of November, A.D. 2016

Notary Public/~~Justice of the Peace~~
EXP 3/25/2020

NEW HAMPSHIRE INSURANCE DEPARTMENT

MARKET CONDUCT TARGETED EXAMINATION

OF

CIGNA HEALTH & LIFE INSURANCE COMPANY

900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

NAIC# 67369

FOR THE PERIOD OF JANUARY 1, 2015 THROUGH SEPTEMBER 30, 2015

REGARDING THE HANDLING OF SUBSTANCE USE DISORDER BENEFITS AND

MENTAL HEALTH PARITY

FINAL

AS OF

FEBRUARY 7, 2017

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Scope

Pursuant to RSA Chapter 400-A:37, the New Hampshire Insurance Commissioner (Commissioner) issued an examination warrant for the purpose of examining Cigna Health and Life Insurance Company's (Cigna) administration of benefits for Substance Use Disorder (SUD) and Addiction treatment services.

The goal of the examination was to ascertain how carriers regulated by the New Hampshire Insurance Department (Department) are providing coverage for SUD treatments and to ensure that benefits are consistently applied within the requirements of state and federal law and are not subject to more stringent requirements than for Medical/surgical benefits during the examination period of January 1, 2015 through September 30, 2015.

Specifically, this examination encompassed all regulatory requirements under RSA Title XXXVII that apply to the health carrier's practices for the handling of SUD services under both New Hampshire and federal law, including but not limited to:

1. RSA 417-E:1, V and RSA 420-B:8-b, V, which authorize the Commissioner to enforce the provisions of the federal Mental Health Parity Addiction Equity Act of 2008, codified at 29 U.S.C § 1185a (MHPAEA) that relate to the business of insurance, including federal regulations adopted under MHPAEA, 45 CFR Section 146.136, Parity in mental health and substance use disorder benefits (federal parity rule)[1];
2. RSA 420-N:5, which authorizes the Commissioner to enforce the consumer protections and market reforms set forth in the Affordable Care Act (ACA) including the ACA's amendments to MHPAEA;
3. RSA 415:18-a, requiring coverage for mental or nervous conditions and treatment for chemical dependency under group health plans;
4. RSA 420-B:8-b, requiring Health Maintenance Organizations (HMOs) provide coverage for mental and nervous conditions and chemical dependency;
5. RSA 417-E:1, requiring coverage for certain biologically-based mental illnesses that is in parity with coverage for physical illness; and
6. Provisions of New Hampshire's Managed Care Law, including RSA 420-J:5 through 5-e, governing appeals; RSA 420-J:7, regarding network adequacy; RSA 420-J:8-a, requirements for prompt pay; RSA 420-J:4 governing provider credentialing and RSA 420-J:6, regarding utilization review.

[1] This Examination applied the federal parity rule rather than New Hampshire's parity rule, N.H. Code of Admin. R. Ins Part 2702, as the federal rule is more recent and more comprehensive. As noted below, the Examination applied state law requirements in addition to federal requirements when the state requirements were stricter and/or more protective of the consumer.

The examination was conducted in two phases. Phase I included sending interrogatories to obtain initial information regarding the following areas: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals and Claims. Phase II included a series of interrogatories to verify Medication Assisted Treatment (MAT) practices and overall compliance with both quantitative and non-quantitative requirements of the MHPAEA.

For the purposes of this examination, the Department contracted with the following as outside examiners (1) an Independent Review Organization (IRO) that provided the medical expertise of addiction specialists; (2) a mental health parity expert; and (3) a pharmacist to assist with the interpretation of the documentation provided with respect to pharmacy benefits.

Phase I

On December 4, 2015, the Department sent interrogatories and a Behavioral Health Survey to Cigna. Cigna was requested to provide a detailed response to the survey and interrogatory questions as they relate to fully-insured group health benefit plans. When referencing small and large groups, the Department requested that the employer/group contract must be situated in the state of New Hampshire with one or more New Hampshire employees.

Cigna was required to provide information relative to the following operational areas:

- Delegated Service Contracts
- Network Adequacy
- Pre-authorizations
- Grievances and Appeals
- Claims

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

The Department's primary objective in conducting Phase I of the examination was to evaluate whether the carrier is covering SUD benefits no less favorably than Medical/surgical benefits. The goals and objectives in conducting the Examination included but were not limited to the following:

1. Evaluate the carrier's delegated service contracts to ensure that if the carrier has delegated SUD utilization or case management reviews, that:

- The delegated entity has the appropriate expertise to perform SUD reviews;
- The delegated entity has applied clinically appropriate criteria and guidelines; and,
- The criteria and guidelines utilized do not impose any limitations on SUD services that are more stringent than those applied to Medical/surgical services.

2. Evaluate the carrier's provider network to determine whether there are a sufficient number of providers, including providers that specialize in Behavioral Health/SUD services, and to ensure that consumer access to services is available without unreasonable delay.
    - Review and test the carrier's website for ease of use and accuracy of on-line directory
3. Evaluate the carrier's entire universe of SUD pre-authorization denials during the examination period to ensure that denials were appropriate based on medically sound criteria.
4. Test 100% of the carrier's SUD grievances and appeals during the examination period to determine:
    - If the appeal determination was made in accordance with clinically appropriate criteria and guidelines, contractual obligations and all applicable state and federal laws; and
    - That all adverse benefit determination letters included information regarding any right to external review and all required contact information.
5. Measure the carrier's claims to quantify volumes of SUD claims for services in comparison to Medical/surgical services.

Phase II

This phase consisted of two major components: Medication Assisted Treatment (MAT) and carrier compliance relative to the MHPAEA and the federal parity rule. This included an in depth review by a contracted pharmacist of Cigna's practices for MAT to establish a baseline for the program.

The Department's primary objective in conducting the examination was to evaluate whether the carrier is covering Behavioral Health benefits no less favorably than Medical/surgical benefits. The goals and objectives in conducting Phase II of the Examination included but are not limited to the following:

1. Identify all market segments that are subject to MHPEA to determine that the carrier is not limiting coverage or benefits inappropriately in any market.
2. Identify any variations for coverage or benefits for these market segments and ensure that any identified variances are in compliance with the

appropriate statutes and regulations, including all allowed variances outlined in 45 CFR § 146.136.

3. Determine that the Behavioral health benefits provided in the classifications identified by 45 CFR §146.136 (a)(c)(2)(ii)(A); in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency and pharmacy, are paid in parity with benefits in the same classification under Medical/surgical.
4. Evaluate the carrier's quantitative and non-quantitative benefit limits to ensure that limitations are consistently applied through Behavioral Health and Medical/surgical benefits and that any quantitative limitations imposed meet the two-thirds threshold of the substantially all requirement outlined in 45 CFR § 146.136 (a)(c)(3)(i).
5. Evaluate the carrier's Medical Necessity policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral Health treatments than on Medical/surgical.
    a. Evaluate the Medical Necessity requirements to determine that the guidelines are clearly outlined and presented to consumers in a format compliant with all applicable statutes and regulations.
6. Evaluate the carrier's Pre-certification/prior-authorization policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral Health treatments than on Medical/surgical.
7. Evaluate the carrier's reimbursement fee schedule to determine if the reimbursement fees are consistently applied to Behavioral health and Medical/surgical, and to determine that any fee updates are consistently applied to both Behavioral health and Medical/surgical providers.
8. Evaluate the carrier's Usual and Customary allowances to determine that benefit reductions are not applied more strictly to Behavioral Health than to Medical/surgical benefits.
9. Measure the carrier's claims to quantify volumes of SUD claims for services in comparison to Medical/surgical services which include Behavioral Health.

In the MAT portion of Phase I and II, interrogatories were sent to the carrier by the pharmacist and detailed responses were requested. The information received was reviewed by the pharmacist with oversight by the Department's examiners. The examiners and contracted pharmacist worked with the carrier to answer follow-up questions or discuss deficiencies.

In Phase II's area of Mental Health Parity compliance, on May 17, 2016, the contractors acting on behalf of the Department sent interrogatories based on Cigna's responses to the Behavioral Health Survey the carrier had completed as part of the initial phase of

the examination. Cigna was requested to provide a detailed response to the interrogatory questions as they relate to fully-insured group health benefit plans. On June 23, 2016, follow-up interrogatories were sent.

Specifically, Cigna was required to provide information relative to the following:
Medication Assisted Treatment (MAT)

- Formularies to determine the number of SUD medications offered
- Documentation to ensure that inappropriate age limitations were not imposed through discriminatory benefit designs for MAT medications
- Processes and policy language presented to the consumer that explain how to request an exception for coverage of medications not covered under the plans formulary
- Documentation regarding the dosage and refill limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Documentation regarding lifetime or annual limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Preauthorization, re-authorization or step therapy processes or any other utilization review requirements specific to methadone and/or buprenorphine
- Information regarding penalties or exclusions of coverage for failure to complete a course of treatment specific to methadone and/or buprenorphine
- Medical necessity standards applied to methadone and/or buprenorphine

Mental Health Parity and Addiction Equity Act (MHPAEA):

- Market segments served by the carrier which are subject to MHPAEA
- Variances in requirements for Medical/surgical benefits and Behavioral Health benefits
- Classification and sub-classification of benefits for both Medical/surgical Medical/surgical and Behavioral Health in the following categories
    - In-network inpatient
    - Out-of-network inpatient
    - In-network outpatient
    - Out-of-network outpatient
    - Emergency
    - Pharmacy
- Quantitative and Non-quantitative Treatment limits for both Medical/surgical benefits and Behavioral Health benefits
    - Medical Necessity Requirements including notifications provided to members outlining the Medical Necessity Requirements for both Medical/surgical and Behavioral Health

- Precertification/Pre-authorization requirements for both Medical/surgical and Behavioral Health including policy language
- Provider reimbursement rates and fee schedules for both Medical/surgical and Behavioral Health
- Processes and Procedures for determining Usual and Customary and frequency of updates of such for both Medical/surgical and Behavioral Health; and
- Claims volume for both Medical/surgical and Behavioral Health

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

Company Profile

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as ‘‘Cigna,’’ the ‘‘Company,’’ ‘‘we,’’ ‘‘our’’ or ‘‘us’’) is a global health services organization dedicated to a mission of helping individuals improve their health, well-being and sense of security. To execute on our mission, Cigna’s strategy is to ‘‘Go Deep’’, ‘‘Go Global’’ and ‘‘Go Individual’’ with a differentiated set of medical, dental, disability, life and accident insurance and related products and services offered by our subsidiaries.

On April 1, 2008, Connecticut General Life Insurance Company (“CGLIC”) entered into an asset and stock purchase agreement with Great-West Life & Annuity Insurance Company (“Great-West”) whereby CGLIC acquired the health care division of Great-West through a fully assumed indemnity reinsurance agreement and acquired Alta Health and Life Insurance Company (“Alta), an Indiana-domiciled life and health insurer, through a stock purchase. As a result, Alta became a direct wholly-owned subsidiary of CGLIC and an indirect subsidiary of Cigna Corporation. On March 3, 2010, Alta was redomesticated from Indiana to Connecticut and its name was changed to Cigna Health and Life Insurance Company (“CHLIC”).

CHLIC is licensed in the 50 states and the District of Columbia, Puerto Rico and US Virgin Islands. It offers group life, accident, disability and health and dental insurance products. In several states, it also offers individual health insurance products. It also contracts with employers, unions and other groups to administer self-insured group health benefit plans and provide related services. In New Hampshire, CHLIC is licensed for accident, health, life and variable products lines of business.

Executive Summary

The following summary of this targeted market conduct examination of the carrier is intended to provide a high-level overview of the examination results. The report includes sections which detail the scope of the examination, tests conducted, findings and observations. Appendices include the Interrogatories and Data Requests sent to Cigna.

One of the most predominant observations Examiners wish to note is the overall shortage in New Hampshire of available SUD and Behavioral Health providers in which to contract.

The examination included the following areas of review: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals, Claims, and Medication Assisted Treatment specific to SUD, as well as Parity between Behavioral Health and Medical/surgical services. Based upon our review of the information received from the carrier, the following is a summary of our findings/observations:

Delegated Services

Cigna has intercompany agreements with its affiliate, Cigna Behavioral Health, Inc. (CBH), in which CBH provides Cigna access to its behavioral health provider network and provides claims administration and utilization review services for SUD.

Network Adequacy

Deficiencies in the availability of servicing providers were identified, based upon New Hampshire Network Adequacy Standards RSA 420-J:7 and N.H. Code of Admin. R. Ins. Part 2701. These deficiencies are a result of a lack of providers in this area in New Hampshire.

Examiners determined that Cigna has a process in place to address deficiencies in network adequacy when identified.

Web-site Ease of Access

As a result of the network adequacy deficiencies, examiners extended their review to carrier website ease-of-use for identification of Behavioral Health providers.

Examiners found no exceptions.

Provider Directory Accuracy

As a result of the network adequacy deficiencies, examiners extended their review to the carrier's on-line provider directory to confirm the accuracy of the listing.

Examiners found no exceptions.

Pre-Authorizations

The Department contracted with a certified independent review organization (IRO) that provided 16 addiction specialists, to conduct a review of all pre-authorization medical necessity denials. This review consisted of 100% of all denials for SUD during the examination period of January 1, 2015 through September 30, 2015. The IRO agreed with Cigna's determination in all eight (8) cases reviewed for services rendered during the examination period.

In addition, the medical director of the IRO was asked to review the criteria used for the evaluation of Medical Necessity for SUD treatment and confirm that it is consistent with current medical standards. The medical director stated, "It is my medical opinion that the protocols are medically reasonable."

Grievances and Appeals

A review of all SUD Grievances and Appeals letters for the scope of the exam was conducted for compliance with RSA 420-J:5.

No compliance issues were identified.

Claims

Examiners quantified the overall volume and percentage of SUD claims in relation to Medical/surgical claims, but did not evaluate claim accuracy and timeliness. The data provided shows that SUD claims accounted for 1.32% of the overall processed claim volume for the examination period, while the SUD total paid charges equated to .42 % of the total paid charges.

Medication Assisted Treatment

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Cigna's MAT program in New Hampshire.

Medication assisted treatment is defined as any opioid addiction treatment that includes a Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction. The interrogatories that were developed reflect the most up-to-date information on opioid addiction and treatment with an understanding that opioid addiction is a chronic disease.

Examiners found no exceptions with Cigna's MAT program.

Mental Health Parity

For purposes of this report, this section refers to the services to which the parity laws are applicable interchangeably as either Mental Health or Behavioral Health benefits, categories which also include SUD services. Many documents presented by the carrier uses the term Behavioral Health rather than Mental Health. This term is used as an all-encompassing term that not only includes promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim to preventing or intervening in substance abuse or other addictions. However, because the term "Mental Health" is used in MHPAEA, the report does on occasion use the term "Mental Health" rather than "Behavioral Health." In several areas, the Parity review focuses on concerns of parity with respect to SUD services more narrowly, rather than looking at all areas that would fall under Mental Health or Behavioral Health.

A Mental Health Parity review was completed on the carrier's internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete the review, examiners looked at the responses received to the original Mental Health Parity Survey, follow-up interrogatory responses and the carrier's documented procedures. This review was performed to identify potential areas where procedures and protocols as well as access to Behavioral Health benefits were less favorable than the same for Medical/surgical benefits.

The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

Market Coverage

Examiners requested information on the markets in which the carrier writes business that is subject to MHPAEA. Examiners then reviewed information regarding the markets for both Medical/surgical and Behavioral Health coverage to ensure there were no disparities or gaps in coverage in a market.

Cigna provides Behavioral Health coverage in the Small Group and Large Group markets in New Hampshire. The same requirements are applied through both markets.

Cigna's practices as they relate to each market are consistent and compliant with the identified regulations.

The examiners found no exceptions in terms of inclusion of all relevant markets under parity procedures.

Quantitative Treatment Limits

In accordance with the federal mental health parity rule (45 CFR § 146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying quantitative limits.

Under the rule, quantitative treatment limitations are those for which the extent of benefits provided are based on accumulated amounts, such as an annual or lifetime day or visit limit.

A review of documents provided indicates that the carrier applies quantitative limitations consistently between Mental Health benefits and Medical/surgical benefits.

Examiners found no exceptions.

Non-Quantitative Treatment Limits

Non-quantitative treatment limits include (but are not limited to) the following:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);

- Standards for provider admission to participate in a network, including reimbursement rates;
- Methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and precertification requirements for Behavioral Health and Medical/surgical benefits were consistently applied and did not incorporate more stringent factors for mental health benefits that would limit or discourage access for treatment.

Medical Management Policies and Procedures

Examiners determined that the carrier has developed robust Medical Necessity criteria for both Behavioral Health and Medical/surgical services.

Examiners found no exceptions.

Consumer Medical Management Policy/Guideline Access

Examiners noted that while the Medical Policies and Clinical Utilization Management Guidelines are available on-line for reference, they were not easily obtained.

Examiners will require Cigna to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's website.

Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain a Utilization Review policy or Clinical Guideline from the carrier's website.

Policy Development and Updates

Examiners reviewed methodologies that the carrier utilized to create, amend, or update policies and procedures. The purpose of this section of the review was to determine if the carrier was utilizing the most up-to-date policies and procedures based on current medical standards, and ensuring that the policies and procedures for Behavioral Health are updated as frequently, if not more frequently that the policies and procedures established for Medical/surgical benefits.

Examiners found no exceptions.

Pre-certification and Prior-Authorization

In order to determine parity between pre-certification and prior-authorization requirements for both Behavioral Health and Medical/surgical benefits, examiners reviewed all of the carrier's internal processes for both areas as well as samples of policy language from a large group and small group plan.

Examiners determined that Cigna has established and applies pre-certification and prior-authorization requirements consistently between Behavioral Health and Medical/surgical benefits.

Cigna provides detailed information regarding their pre-certification and prior-authorization requirements; however when examiners performed a website search for information regarding pre-certification, 101 distinct documents were presented.

Examiners will require Cigna to ensure that pre-certification and prior-authorization information is easily accessible to consumers on the carrier's website.

Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain pre-certification and prior-authorization information from the carrier's website.

Provider Reimbursement Rates and Fee Schedules

The examiners reviewed the policies and procedures utilized to update reimbursement rates and fee schedules. Documentation reviewed shows that the carrier reviews its fee schedules utilizing the Centers for Medicare & Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS) methodology as well as recent trends in services.

The carrier reimburses in-network Medical/surgical services on an assigned diagnosis-related group (DRG), or case rate basis and on a per diem basis, however only reimburses in-network facility bases services on a per diem basis. This fee structure may allow a greater benefit consideration for Medical/surgical versus Behavioral Health.

Examiners will request that the carrier review their current provider reimbursement rates and fee schedules to ensure that the determined fee schedules to ensure they are consistent with current market standards and are not limiting access to coverage for Behavioral Health services due to lower reimbursement rates for Behavioral Health Specialists.

Examiners will require that Cigna provide detail as to why the disparity in reimbursement methodology is not a parity violation.

Processes and Procedures for Determining Usual and Customary

The examiners reviewed the processes and procedures for determining Usual and Customary reimbursement rates. It was determined that the carrier updates its fee schedules (Medical/surgical and Behavioral Health) annually or more frequently. The fee schedules are based on resource-based relative values by CMS, incorporate Berenson-Eggers Type of Service, as well as employer group demands and concerns.

When the carrier updates the fee schedules, which is typically annually, they take into consideration relative value changes by Medicare, geographic and economic factors for the customers (members and employers), as well as current employer group demands and concerns.

Examiners determined that the carrier reviews their Behavioral Health and Medical/surgical fee schedules in the same manner whenever the regular updates occur.

Examiners would like to acknowledge Ms. Judy Flagg, Cigna’s Examination Coordinator, for her cooperation and expedient responses to the examiners and contracted examiners requests for information.

FINDINGS

DELEGATED SERVICE CONTRACTS

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.
NAIC Market Regulation Handbook – Chapter 16, page 222

Regulatory Authority

RSA 402-H:6 Responsibilities of the Insurer.
III. In cases in which an administrator administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semi-annually, conduct a review of the operations of the administrator. At least one such review shall be an on-site audit of the operations of the administrator.

The examiners requested all contract provisions and the supporting documentation of all delegated services to determine the handling of SUD Utilization Management (UM) and operational processes and procedures.

Cigna has its own UM servicing entity within its corporate structure and does not delegate services related to the management of SUD benefits.

Examiners' Comment

Delegated Service compliance does not apply.

NETWORK ADEQUACY

Standard 1

The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers that ensure all services to covered persons will be accessible without unreasonable delay.
NAIC Market Regulation Handbook – Chapter 20, page 530

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons.
NAIC Market Regulation Handbook – Chapter 20, page 531

Regulatory Authority

RSA 420-J:7 Network Adequacy.

A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

IV. Annually, the health carrier shall submit a report to the commissioner demonstrating compliance with the rules for network adequacy.

Ins 2701.10 Enforcement.

If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area or that a health carrier's health care certification of compliance report does not assure reasonable access to covered benefits, the commissioner shall issue an order requiring the health carrier to institute a corrective action, or shall use other enforcement powers under RSA 420-J to ensure that covered persons have access to covered benefits.

Specific requirements for Network Adequacy under RSA 420-J:7 and Ins 2701.06 Standards for Geographic Accessibility are as follows:

For at least 90% of the enrolled population within each county or hospital service area, the travel time interval to a provider of outpatient mental health services shall be no greater than 25 miles or 45 minutes travel time. Within the same service area, access to a general inpatient psychiatric facility, emergency mental health providers and short term facility for substance abuse treatment must be within 45 miles or 60 minutes of travel time.

Exceptions to the geographic requirements may be permitted if a carrier can establish that there are an insufficient number of qualified providers or facilities available in the county or hospital service area, if there is a community mental health program approved

by the commissioner of DHHS (Department of Health and Human Services) and the program has been deemed to provide a level of geographic access that is at least equal to the customary practice and travel arrangements and the carrier has taken reasonable steps to mitigate any detriment to their enrollees.

Examiners requested the carrier to provide the following information for review and analysis during this examination:

- A listing of all contracted providers including,
  - The type of services they provide in relation to SUD
  - Which providers are accepting new patients
  - Patient capacity for outpatient and inpatient settings
- Two (2) GEO Access reports
  - One (1) report specific to SUD providers throughout New Hampshire
  - One (1) report specific to all of Cigna's existing membership

Cigna only has membership in four cities (Nashua, Manchester, Salem and Dover) for its fully insured group plans.

Network capability for SUD Inpatient, SUD Intensive Outpatient and SUD Rehabilitation services was reviewed to identify deficiencies in the availability of servicing providers based on New Hampshire Network Adequacy Standards RSA 420-J:7 and Ins. 2700.06.

Current NH law does not require that carriers document the availability of specialty care providers including SUD providers. The examiners requested SUD specific provider availability for the examination period and Cigna reported the following deficiencies for Dover only:

- Mental Health/Substance Abuse – Outpatient/Partial Hospitalization

Cigna was asked to clarify data submitted relative to the examination as well as the annual Network Adequacy Report filing which did not indicate the deficiency identified for partial hospitalization services in the Dover area. Cigna did resubmit the updated information as requested and concurs with the Department's assessment of the deficiency.

The carrier stated, "In light of this network adequacy issue, in the event an insured residing in the Dover area required SUD partial hospitalization services, the Company would follow its standard Network Adequacy Provision Policy which sets forth if at least one (1) participating health care provider is not available within the established mileage

specifications from the customer's home, the customer may receive authorization to visit a non-participating health care professional at the in-network benefit level."

Examiners' Comment

Cigna has provisions in place to address network deficiencies if identified.

Examiners found no exceptions.

Examiners' concerns regarding network deficiencies and current consumer complaints prompted an additional review of the website for ease of access and the network via the on-line provider directory. Although this testing fell outside of the examination period due to the need to complete "live" testing, it was appropriate due to regulatory authority under *CFR Title 45, Part 156 Subpart C §156.230 (b) (2)*.

Website consumer ease of access

Regulatory Authority

CFR Title 45, Part 156 Subpart C §156.230 (b) (2) For plan years beginning on or after January 1, 2016 a QHP issuer must publish an up-to-date, accurate and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when –

(i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

Examiners expanded the review to include a test of Cigna's current website for accessibility and ease of consumer use which resulted in the following observations:

- Cigna provides a separate directory specific to behavioral health providers
- Examiners were unable to search specifically for a psychiatrist. Psychiatrists are included with therapists in the search criteria.
- Examiners found no ability to print the search results for psychiatrists/therapists

- Search results identified individual providers with multiple service locations

Examiners' Comment

Although Cigna has a separate directory for Behavioral Health specialists, the inability to print search results or search separately for psychiatrists may be challenging for consumers.

Provider Directory Accuracy

Examiners reviewed the search results produced and conducted outreach with no inaccuracies identified.

In addition to reviewing the on-line directory, examiners reviewed Cigna's on-line provider information regarding provider directory changes. Cigna contracted providers can correct or update their demographic information by logging into the Cigna for HealthCare Professionals web page and completing an on-line change form.

Examiners' Comment

Examiners found no accuracy errors in Cigna's on-line provider directory.

Examiners' Recommendation

Examiners determined that no immediate additional follow-up regarding provider directory accuracy is needed; however, future assessment may be conducted.

PRE-AUTHORIZATION

Standard 1
The health carrier shall operate its utilization review program in accordance with final regulations established by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury).
NAIC Market Regulation Handbook, Chapter 20A, page 689

Standard 2
The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.
NAIC Market Regulation Handbook, Chapter 20, page 565

Regulatory Authority

RSA *415-A:4-a Minimum Standards for Claim Review; Accident and Health Insurance.* – Any carrier that offers group health plans and employee benefit plans shall establish and maintain written procedures by which a claimant may obtain a determination of claims and by which a claimant may appeal a claim denial.

It was established as part of the scope of the exam that the Department would require medical expertise to determine the appropriateness of the pre-authorization denials as well as to ascertain whether the protocols used by Cigna meet acceptable standards of care. For the purpose of these reviews, the Department represented the consumers associated with the pre-authorization denials.

An Independent Review Organization (IRO) with medical reviewers specializing in addiction and SUD was retained by the Department to conduct the reviews of all denied pre-authorizations. This review was undertaken to determine, on a case by case basis, if the carrier issued denials appropriately due to lack of medical necessity or because the treatment (proposed or provided) would be inconsistent with generally accepted medical protocols.

The IRO provided the Department with a detailed report indicating the number of requests appropriately denied, those that were questionable, and those in which the reviewer disagreed with the carrier rationale for denial. The reviewer provided a description of the reason(s) that a claim denial determination was questionable or inappropriate.

The pre-authorizations under review were transmitted electronically through a secured platform from the Department to the IRO and final determinations were sent back to the Department via secured e-mail.

All data was transmitted by Joelien Atwater, Examiner-in-Charge (EIC) of this examination and returned back to the EIC for confidentiality purposes.

H.H.C. Group, a URAC accredited and NH certified independent review organization was the IRO retained as the medical reviewer for this examination. They are also contracted with the Department to handle consumer external reviews under RSA 420-J:5-a – 5-e.

All records reviewed, including medical information, will remain confidential under RSA 400-A:37 Examination Law, and are subject to restrictions as stated in the Business Associates Agreement executed between the Department and H.H.C. Group.

Examiners requested 100% of all pre-authorization requests for SUD services that were denied during the period under examination, January 1, 2015 through September 30, 2015 for a total of eight (8) pre-authorization denials.

The IRO was asked to consider the following questions in their review:

1. Are the medical records and accompanying information sufficient to answer the following questions?
2. Please determine if the recommended or requested health care service is considered medically necessary.
3. Do you agree or disagree with carriers' final determination for denial?

The IRO agreed with the carrier's determination on all eight (8) cases. It should be noted that in each instance where a pre-authorization request was denied, Cigna offered SUD intensive outpatient programs or SUD outpatient programs which were approved at the lesser level of care.

Examiners' Comment

Examiners found no exceptions.

Protocol Review

The Department also asked the IRO to determine whether the protocols used by Cigna for SUD meet acceptable standards of care and are in alignment with The American Society of Addiction Medicine (ASAM) criteria.

H.H.C's response to the Department's request is as follows:

"Recent treatment has moved away from diagnosis-based treatment to one that is more holistic. The American Society of Addiction Medicine (ASAM) has some of the most widely respected and followed treatment guidelines. The latest edition of the ASAM Criteria support treatment that is interdisciplinary and individualized according multiple dimensions of factors such as withdrawal risk, biomedical conditions, psychiatric and cognitive conditions, readiness to change, relapse potential, and living environment. Although all three protocols do not draw from the ASAM Criteria verbatim, they either

explicitly recommend or allow for a quality of treatment that is in accordance with ASAM. It is my medical opinion that the protocols are medically reasonable". (sic)

Examiners' Comment

Examiners have determined that no further action is required as protocols are medically reasonable per the IRO review. The Department is encouraged that Cigna will be able to comply with New Hampshire statutory requirements effective 1/1/17 with regards to the implementation of ASAM protocols.

GRIEVANCES AND APPEALS

Standard 2
The health carrier shall comply with grievance procedure requirements, in accordance with final regulations by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury).
NAIC Market Regulation Handbook – Chapter 20A, page 626

Standard 3
The carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.
NAIC Market Regulation Handbook – Chapter 20, page 515

Regulatory Authority

RSA 420-J:5 Grievance Procedures. – Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

The examiners requested an excel spreadsheet list and all supporting documentation of all upheld and overturned grievances/appeals for SUD services. The following data points were required:

- Method of receipt (mail, fax, etc.)
- Source of the request (member, provider)

- Date of receipt
- Date of 2nd level appeal request (if applicable)
- Date of final determination

Examiners received one (1) grievance from Cigna for the period under examination. The determination letter reviewed was found to be fully compliant with New Hampshire requirements.

Examiners' Comment

Examiners found no exceptions.

CLAIMS

Quantitative Analysis

In order to quantify the SUD claim activity for the time period under examination, the examiners requested data relative to the total number of claims processed and the total billed amount of the claims processed for both SUD and Medical/surgical benefits.

The claims request was split into two separate requests; claims for ICD codes within the 304 (drug dependence, opioid dependence) coding criteria (SUD claims) and all other ICD codes (Medical/surgical claims).

Summary

Total claims activity provided by Cigna, for the examination period of January 1, 2015 through September 30, 2015 shows that 90,937 claims were processed for a total $33,141,205.95 in claims amount paid.

It should be noted that total billed amounts are subject to provider contractual arrangements and total paid amounts are subject to consumer out-of- pocket obligations in accordance with their contract.

Type of Claim	Volume	Total Billed	Total Paid
SUD	1,199	$277,927.61	$139,857.75
Med/Surgical	89,738	$66,397,586.20	$33,001,348.20
Total	90,937	$66,675,513.81	$33,141,205.95

The above totals are reflected in the tables below for comparison. Of the total amount of billed charges for denied Medical/surgical claims and denied SUD claims, SUD claims equated to .46% of the denied claims total.

In addition, the SUD claims volume was 1.32% of the total volume of claims processed during the examination period.

Denied Claims

Type of Claims	Number of Claims	Total Billed Amount
Substance Use Disorder	185	$57,166.89
Medical/surgical	8,688	$12,351,939.19

Paid Claims

Type of Claim	Number of Claims	Total Billed Amount	Total Paid Amount
Substance Use Disorder	1,014	$250,760.72	$139,707.72
Medical/surgical	81,050	$66,397,586.20	$33,001,348.20

Examiners' Observation

SUD claims data was provided for both of Cigna's claims processing systems, Cigna East and Cigna West. The SUD claims breakdown of detail included totals for deductible, co-insurance and co-payments.

MEDICATION ASSISTED TREATMENT

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Cigna's MAT program in New Hampshire.

Medication Assisted Treatment is defined as any opioid addiction treatment that includes a Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction. The interrogatories that were developed reflect the most up-to-date information on opioid addiction and treatment with an understanding that opioid addiction is a chronic disease.

The resources used by the pharmacist to complete the MAT baseline evaluation can be found in Appendix F.

Formulary Design

The pharmacist requested documentation regarding the following medications used for Medication Assisted Treatment:

- Methadone
- Buprenorphine
- Buprenorphine/naloxone
- Naloxone
- Naltrexone

Cigna stated in their response that their insured health plans cover the indicated medications for opioid dependence in accordance with the Cigna Drug and Biologic Coverage policy on Medication Assisted Treatment.

The pharmacist sent a follow-up interrogatory to Cigna regarding their coverage of Naloxone as it was not indicated in the prescription drug coverage documentation sent for review. Cigna responded that Naloxone is covered as a medical benefit and not a prescription drug benefit.

Examiners' Comment

The examiners found no exceptions.

Age Limitations

Cigna responded to the interrogatory by stating that they do not impose an age limit for the Medication Assisted Treatment program.

Examiners' Comment

The examiners found no exceptions.

Formulary Exception Process

Cigna's response to the interrogatory states that they have a process in place that allows enrollees or their provider to request an exception to provide coverage for a medication not covered under the formulary or an exception to any quantity or dosage limit.

Examiners' Comment

Examiners found no exceptions.

Dosage and Refill Limit

Examiners reviewed Cigna's Drug and Biologic Coverage Policy on Medication Assisted Treatment for opioid dependence, which includes provisions regarding FDA approved dosing.

Examiners' Comment

Examiners found no exceptions.

Lifetime/Annual Limits

Cigna's interrogatory response indicates that they do not impose lifetime or annual limits for methadone or buprenorphine.

Examiners' Comment

Examiners found no exceptions.

Pre-authorization for Methadone and Buprenorphine

Cigna's interrogatory response states that "Vivitrol, ReVia, naltrexone and methadone do not require prior authorization. Suboxone, Bunavail, Zubsolv and buprenorphine HCI/naloxone HCI require prior authorization."

"Cigna requires prior authorization for some prescription drugs used to treat medical conditions and for some prescription drugs used to treat Mental Health and SUD conditions based upon the same array of factors, including cost, utilization, variability in cost and quality and clinical efficacy."

Examiners' Comment

Examiners found no exceptions.

Penalties or Exclusions for Failure to Complete a Course of Treatment

Cigna's response to the interrogatory stated that they do not impose any penalty or exclusion of coverage for the failure to complete a course of treatment applicable to MAT for methadone and/or buprenorphine.

Examiners' Comment

The examiners found no exceptions.

Medical Necessity Standards for Methadone and Buprenorphine

Cigna has medical necessity standards for the medication component of MAT.

The pharmacist sent an additional interrogatory to Cigna asking for clarification regarding the guidelines for history or dependence documented in the Cigna Standards and Guideline/Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders (June 2015). This guideline states that an enrollee must have one year of documented dependency to satisfy the medical necessity requirements.

Cigna's response indicated that they do not require prior authorization for MAT programs and that this is merely a guideline for which exceptions would be allowed based upon the needs and circumstances of the enrollee.

Examiners Comment

Examiners found no exceptions.

MENTAL HEALTH PARITY

Standard 3

The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

Market Regulation Handbook, Chapter 20 – page 508

Regulatory Authority

29 USC § 1185a parity in mental health and substance use disorder benefits

(a)(1) Aggregate lifetime limits

(a)(2) Annual limits

(a)(3) Financial requirements and treatment limitations

(A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that –

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(a)(4) Availability of plan information

(a)(5) Out-of-network providers

45 CFR § 146.136 (c)(3)(iii)(C) states: *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

(1) Office visits (such as physician visits), and

(2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

A Mental Health Parity review was completed on the carrier's internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete this review, examiners looked at Cigna's response to the Behavioral Health Survey the Department sent in December of 2015, follow-up interrogatory responses and the carrier's documented procedures. This review was performed to identify areas where procedures and protocols and access to Mental Health benefits were potentially less favorable than the same for Medical/surgical benefits. The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

Market Review

Cigna offers health plans within the small group and large group markets, which are subject to MHPAEA. A review of grandfathered or transitionary small group plans was not performed as these are not subject to the parity requirements outlined in the ACA.

Examiners reviewed each market for both Medical/surgical and Mental Health coverage to ensure there were no disparities or gaps in coverage within a market.

Cigna's practices as they relate to each market are consistent and compliant with the identified regulations. The examiners found no exceptions in terms of inclusion of all relevant markets under parity procedures.

Examiners' Comment

Examiners found no exceptions.

Quantitative Treatment Limits

In accordance with the federal parity rule, examiners reviewed the carrier's policies and procedures in applying quantitative treatment limits. Under the rule, quantitative treatment limits are those for which the extent of benefits provided is based on accumulated amounts, such as annual or lifetime day or visit limits.

The purpose of the review was to inquire into whether limitations and standards were being applied consistently between Behavioral Health and Medical/surgical benefits and to ensure that the carrier has processes in place to determine all financial limitations

met quantitative requirements outlined in 45 CFR§146.136 (a)(3)(i)(A) (e.g., two-thirds/substantially all).

A review of documents provided indicates that the carrier applies quantitative limitations consistently between Mental Health Benefits and Medical/surgical benefits. The carrier acknowledged that they review quantitative limits on an annual basis for both Mental Health and Medical/surgical benefits. The carrier also presented documentation showing that in certain instances, a review of quantitative limits is performed more frequently than annually.

Examiners' Comment

Examiners found no exceptions

Non-Quantitative Treatment Limits

In accordance with the federal parity rule, (45 CFR §146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying non-quantitative treatment limits. Under the rule, non-quantitative limits include but are not limited to:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage)

To perform a non-quantitative review, Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and pre-certification requirements for Mental Health and Medical/surgical benefits were

consistently applied and did not incorporate more stringent factors for Mental Health benefits that would limit or discourage access for treatment. Comprehensive information, including findings and recommendations is provided below for identified areas.

Medical Management Policies and Procedures

Examiners reviewed the carrier's Medical Necessity requirements, including Utilization Review and Management Guidelines and Clinical Guidelines specific to Mental Health as well as Medical/surgical. The purpose of the review was to ensure that the carrier has policies and procedures in place to quantify the requirements for Medical Necessity determinations and to verify that the policies and procedures are accurate, consistently applied for Mental Health and Medical/surgical benefits, updated timely with input from appropriately credentialed professionals, and disseminated appropriately to members.

Examiners also ensured that the requirements outlined in NH RSA 420-J were applied to the Medical Management standards and that Utilization Review requirements established conform to the standards of either the Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurances (NCQA) and are subject to all applicable rules issued pursuant to RSA 420-E:7.

Cigna develops their own processes and procedures as they relate to Medical Management standards. The examiners determined that each procedure is reviewed at least annually, but recommendations of updates may be completed more frequently based on changes in the marketplace.

Examiners reviewed 14 of the carrier's internal documents regarding Utilization Management. These documents included:

- Communication, Access and Availability of Staff;
- Use of Board Certified Specialty Physician Reviewers;
- Release of Guidelines or Criteria;
- Interact and Medical Director Case Review;
- Precertification of Inpatient, Outpatient and Ambulatory Services;
- Qualified Health Professionals Render UM Decisions;
- Adverse Determination Notification Elements;
- Retrospective review of Inpatient and Outpatient Services;
- Peer-to-Peer requests;
- Pre-Determinations;
- Timeliness of Health Services Decisions;

- Lack of Information Concurrent Review;
- Lack of Information Pre-Service; and
- Prospective review patient safety.

Examiners reviewed eight (8) of the carrier's internal documents regarding Clinical Reviews. These documents included:

- Availability and Use of Psychiatrists for Review Determinations;
- Clinical and Administrative Information for Making a Determination of Coverage;
- Clinical Review Policy;
- Clinical Triage Policy;
- Communication regarding Utilization Management;
- Peer-to-Peer Review;
- Timeliness of UM Decisions on Notifications; and
- Utilization Management Decisions Appropriate Professional Assessment.

It was determined that there were no discrepancies between the non-quantitative measures put in place for Medical/surgical and Behavioral Health services. Policies and procedures that were not specific to Behavioral Health services were applied consistently between Medical/surgical and Behavioral Health services.

Examiners' Comment

Examiners found no exceptions.

Policy Development and Updates

Examiners also reviewed methodologies that the carrier utilizes to create, amend, or update policies and procedures to ensure that the carrier is developing procedures consistently with NH RSA 420-J:6 VI. The clinical review criteria used by the health carrier or its designee utilization review entity shall be:

a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;
b) Updated at least biennially and as new treatments, applications and technologies emerge;
c) Developed in accordance with the standards of national accreditation entities;
d) Based on current, nationally accepted standards of medical practice; and
e) If practicable, evidence-based;

and ensure that the policies and procedures for Behavioral Health are updated as frequently, if not more frequently than, the policies and procedures established for Medical/surgical benefits.

The carrier has incorporated The Medical Technology Assessment Committee (MTAC) which establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that assert when a Medical/surgical service, procedure, device, technology, etc. and/or a Behavioral Health service or technology is experimental and investigative.

The criteria established by MTAC incorporate clinical care guidelines of the American Psychiatric Association; the American Association of Pediatrics; and the National Institute on Alcohol Abuse and Alcoholism due to their national acceptance as the best of evidence-based practice for Mental Health and SUD. In addition, when developing its "Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders", the carrier solicits and considers feedback received from patients, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association, American Psychological Association, NASW, AAMFT, and ASAM), psychiatrists, psychologists, and therapists across the country.

The carrier has also established a Committee specific to Behavioral Health Quality. At least annually, practitioners participating in Cigna's Behavioral Health Quality Committee (BHQC), as well as practitioners from local communities, provide feedback on the proposed medical necessity criteria which is reviewed, revised (as needed) and adopted by the BHQC. Examiners reviewed the criteria for the personnel involved in this committee to determine that the appropriate expertise is presented. The carrier has incorporated Behavioral Health Specialists into the committee who have the appropriate background and experience to make these determinations.

The examiners determined that the carrier has developed robust Medical Necessity criteria for both Behavioral Health and Medical/surgical services.

Examiners' Comment

Examiners found no exceptions.

Consumer Medical Management Policy/Guideline Access

Examiners noted that while the Medical Policies and Clinical Utilization Management Guidelines are available on-line for reference, they were not easily obtained.

Examiners' Recommendation

Examiners will require Cigna to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's website.

Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain a Utilization Review policy or Clinical Guideline from the carrier's website.

Company Response

On December 5, 2016 Cigna responded to the verified report with the following statement:

"In addition, the Company will be implementing measures to ensure its Coverage Policies for medical/surgical services and its "Medical Necessity Criteria for Behavioral Health and Substance Use Disorders" are accessible from its member portal: https://my.cigna.com/web/public/guest during Q3 2017."

Examiners' Comment

As of December 6, 2016, no further action is required.

Pre-certification/Prior-authorization

A *prior-authorization* requirement means that the carrier will not pay for a service unless the provider (a physician or hospital, usually) gets permission to provide the service. Sometimes this permission is to ensure that a patient has benefit dollars remaining (for example, a carrier may limit a patient to 12 chiropractor visits in a calendar year), other times it is to ensure that a specific kind of service is eligible for payment under the patient's contract. Authorization can be also granted retroactively, for example, a patient or hospital may have a 24-hour window to notify a carrier after receiving emergency care.

A *pre-certification* requirement means that a carrier must review the medical necessity of a proposed service and provide a certification number before a claim will be paid. This is often true with services such as elective surgeries. Usually, a representative with the carrier must review a physician's order and the medical record to agree that a proposed procedure is medically appropriate.

For pre-certification, and prior-authorization, Cigna incorporates a tiered approach of standards.

Pre-Service Review of Inpatient Services

When determining which Medical/surgical inpatient benefits and which Behavioral Health inpatient benefits are subject to utilization management (a/k/a prior-authorization/pre-certification), the carrier conducts a cost benefit analysis which takes into consideration: the cost of treatment/procedure, whether treatment type is a driver of high cost growth, variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region, annualized claim volume for treatment type including total paid and denied claims, treatment types subject to a higher potential for fraud, waste and/or abuse, administrative cost of conducting utilization management and appeals for treatment type if placed on pre-certification list, projected return on investment and/or savings if treatment type is subjected to utilization management, if the benefit of conducting utilization management of the treatment type outweighs the administrative costs associated with conducting Utilization Management of the treatment type, the treatment type is subject to Utilization Management (a/k/a prior-authorization/pre-certification). Based upon this cost-benefit analysis, the carrier subjects non-emergent Medical/surgical inpatient services and non-emergent Behavioral Health inpatient services assigned to the inpatient classification(s) of benefits to pre-service review (a/k/a prior-authorization).

Inpatient Concurrent Care Review

Based upon the same cost-benefit analysis presented for inpatient pre-service review, the carrier also provides a cost-benefit analysis of concurrent care review services consisting of: Medical/surgical in-network inpatient services and Behavioral Health in-network inpatient services rendered by contracted facilities reimbursed on a per diem basis, Medical/surgical out-of-network inpatient services and Behavioral Health out-of-network inpatient services reimbursed on a fee for service/MRC basis.

Documents reviewed show that while the frequency of concurrent care reviews varies, the carrier typically authorizes one to four inpatient days at a time on both the

Medical/surgical side and the Behavioral Health side. Concurrent care reviews are typically initiated a day or two before the last covered/authorized day.

Pre-certification/Prior-Authorization Requirements for Outpatient Benefits Pre-Service Review of Outpatient Services

When determining which Medical/surgical outpatient benefits and which Behavioral Health outpatient benefits are subject to utilization management (a/k/a prior-authorization/pre-certification), the carrier also conducts a cost benefit analysis based upon the following factors: the cost of treatment/procedure, whether treatment type is a driver of high cost growth, variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region, annualized claim volume for treatment type including total paid and denied claims, treatment types subject to a higher potential for fraud, waste and/or abuse, administrative cost of conducting utilization management and appeals for treatment type if placed on pre-certification list, projected return on investment and/or savings if treatment type is subjected to utilization management. If the benefit of conducting utilization management of the treatment type outweighs the administrative costs associated with conducting Utilization Management of the treatment type, the treatment type is subject to Utilization Management (a/k/a prior-authorization/pre-certification).

Based upon the above referenced cost benefit analysis, the carrier subjects non-routine Medical/surgical outpatient services and non-routine Mental Health/SUD outpatient services subject to a higher cost and/or utilization to pre-service review (a/k/a prior-authorization). On the Medical/surgical side, this generally includes advanced radiology (MRI/CT/PET), home health care, radiation therapy, chemotherapy, hospice, DME, etc. On the Behavioral Health side, this generally includes partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA), etc.

The carrier utilizes a similar approach for Outpatient Concurrent Care Review Services. A review of the documents determined that the carrier has established and applies pre-certification and prior-authorization requirements consistently between Behavioral Health and Medical/surgical benefits.

Cigna provides detailed information regarding their pre-certification and prior-authorization requirements; however when examiners performed a website search for information regarding pre-certification, 101 distinct documents were presented.

Examiners' Recommendation

Examiners will require Cigna to ensure that pre-certification and prior-authorization information is easily accessible to consumers on the carrier's website.

Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain pre-certification and prior-authorization guidelines from the carrier's website.

Company Response

On December 5, 2016, Cigna responded to the verified report with the following information:

"While Cigna's pre-certification and prior-authorization information is generally referenced within its issued Policy Certificates, Evidence of Coverage and Summary of Benefit Coverages, the information is not currently available on the Company's website. The Company will be implementing measures to ensure this information is accessible from its provider and member portals during Q3 of 2017."

Examiners' Comment

As of December 6, 2016, no further action is required.

Provider Reimbursement Rates and Fee Schedules

The carrier reviews its fee schedules utilizing the Centers for Medicare & Medicaid (CMS) methodology as well as recent trends in services and utilization and employer groups' demands to assist in the development of the Maximum Allowable Benefit (MAB).

The examiners reviewed the information presented for provider reimbursement rates to determine if there are any discrepancies in the reimbursement schedule for Medical/surgical benefits and Behavioral Health. The carrier utilizes distinct methodology to determine provider reimbursement rates for in-network Medical/surgical services. Documents reviewed show that Medical/surgical in-network facility based services are reimbursed on an assigned diagnosis-related group (DRG) or case rate basis and on a per diem basis. Behavioral Health in-network facility based services are reimbursed on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure within the geographic market.

The examiners determined that Medical/surgical and Behavioral Health non-facility based outpatient services are reimbursed on a fee-for-service basis by procedural code based upon the competitive rate for the type of service or procedure within the geographic market.

The carrier provides an in-network provider reimbursement methodology for Medical/surgical providers and Behavioral Health providers that is based upon the factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty), type of provider (i.e. hospital, clinic and practitioner) and/or specialty, supply of provider type and/or specialty, network need and/or demand for provider type and/or specialty, Medicare reimbursement rates, training, experience and licensure of provider.

The carrier also reviews supply and demand of Medical/surgical provider types and/or specialties and Behavioral Health provider types and/or specialties based upon the same indicators including, but not limited to NCQA and National Association of Insurance Commissioners (NAIC) network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

Cigna’s policies and procedures are consistent for determining reimbursement fees for non-facility based outpatient services, and in-network provider reimbursements. The carrier reimburses in-network Medical/surgical services on an assigned DRG, or case rate basis and on a per diem basis, however only reimburses in-network facility based services on a per diem basis. This fee structure may allow a greater benefit consideration for Medical/surgical services versus Behavioral Health services.

Examiners’ Recommendation

Examiners will require that Cigna provide detail as to why the disparity in reimbursement methodology is not a parity violation.

Company Response

On December 5, 2016, Cigna responded to the verified report with the following information:

"In-network medical/surgical services are reimbursed based on negotiated rates for an assigned diagnosis-related group (DRG) a/k/a case rate and on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure within the geographic market. In network MH/SUD services are reimbursed based on negotiated rates on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure within the geographic market. [MH/SUD services are typically not reimbursed on a DRG or case rate basis because unlike an appendectomy or cesarean birth, it is more difficult to assess an average length of stay for a mental health condition or substance use disorder due to the unique and varying clinical needs of the patient; their insight into their illnesses; and their motivation to comply with proposed treatment plans].

Cigna's methodology for negotiating contracted rates for in-network medical/surgical services on a per diem basis (and a MS-DRG basis) and in-network MH/SUD services on a per diem is based upon the same array of factors, including but not limited to:

- Geographic market (i.e. market rate and payment type for provider type and/or specialty)
- Type of provider (i.e. hospital, clinic and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience and licensure of provider

Assessing supply and demand of medical/surgical provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

In short, applies the same reimbursement methodology when negotiating rates for in-network medical/surgical services and in-network MH/SUD services in compliance with the MHPAEA regulations."

Examiner's Comment

As of December 6, 2016, no further action is required.

Processes and Procedures for Determining Usual and Customary

In determining methodology for provider reimbursement rates for out-of-network services the carrier reimburses out-of-network Medical/surgical services and out-of-network Behavioral Health services based upon the Maximum Reimbursable Charge (MRC) or by applying an external vendor's supplemental network negotiated rate for the service. Members are given the option to elect a U&C-based MRC (MRC1) option or a Medicare-based MRC (MRC2) option.

If a CMS reimbursement rate is not available for the service at issue then the Maximum Reimbursable Charge is determined based on the lesser of: the health care professional's normal charge for a similar service or supply; or the 80th percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled by the FAIR Health database.

Examiners' Comments

Examiners found no exceptions.

Judy A. Flagg
Compliance Senior Specialist
Market Conduct
Regulatory & State Government Affairs
Cigna Legal

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December 5, 2016

Joelien Atwater
LAH Market Conduct Division-EIC
New Hampshire Insurance Department
21 So. Fruit Street Suite #14
Concord, NH 03301

Via email Joelien.Atwater@ins.nh.gov
& UPS Overnight Delivery

Re: Cigna Health and Life Insurance Company (NAIC #67369)
New Hampshire Insurance Department Market Conduct Targeted Examination
Regarding the Handling of Substance Use Disorder Benefits and Mental Health Parity

Dear Ms. Atwater,

Cigna Health and Life Insurance Company (the Company) accepts the New Hampshire Insurance Department Market Conduct Examination Report covering the above referenced examination of the Company, dated November 1, 2016 as written.

Further to your instructions, the Company submits the following in response to the Examiners' Recommendations.

Consumer Medical Management Policy/Guideline Access
Examiners' Recommendation
Examiners will require Cigna to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's website.
Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain a Utilization Review policy or Clinical Guideline from the carrier's website.

Company Response:
The Company's Medical Necessity Criteria for medical/surgical services (a/k/a Coverage Policies) are accessible from:

- Cigna's Provider Portal: https://cignaforhcp.cigna.com - Just click on "Resources" (top left of page) and then "Coverage Policies"; and from
- https://www.cigna.com – Just click on "Health Care Professionals" and then "View Policies"

The Company's Medical Necessity Criteria for Mental Health and Substance Use Disorder (MH/SUD) services is accessible from:

- Cigna's Provider Portal: https://cignaforhcp.cigna.com - Just click on "Resources" (top left of page); then "Behavioral Health Resources"; and then "Medical Necessity Criteria – View Documents"; and from

- CBH Member Portal: https://apps.cignabehavioral.com/web/consumer.do#/consumer - Just click on "Education and Resource Center"; and then "Cigna Standards and Guidelines/Medical Necessity Criteria for Behavioral Health and Substance Use Disorders"

In addition, the Company will be implementing measures to ensure its Coverage Policies for medical/surgical services and its "Medical Necessity Criteria for Behavioral Health and Substance Use Disorders" are accessible from its member portal: https://my.cigna.com/web/public/guest during Q3 2017.

Pre-certification/Prior-authorization
Examiners' Recommendation
Examiners will require Cigna to ensure that pre-certification and prior-authorization information is easily accessible to consumers on the carrier's website. Within 30 days of the final report, Cigna must provide the Department with the instructions that outline the steps a consumer must take in order to obtain precertification and prior-authorization guidelines from the carrier's website.

Company Response:
While Cigna's pre-certification and prior-authorization information is generally referenced within its issued Policy Certificates, Evidence of Coverage and Summary of Benefit Coverages, the information is not currently available on the Company's website. The Company will be implementing measures to ensure this information is accessible from its provider and member portals during Q3 2017.

Provider Reimbursement Rates and Fee Schedules
Cigna's policies and procedures are consistent for determining reimbursement fees for non-facility based outpatient services, and in-network provider reimbursements. The carrier reimburses in-network Medical/surgical services on an assigned DRG, or case rate basis and on a per diem basis, however only reimburses in-network facility based services on a per diem basis. This fee structure may allow a greater benefit consideration for Medical/surgical services versus Behavioral Health services.

Examiners' Recommendation
Examiners will require that Cigna provide detail as to why the disparity in reimbursement methodology is not a parity violation.

Company Response:
In-network medical/surgical services are reimbursed based on negotiated rates for an assigned diagnosis-related group (DRG) a/k/a case rate and on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure within the geographic market. In network MH/SUD services are reimbursed based on negotiated rates on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure within the geographic market. [MH/SUD services are typically not reimbursed on a DRG or case rate basis because unlike an appendectomy or cesarean birth, it is more difficult to assess an average length of stay for a mental health condition or substance use disorder due to the unique and varying clinical needs of the patient; their insight into their illnesses; and their motivation to comply with proposed treatment plans].

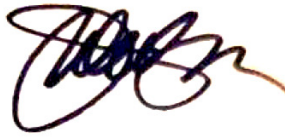
Cigna's methodology for negotiating contracted rates for in-network medical/surgical services on a per diem basis (and a MS-DRG basis) and in-network MH/SUD services on a per diem is based upon the same array of factors including, but not limited to:

- Geographic market (i.e. market rate and payment type for provider type and/or specialty)
- Type of provider (i.e. hospital, clinic and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience and licensure of provider

Assessing supply and demand of medical/surgical provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

In short, Cigna applies the same reimbursement methodology when negotiating rates for in-network medical/surgical services and in-network MH/SUD services in compliance with the MHPAEA regulations.

Respectfully,



Judy A. Flagg
Compliance Senior Specialist
Market Conduct

APPENDIX A: MENTAL HEALTH PARITY SURVEY

The New Hampshire Insurance Department requested each carrier provide a detailed response to the following questions as they relate to full-insured group and individual health benefit plans. When referencing small and large groups, the employer/group contract must be situated in the state of New Hampshire with one or more New Hampshire employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).
    a. Do you have the same or different requirements for MHPAEA compliance within each market?
    b. If the requirements are different between markets, describe the difference.

2. The MHPAEA final rule 1 differentiates between six different classifications of benefits:
   (1) Inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient out-of-network; (5) emergency care; and (6) prescription drugs. MHPAEA requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be for medical and surgical conditions.
    a. How do you determine into which classification a particular benefit belongs?
    b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.

3. To comply with MHPAEA's general parity requirement, a plan may not apply any "financial requirement" or treatment limitation" to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" financial requirement of treatment limitation of that type applied to "substantially all" medical/surgical benefits in the same classification.
    a. Please describe the process that you use to determine whether the "substantially all" test is met.
    b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.

c. Provide a detailed example of your process using your plan with the most enrollees in New Hampshire (please specific market).

4. Under MHPAEA, a plan may not impose a non-quantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. Under MHPAEA, NQTL's include:
    a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
    b. Formulary design for prescription drugs;
    c. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
    d. Standards for provider admission to participate in network, including reimbursement rates;
    e. Plan methods for determining usual, customary, and reasonable charges;
    f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
    g. Exclusions based on failure to complete a course of treatment; and
    h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

a. Provider a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what carrier to you use?
b. Is that carrier different that the PRA you use for medical/surgical benefits? If so, what steps does your carrier take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

    a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.
    b. Explain how your determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.
    c. Explain your process for grievance and appeals related to mental health/substance use disorder claims.
7. Provider Networks
    a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
    b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.
    c. Provide information regarding accessibility issues with in-network providers to include options for members when an in-network provider for mental health/substance use disorders is not available.

APPENDIX B: INTERROGATORIES – MENTAL HEALTH PARITY

1. How many pre-service reviews resulted in a denial or reduction in benefits for Medical/Surgical services, and how many pre-service reviews resulted in a denial or reduction in benefits for Mental Health/Substance Use Disorder services?
2. Please provide examples of information and disclosures presented to the policyholder regarding Non Quantitative Treatment Limitations (NQTL's), including policy language. Also, please include a username and password to access the on-line consumer portal.
3. What oversight does Cigna incorporate for Cigna Behavioral Health, Inc. (CBH), NH to ensure that the appropriate policies and procedures are being followed and determinations are in alignment with published medical standards for the Utilization Reviews of Mental Health and Substance Use Disorder Benefits? Is CBH required to do a self-audit of the processes and procedures, and if so, how are thy results of the audit communicated to Cigna?
4. Please provide copies of the Coverage Policies (aka medical necessity criteria) and Milliman Care Guidelines (aka MCG) as well as the Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders. Additionally, please provide the latest feedback presented by the Behavioral Health Quality Committee (BHQC).
5. Please provide a list of the 14 prescriptions drug classifications in which Step Therapy is applied. Additionally, please list the tier (formulary) classification, and whether Cigna classifies each as a treatment for Medical or Mental Health treatment.
6. How frequently are the fee schedules reviewed, and how often are they updated? Are the rates consistent between Mental/Health and Medical/Surgical benefits? Please provide the last date of reimbursement rate updates as well as the current reimbursement rates for both Mental Health/Substance Use Disorder and Medical/Surgical benefits.
7. Do you currently use ASAM screening and assessment tools for prevention of, or early intervention in addiction? How frequently are the fee schedules reviewed and how often are they updated? Please provide the last date of reimbursement rate updates.

For Medical Management Standards, please provide the following information:

1. Medical Necessity Requirements:
    - Including all documented processes and procedures, manuals and criteria utilized in determining Medial Necessity

- Additionally, please include all notifications that are provided to members outlining the Medical Necessity Requirements when requested;

2. Precertification/Preauthorization requirements:
    - Including processes and procedures, and criteria for both Medical/Surgical and Mental Health.
    - Additionally, please include policy language regarding Precertification/Preauthorization for Medical/Surgical and Mental Health for the most popular Large Group, Small Group and Individual Plans;
3. Provider reimbursement rates, and fee schedules for both Medical/Surgical and Mental Health reimbursements;
4. Usual and Customary (U&C) fee schedule;
    - Processes and procedures for determining U&C and the frequency of U&C updates for both Medical/Surgical and Mental Health services; and,
5. Utilization Management Practices:
    - Including the Utilization Program's Proof of Registration with the Department of Insurance as required by RSA 420-E:7 and Chapter 2001.04 of the New Hampshire Code;
    - Advisement of Appeal Rights due to an adverse Utilization Review determination.

APPENDIX C: DATA REQUESTS

The following data was requested from each Carrier:

Delegated Service Contracts

- Please provide a copy of all Third Party Administrator contracts and Service agreements in effect as of January 1, 2015 for all Utilization Review, pre/post authorizations, claims processing or any support functions presently delegated to other entities relative to Substance Use Disorder (SUD).
- Please provide a brief summary of each contract defining the delegated service.
- If services are provided by the carrier, please provide a diagram/flow chart of the internal process associated with the handling of SUD.
- If the process differs for SUD from the standard process, please provide a full explanation of any deviations from the standard process.

Network Access

- Please provide a list of all contracted providers, and the type of service they provide that are presently utilized within your network to perform SUD services to include (hospitals, rehabilitations centers, specialists, etc.) Also, document availability of each provider by indicating which providers are presently accepting patients and patient capacity within inpatient and outpatient settings.
- Please provide (2) two separate GEO Access reports. One report should demonstrate network providers for SUD treatment throughout New Hampshire and the other report should show all of your existing membership.

Pre-authorizations

- Please provide a list of all services requiring a pre-authorization for SUD and Medical Surgical requests.
- Please provide an Excel spreadsheet listing all Inpatient and Outpatient pre-authorizations to include any/all SUD requests for services received for in and out of network from January 1, 2015 through September 30, 2015 that were full or partial denials for SUD.
- Please include the following data within the Excel spreadsheet provided:
    - Patient ID#
    - Procedure/Service Type
    - Provider Name
    - Date Received (20YY/MM/DD)
    - Type of Request – urgent, expedited, standard, etc.
    - Type of Review – pre-authorizations, reconsideration, etc.
    - Date(s) of Service (20YY/MM/DD)

- Type of Service
- Place of Service
- Method of Receipt – physician/specialty provider, patient or other
- Date of Request (20YY/MM/DD)
- Date of Clinical Request for additional information (20YY/MM/DD)
- Date of Clinical Information Received (20YY/MM/DD)
- Date of Medical Director Review (20YY/MM/DD)
- Date of Final Determination (20YY/MM/DD)
- Type of Adverse Determination – Full or Partial Denial
- Method of Notification
- Explanation of the final adverse determination

Appeals/Grievances

- Please provide an Excel spreadsheet reporting all upheld/reversed and overturned appeals/grievances for SUD. (Include how it was requested – mail, fax, telephonic or other). Identify who made the request – provider, consumer, lawyer, etc.
- Date Request Received (20YY/MM/DD)
- Dates for second level appeal or grievance if applicable (20YY/MM/DD
- Date Final Determination was initiated (20YY/MM/DD)
- Date Final Determination was completed (20YY/MM/DD)
- Also attach the following:
  - An electronic copy of the initial request to include any subsequent request.
  - An electronic copy of the final determination letter to include any relevant supporting documentation
- Please provide within the Appeals/Grievance spreadsheet an indicator of those appeals that an external review was requested. Include the final status of the external review and the final notification letter(s).
- If a separate report on external reviews is available, please provide a copy.

Claims

- Please provide an Excel spreadsheet of all denied claims for ICD codes within the 304 coding criteria (ICD Code 204 is classified as Dependency)
- Please provide an excel spreadsheet of all paid claims for ICD codes within the 304 coding criteria.
- The following data should be included within each spreadsheet:
  - Member ID#
  - Date of Birth (20YY/MM/DD)
  - Date of Service (20YY/MM/DD)

- ICD Code
- CPT Code
- Date Received (20YY/MM/DD)
- Date Processed (20YY/MM/DD)
- Date Denied/Partial Denial/Paid (20YY/MM/DD)
- Amount Billed
- Amount Paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)

Behavioral Health Parity Survey

A Behavioral Health Parity Survey was also requested.

APPENDIX D: INTERROGATORIES – MAT

1. Does the Company cover the following medications used for MAT:
    a. Methadone
    b. Buprenorphine
    c. Buprenorphine/Naloxone
    d. Naloxone
    e. Naltrexone

2. For what FDA approved indications does the Company cover for the following FDA approved medications:
    a. Methadone
    b. Buprenorphine
    c. Buprenorphine/Naloxone
    d. Naloxone
    e. Naltrexone

3. What are the dose and/or refill limits applied to the covered medications?
4. Does the Company impose any lifetime or annual limits on MAT for methadone and/or buprenorphine?
5. Are there preauthorization, reauthorization or step therapy processes or other utilization management requirements (limitations on drug screenings, requirements that a physical examination be performed, etc.) applicable for MAT for methadone and/or buprenorphine?
6. Does the Company impose any penalty or exclusion of coverage for the failure to complete a course of treatment applicable to MAT for methadone and/or buprenorphine?
7. What medical necessity or medical appropriateness standard is applied to the coverage of MAT for methadone and/or buprenorphine?

APPENDIX E: DATA REQUEST – MAT

Please provide electronic files for all non-Mental Health and Substance Use Disorder denied claims received by the Company during the examination period (01/01/15 through 09/30/15). The following data should be included within the files:

- Claim Number
- Member ID Number
- Date of Birth (20YY/MM/DD)
- Date of Service (20YY/MM/DD)
- Type of Service
- ICD Code
- CPT Code (all code categories)
- HCPCS Level II Code
- Date Received
- Date Processed
- Date Denied/Partial Denial
- Amount billed
- Amount paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)
- Data dictionary describing each field abbreviation and the format of the field (column).

Separately list each line item. In addition, provide separate listings for Professional, Hospital and RX claims. When providing the data, please ensure the data is provided in delimited or fixed length ASCII text.

APPENDIX F: – Reference material for Medication Assisted Treatment Review

CDC.gov

A Treatment Improvement Protocol (TIP 43): Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs -U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (HHS, SAMHSA).

DATA 2000- Title XXXV, Section 3502 of the Children's Health Act.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

APPENDIX G: MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

45 CFR § **146.136 Parity in mental health and substance use disorder benefits.**

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder

defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits.* This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see § 147.126 of this subchapter.

(1) *General* -

(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either -

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual

dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) *Plan not described in paragraph (b)(2) or (b)(3) of this section* -

(i) *In general.* A group health plan (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either -

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.