Illinois Department of Insurance

JB Pritzker
Governor

Robert H. Muriel
Director

VIA ELECTRONIC MAIL
VIA USPS CERTIFIED MAIL

July 14, 2020

Mr. Michael J. Phillips
President
Cigna Health and Life Insurance Company
525 West Monroe Street, Suite 1650
Chicago, IL. 60661

Re: Cigna Health and Life Insurance Company, NAIC 67369
Market Conduct Examination Report Closing Letter

Dear Mr. Phillips:

The Department has received your Company's proof of compliance. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Chief Market Conduct Examiner
Illinois Department of Insurance
320 West Washington St., 5th Floor
Springfield, IL 62767
Phone: 217-782-1790
E-mail: Erica.Weyhenmeyer@Illinois.gov

ILLINOIS DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION REPORT OF

CIGNA HEALTH AND LIFE INSURANCE COMPANY

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	March 6, 2017 through July 25, 2018
EXAMINATION OF:	CIGNA Health and Life Insurance Company NAIC #67369
LOCATION:	900 Cottage Grove Road Bloomfield, CT 06002
PERIOD COVERED BY EXAMINATION:	December 1, 2015 through November 30, 2016
EXAMINERS:	Lucinda Woods Art Kusserow Brent Stein June Coleman, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner

TABLE OF CONTENTS

I. SUMMARY 1
II. BACKGROUND 5
III. METHODOLOGY 6
IV. SELECTION OF SAMPLES 9
V. FINDINGS 10
A. SUBSTANTIALLY ALL/PREDOMINANT COST-SHARING TESTING 10
B. FORMULARY DESIGNS 10
C. COMPANY OPERATIONS AND MANAGEMENT 10
D. COMPLAINTS 10
E. APPEALS 10
F. MARKETING AND SALES 11
G. PRODUCER LICENSING 11
H. UNDERWRITING 11
I. UTILIZATION REVIEWS 11
J. CLAIMS 12
K. ASSOCIATED MENTAL HEALTH AND SUBSTANCE USE DISORDER FILES 14
VI. INTERRELATED FINDINGS 16

I. SUMMARY

A comprehensive market conduct examination of CIGNA Health and Life Insurance Company (hereinafter referred to as the "Company" or "CIGNA") was performed to determine compliance with Illinois statutes and the Illinois Administrative Code. The lines of business reviewed were individual dental and group health.

In addition, the examination included a review of activities as they pertained to parity in relation to mental health and substance use disorders (MH/SUD) within the Company's group health insurance business. The mental health parity section of the examination was performed to determine compliance with Illinois statutes and the Illinois Administrative Code, as well as federal statutes and rules related to the Mental Health Parity and Addiction Equity Act of 2008.

The objective of the mental health parity section of the examination was to evaluate if the Company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The objectives of the specific areas of review for the examination included but were not limited to the following:

1. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied than those applied to medical/surgical services.

2. Evaluate a sample of MH/SUD claims during the examination period to compare services to medical/surgical services and to ensure denials were appropriate based on medical necessity criteria.

3. Evaluate the universe of appeals during the examination period to determine if the appeal decisions were based on appropriate clinical criteria and policies.

4. Evaluate the medical necessity criteria, policies, and procedures to ensure the Company was not imposing more restrictive requirements and determinations for MH/SUD treatments and services than on medical/surgical treatments and services.

5. Determine that the MH/SUD benefits provided in the classifications identified by 45 CFR §146.136 (a)(c)(2)(ii)(A): inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs, are paid in parity with benefits in the same medical/surgical classifications.

6. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits and that any financial requirements and QTLs imposed meet the two-thirds threshold of the substantially all requirements outlined in 45 CFR § 146.136 (a)(c)(3)(i).

7. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the Company was not being more restrictive as outlined in 45 CFR § 146.136 (4)(i) and 45 CFR § 146.136 (4)(ii).

8. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure they were no more restrictive than the comparable medical/surgical policies and procedural requirements.

9. Determine that the policies and procedures for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

For this examination, a MH/SUD subject matter expert and a pharmacist assisted in the interpretation of the documentation provided with respect to MH/SUD parity and pharmacy benefits.

The following table represents general findings with specific details in each section of the report.

Table of Total Violations

Criticism Number	Statute/Rule	Description of Violations	Population	Files Reviewed	No. of Violations
38-Formulary Designs	215 ILCS 5/370c.1(a)(2), 45 CFR 146.136(4)(i) and 45 CFR 146.136(4)(ii)	Imposed a NQTL with respect to mental health or substance use disorder benefits more stringently than to medical/surgical benefits by adding a criteria of step therapy of "limiting to depression diagnosis only" for Serotonin Selective/Serotonin Norepinephrine Receptor Inhibitor Antidepressants drug class.	N/A	N/A	N/A
34-Company Operations and Management	215 ILCS 5/370c(b)(3)	Failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders.	N/A	N/A	N/A

Table of Total Violations					
Criticism Number	**Statute/Rule**	**Description of Violations**	**Population**	**Files Reviewed**	**No. of Violations**
05-DOI Complaints	50 Ill. Adm. Code 926.40(a)	Failed to respond to Department of Insurance complaint within 21 days.	10	10	1
03-Appeals	215 ILCS 134/45(c)	Failed to render a decision on appeals within 15 business days after receipt of the required information.	192	192	14
04-Appeals	215 ILCS 180/20(b)(3)	Failed to respond to an expedited internal review request within the required 48 hours.	192	192	1
06-Appeals	215 ILCS 134/45(c)	Failed to notify parties involved in the appeal orally of its decision, in addition to the written notice the Company provided of the determination of the appeal.	192	192	191
07-Appeals	215 ILCS 5/368a(c)	Failed to pay interest on health claims paid beyond 30 days of receipt of written proof of the loss.	192	192	1
09-Individual Dental New Business	215 ILCS 5/355a(5)(a)	Failed to provide proof that the Company delivered a policy with the outline of coverage and a notice stating the policyholder has the right to return the policy within 10 days of its delivery.	2,206	115	4
11-Dental Utilization Review	215 ILCS 5/154.6(b)	Failed to notify the insured of the utilization review determination for preauthorization of a dental procedure(s). The Company failed to acknowledge with reasonable promptness pertinent communications.	1,784	114	37
12-Dental Utilization Review	215 ILCS 5/368a(c)	Failed to pay interest on health claims paid beyond 30 days of receipt of written proof of the loss.	1,784	114	3

Table of Total Violations					
Criticism Number	**Statute/Rule**	**Description of Violations**	**Population**	**Files Reviewed**	**No. of Violations**
14-Dental Paid Claims	215 ILCS 5/368a(c)	Failed to pay claims within 30 days after receipt of due written proof of loss.	46,987	109	1
15-Dental Denied Claims	50 Ill. Adm. Code 919.70(a)(2)	Failed to provide a written explanation for the delay of the claim.	30,768	109	2
16-Preventive Paid Claims	215 ILCS 5/368a(c)	Failed to pay claims within 30 days after receipt of due written proof of loss.	13,395	109	1
17-Preventive Paid Claims	50 Ill. Adm. Code 919.70(a)(2)	Failed to provide a written explanation for the delay of the claim.	13,395	109	1
19-Preventive Denied Claims	50 Ill. Adm. Code 919.70(a)(2)	Failed to provide a written explanation for the delay of the claim.	838	105	1
21-Medical Paid Claims	215 ILCS 5/368a(c)	Failed to pay claims within 30 days after receipt of due written proof of loss.	52,831	109	3
24-MH/SUD Paid Claims	215 ILCS 5/368a(c)	Failed to pay claims within 30 days after receipt of due written proof of loss.	2,632	108	3
25-MH/SUD Paid Claims	50 Ill. Adm. Code 919.70(a)(2)	Failed to provide a written explanation for the delay of the claim.	2,632	108	2
28-MH/SUD Denied Claims	50 Ill. Adm. Code 919.50(a)	Failed to provide the denial of the claim within a reasonable time after receipt of due proof of loss.	366	82	1
32-MH/SUD Denied Claims	215 ILCS 5/370c(4)(A)(iii)	Failed to provide coverage for 20 additional outpatient speech therapy visits for treatment of pervasive developmental disorders that was in addition to speech therapy provided with 60 visits for outpatient treatment.	366	82	1

II. BACKGROUND

CIGNA Health and Life Insurance Company - NAIC #67369

The Company was formed in 1982 through the combination of Insurance Company of North America (INA) and Connecticut General Life Insurance Company (CG). The name mixes the letters INA and CG together. INA was founded in 1792 in Philadelphia offering marine and fire insurance. CG began business in Hartford in 1865 as a life insurance company mainly providing low-cost policies to the residents of small towns in New England and New York.

The Company focuses on health care and employee benefits after divesting its individual life insurance business in 1998, domestic and international property and casualty operations in 1999, and retirement business in 2004.

The Company's 2016 NAIC Annual Statement, Page 24 (Illinois), reflects the following information for group accident and health:

Line	Direct Premiums Written	Direct Premiums Earned	Direct Losses Paid	Direct Losses Incurred
24. Group Policies	$302,084,731	$304,028,009	$226,203,089	$227,886,978

III. METHODOLOGY

The market conduct examination process places emphasis on an insurer's systems and procedures used in dealing with insureds and claimants. The individual dental and group health business was reviewed in this examination.

The scope of this examination was a comprehensive examination including a review of the following areas:

A. Substantially All/Predominant Cost-Sharing Testing in Health Plans
B. Formulary Designs
C. Company Operations and Management
D. Complaints
E. Appeals
F. Marketing and Sales
G. Producer Licensing
H. Underwriting
I. Utilization Reviews
J. Claims

The review of these categories was accomplished through examination of material related to the Company's operations and management, complaint files, producer lists, underwriting files, risk selection files, and claim files, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, interrogatories, and criticisms.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Substantially All/Predominant Cost-Sharing Testing in Health Plans

The Company was requested to provide the mental health parity testing of its health plans and the benefit classifications for medical/surgical and MH/SUD categories. The benefits, as classified accordingly, were evaluated for financial requirements and QTLs compliance. The parity analyses of the health plans were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008, as well as the Mental Health Parity Addiction Equity Act (MHPAEA) and related regulations.

Formulary Designs

The Company was requested to identify and provide all formulary designs and pharmacy policies and procedures used during the experience period for MH/SUD requirements. In accordance with the requirements of the examination, the data and responses to follow up information requests were reviewed. The pharmacy documentation and responses to follow up information requests and interrogatories were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008, as well as the Mental Health Parity Addiction Equity Act (MHPAEA) and related regulations.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third party vendors, internal audits, certificate of authority, previous market conduct examinations, and annual statements. These documents were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

Complaints

The Company was requested to identify all consumer and Illinois Department of Insurance (ILDOI) complaints received during the examination period, plus six (6) months prior for trending purposes, and to provide copies of the complaint logs. All complaint files and logs were received. The files were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

Appeals

The Company was requested to identify all appeals for the experience period. All appeal files were received and reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008

Marketing and Sales

The Company was requested to provide a list of all marketing and sales materials used in Illinois during the examination period. Samples of the materials were made by the examiners and submitted to the Company. The materials were received and reviewed to ensure that the material was in compliance with Illinois statutes and the Illinois Administrative Code.

Producer Licensing

The Company was requested to provide a list of all producers licensed to do business in Illinois and a list of those producers paid commissions in Illinois during the examination period. The

Company identified a universe of producers. A random sample of producers was reviewed in comparison to the Illinois licensing database for compliance with Illinois statutes and the Illinois Administrative Code. Newly issued business was also reviewed to determine if solicitations were made by duly licensed persons. There were no exceptions noted.

Underwriting

The Company was requested to provide a list of all new issued and in force individual dental and group health policies. The Company identified the universe of policies; random samples of the files were made by the examiners and submitted to the Company. The files were received and reviewed. The files were reviewed to ensure that the policies were processed in compliance with Illinois statutes and the Illinois Administrative Code. New policies were also reviewed to determine the correct use of filed forms, and for compliance with the Company underwriting and policy guidelines.

Utilization Reviews

The Company was requested to identify all utilization reviews for the experience period. The Company identified the universe of utilization reviews; random samples of the files were made by the examiners and submitted to the Company. The utilization review files and responses to information requests were received and reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

Claims

The Company was requested to provide a list of all claims in various categories during the examination period, to include paid and denied. Due to various disqualifying factors, some individual files in the samples were replaced with another file. The files and responses to information requests and interrogatories were reviewed to ensure the claims were processed in compliance with the policy, Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

IV. SELECTION OF SAMPLES

Survey	Population	Number Reviewed	Percentage Reviewed
Complaints			
Consumer Complaint – ILDOI	10	10	100%
Consumer Complaints – Received by the Company	25	25	100%
Appeals			
Appeals – Consumer	192	192	100%
Marketing and Sales			
Marketing and Sales Materials	367	56	15%
Producer Licensing			
Active Producers	3,828	115	3%
Underwriting			
Group Health – New Business	49	49	100%
Individual Dental – New Business	2,206	115	5%
Utilization Reviews			
Individual and Group Dental	1,784	114	6%
Group Medical	1,638	114	7%
Claims			
Individual and Group Dental - Paid	46,987	109	<1%
Individual and Group Dental – Denied	30,768	109	<1%
Group Preventive – Paid	13,395	109	<1%
Group Preventive – Denied	838	105	13%
Group Medical – Paid	52,831	109	<1%
Group Medical – Denied	4,786	108	2%
Group MH/SUD – Paid	2,632	108	4%
Group MH/SUD – Denied	366	82	22%
Group Pharmacy – Paid	8,858	109	1%
Group Pharmacy – Denied	455	83	18%

V. FINDINGS

A. SUBSTANTIALLY ALL/PREDOMINANT COST-SHARING TESTING

There were no criticisms in the substantially all/predominant cost-sharing testing.

B. FORMULARY DESIGNS

When reviewing the Company's Step Therapy Coverage Policy #1109, it was noted that the Company added in the Serotonin Selective/Serotonin Norepinephrine Receptor Inhibitor Antidepressants drug class that the criteria of step therapy was "limited to depression diagnosis only". The Company imposed a NQTL with respect to mental health or substance use disorder benefits more stringently than to medical/surgical benefits in the classification. This is a violation of 215 ILCS 5/370c.1(a)(2), 45 CFR 146.136(4)(i) and 45 CFR 146.136(4)(ii).

C. COMPANY OPERATIONS AND MANAGEMENT

The Company provided its medical necessity criteria guidelines. The Company utilized its own internally developed medical necessity criteria for substance use disorder levels of care. The Company failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders. This is in violation of 215 ILCS 5/370c(b)(3).

D. COMPLAINTS

1. Department of Insurance Consumer Complaints

In one (1) instance of the 10 Department of Insurance complaint files reviewed, for an error percentage of 10%, the Company failed to respond to the Department of Insurance complaint within 21 days. This is a violation of 50 Ill. Adm. Code 926.40(a).

2. Consumer Complaints Received Directly by the Company

There were no criticisms in the consumer complaints survey.

E. APPEALS

In 14 instances of the 192 appeals files reviewed, for an error percentage of 7.29%, the Company failed to render a decision on appeals within 15 business days after receipt of the required information. This is a violation of 215 ILCS 134/45(c).

In one (1) instance of the 192 appeals files reviewed, for an error percentage of .52%, the Company failed to respond to an expedited internal appeal request within the required 48 hours. This is a violation of 215 ILCS 180/20(b)(3).

In 191 instances of the 192 appeals files reviewed, for an error percentage of 99.48%, the Company failed to notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider involved in the appeal orally of its decision. This is a violation of 215 ILCS 134/45(c).

In one (1) instance of the 192 appeals files reviewed, for an error percentage of .52%, the Company failed to properly pay the claim resulting in interest in the amount of $43.22. The Company provided evidence for the payment of interest. This is a violation of 215 ILCS 5/368a(c).

F. MARKETING AND SALES

There were no criticisms in the marketing and sales survey.

G. PRODUCER LICENSING

There were no criticisms in the producer licensing survey.

H. UNDERWRITING

1. Group Health – New Business

There were no criticisms in the group health new business survey.

2. Individual Dental – New Business

In four (4) instances of the 115 individual dental new business files reviewed, for an error percentage of 3.48%, the Company failed to provide proof that it delivered a policy with the outline of coverage and a notice stating the policyholder has the right to return the policy within 10 days of its delivery. This is a violation of 215 ILCS 5/355a (5)(a).

I. UTILIZATION REVIEWS

1. Individual and Group Dental

In 37 instances of the 114 individual dental utilization reviews files reviewed, for an error percentage of 32.46%, the Company failed to notify the insured of the

utilization review determination for preauthorization of a dental procedure(s). The Company failed to acknowledge with reasonable promptness pertinent communications. This is a violation of 215 ILCS 5/154.6(b).

In three (3) instances out of 114 dental utilization reviews files reviewed, for an error percentage of 2.63%, the Company failed to pay claims with interest. The Company provided evidence for the payment of interest. This is a violation of 215 ILCS 5/368a(c) and resulted in the interest amount of $21.51. The Company provided evidence of the payment of interest.

2. Group Health

There were no criticisms in the group health utilization reviews survey.

J. CLAIMS

1. Individual and Group Dental – Paid

The median for payment was three (3) days.

In one (1) instance of the 109 individual dental paid claim files reviewed, for an error percentage of .92%, the Company failed to pay the claim within 30 days after receipt of due written proof. This is a violation of 215 ILCS 5/368a(c).

2. Individual and Group Dental – Denied

The median for denial was one (1) day.

In two (2) instances out of the 109 dental denied claim files reviewed, for an error percentage of 1.83%, the Company failed to provide a written explanation for the delay of the claim. This is a violation of 50 Ill. Adm. Code 919.70(a)(2).

3. Group Preventive – Paid

The median for payment was one (1) day.

In one (1) instance of the 109 preventive paid claim files reviewed, for an error percentage of .92%, the Company failed to pay the claim within 30 days after receipt of due written proof. This is a violation of 215 ILCS 5/368a(c).

In one (1) instance of the 109 preventive paid claim files reviewed, for an error percentage of .92%, the Company failed to provide a written explanation for the delay of the claim to the insured. This is a violation of 50 Ill. Adm. Code 919.70(a)(2).

4. Group Preventive – Denied

   The median for denial was one (1) day.

   In one (1) instance out of the 105 preventive denied claim files reviewed, for an error percentage of .95%, the Company failed to provide a written explanation for the delay of the claim to the insured. This is a violation of 50 Ill. Adm. Code 919.70(a)(2).

5. Group Medical – Paid

   The median for payment was two (2) days.

   In three (3) instances of the 109 medical paid claim files reviewed, for an error percentage of 2.75%, the Company failed to pay the claim within 30 days after receipt of due written proof. This is a violation of 215 ILCS 5/368a(c).

6. Group Medical – Denied

There were no criticisms in the Group Medical- Denied

7. Group MH/SUD – Paid

   The median for payment was six (6) days.

   In three (3) instances of the 108 mental health paid claim files reviewed, for an error percentage of 2.78%, the Company failed to pay the claim within 30 days after receipt of due written proof. This is a violation of 215 ILCS 5/368a(c).

   In two (2) instances of the 108 mental health paid claim files reviewed, for an error percentage of 1.85%, the Company failed to provide a written explanation for the delay of the claim within 45 days. This is a violation of 50 Ill. Adm. Code 919.70(a)(2).

8. Group MH/SUD – Denied

   The median for denial was 10 days.

   In one (1) instance of the 82 mental health denied claim files reviewed, for an error percentage of 1.22%, the Company failed to provide the denial of the claim within a reasonable time after receipt of due proof of loss. This is a violation of 50 Ill. Adm. Code 919.50(a).

In one (1) instance of the 82 mental health denied claim files reviewed, for an error percentage of 1.22%, the Company failed to provide coverage for the 20 additional outpatient speech therapy visits for treatment of pervasive developmental disorders that was in addition to speech therapy provided with 60 visits for outpatient treatment. This is a violation of 215 ILCS 5/370c(4)(A)(iii).

9. Group Pharmacy – Paid

   The median for payment was three (3) days.

   There were no criticisms in the group MH/SUD pharmacy paid claims survey.

10. Group Pharmacy – Denied

    The median for denial was one (1) day.

    There were no criticisms in the group MH/SUD pharmacy denied claims survey.

K. ASSOCIATED MENTAL HEALTH AND SUBSTANCE USE DISORDER FILES

Five (5) top claimants with multiple health and pharmacy claims, utilization reviews, appeals, and complaints were selected for a high-level review. The review was completed to verify the processes and procedures involved in adjudicating the various submissions for each of these subscribers in order to receive the benefits of the health plan.

a. An adult dependent of the subscriber was diagnosed with bipolar disorder, chronic posttraumatic stress disorder and opioid dependence. Ten (10) claims were reviewed. Five (5) claims were submitted for out-of-network family therapy office visits and all five (5) claims were appropriately paid in a timely manner with no restrictions. Three (3) claims were submitted for out-of-network laboratory tests that were appropriately denied due to missing or invalid service code. Two (2) claims were submitted for an in-network inpatient hospital stay and both claims were appropriately paid in a timely manner with no restrictions. All these associated mental health claims were treated in parity and were no more restrictive than the handling of medical claims.

b. A child dependent of the subscriber was diagnosed with phonological disorder. Seven (7) out-of-network claims were submitted for treatment of speech, language, communications, and individual visits. All seven (7) claims were appropriately denied due to the expenses for short term rehabilitative services are not covered for this condition. The denial for one (1) of the seven (7) claims was

untimely and resulted in a violation for not providing a denial explanation within 45 days. All these associated mental health claims were treated in parity and were no more restrictive than the handling of medical claims.

c. An adult subscriber was diagnosed with alcohol dependence. There were six (6) claims, one (1) utilization review and one (1) appeal submitted to the Company. The subscriber appealed an in-network partial hospitalization claim and was denied coverage based on medical necessity. Of the six (6) claims submitted, one (1) claim for in-network physician visit was appropriately paid in a timely manner with no restrictions. Five (5) in-network claims for various laboratory testing were partially denied appropriately due to missing or invalid service code. Lastly, a utilization review was conducted and appropriately approved for in-network outpatient visits. All the associated substance use disorder claims and utilization review were treated in parity and were no more restrictive than the handling of medical claims or utilization review. However, the appeal was in violation of MH/SUD parity because the Company utilized other criteria than the American Society of Addiction Medicine (ASAM) criteria in making the decision.

d. An adult dependent of the subscriber was diagnosed with opioid dependence. Five (5) claims were reviewed. One (1) out-of-network claim was submitted for other psychiatric services and was appropriately denied due to requesting specific information on the professional who had rendered the service to determine the degree/credentials specialty. Four (4) claims were submitted for out-of-network laboratory testing. One (1) laboratory testing claim was paid untimely and was in violation for not paying the claim in 30 days. The remaining three (3) laboratory testing claims were closed without payment due to a special investigation settlement with the provider and at no cost to the subscriber. All the associated substance use disorder claims were treated in parity and were no more restrictive than the handling of medical claims.

e. A child dependent (20 years old) of the subscriber was diagnosed with opioid dependence. There were 17 claims, one (1) utilization review and one (1) appeal reviewed. The utilization review was for an out-of-network step down therapy program which was appropriately approved by the Company. All 17 substance use disorder claims were out-of-network. Five (5) claims for either laboratory testing or physician office visits were appropriately paid in a timely manner with no restrictions. Eleven (11) claims for laboratory testing were denied. Of the 11 laboratory testing claims, five (5) tests were denied appropriately due to missing or invalid service code or service was not rendered. Six (6) laboratory testing claims were improperly denied due to not being medically necessary, charges not payable, or exceeded the maximum units allowed per date of service. An appeal was filed on the laboratory tests that were not deemed medically necessary. It was determined for the denied laboratory testing claims and denied appeal that the

Company was in violation for imposing a NQTL with respect to MH/SUD benefits not in parity with medical/surgical benefits.

VII. INTERRELATED FINDINGS

During the course of the examination, the Company was asked to provide responses to several types of requests in a timely manner. The responses were due within three (3) days to 10 days and extensions were granted when requested. The requests included such items as accumulators for selected files, file content questions, information requests, and criticisms. The Company provided the accumulators for four (4) claim review sections between 33 days to 60 days late. Responses to three (3) file content questions were received from four (4) days to 22 days late. The Company responded to six (6) information requests from one (1) day to 34 days late. The responses to five (5) criticisms were all received three (3) days late.

In addition to responding in an untimely manner, the Company provided an incomplete response to questions on a pharmacy information request. Additional information requests were issued to receive complete responses for the review. The Company also provided information that was not valid for pharmacy claims data and for mental health parity analyses. For example, several attempts were made by the Company in order to provide valid pharmacy claim data. The invalid data lists included non-Illinois residents or the plans were not sitused in Illinois. The mental health parity cost sharing analyses were another example of providing invalid information. The analyses had incorrect deductible, co-pay, or co-insurance amounts. The Company also provided plans that were not related to the analysis.

EXAMINATION DRAFT REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Lucinda Woods
Art Kusserow
Brent Stein
June Coleman, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

Respectfully submitted,

June Coleman
JUNE COLEMAN
EXAMINER-IN-CHARGE

SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF PENNSYLVANIA)
) ss
COUNTY OF LANCASTER)

JUNE COLEMAN, being first duly sworn upon her oath, deposes and says:

That she was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Cigna Health and Life Insurance Company, NAIC #67369, (the "Company").

That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Company's business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Company.

June A. Coleman
Examiner-In-Charge

Subscribed and sworn to before me this 3 day of August, 2018.

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MICHAEL SHANE WERT
Notary Public
RAPHO TWP., LANCASTER COUNTY
My Commission Expires Jun 27, 2020

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

CIGNA HEALTH AND LIFE INSURNACE COMPANY
900 Cottage Grove Road
Bloomfield, CT 06002

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, CIGNA Health and Life Insurance Company ("the Company"), NAIC 67369, is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, they waive any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS AGREED by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures whereby the Company shall notify the party filing the appeal and all other necessary parties of all the information required to evaluate the appeal within three (3) business days and shall orally notify all parties involved in the appeal of its decision as required by 215 ILCS 134/45(c).

2. Institute and maintain policies and procedures whereby the Company shall acknowledge with reasonable promptness pertinent communications with respect to all claims arising under its policies as required by 215 ILCS 5/154.6(b).

3. Institute and maintain policies and procedures whereby the Company shall respond to the Department of Insurance by the date specified when notified of a complaint received by the Department as required by 50 Ill. Adm. Code 926.40(a).

4. Institute and maintain policies and procedures whereby the Company shall utilize patient placement criteria established by the American Society of Addiction Medicine when making medical necessity determinations for substance use disorders as required by 215 ILCS 5/370c(b)(3).

5. Institute and maintain policies and procedures whereby the Company shall implement treatment limitations applicable to mental, emotional, nervous, or substance use disorder or condition benefits which are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy per 215 ILCS 5/370c.1(a)(2).

6. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above five (5) orders within 30 days of execution of this Order.

7. Pay to the Director of Insurance, State of Illinois, a required contribution in the amount of $418,000 to the Parity Advancement Fund created under 215 ILCS 5/370c.1(i) to be paid within 10 days of receipt of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code including, but not limited to, levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of CIGNA Health and Life Insurance Company

Brian P. Marsella

Signature

BRIAN P. MARSELLA

Name

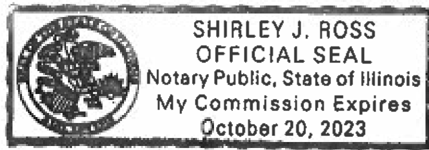
PRESIDENT, MIDWEST MARKET

Title

Subscribed and sworn to before me this
29 day of April 2020.

Shirley J. Ross

Notary Public



DEPARTMENT OF INSURANCE of the State of Illinois:

DATE 5/6/20

Robert Muriel

Robert H. Muriel
Director