IN THE DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION STATE OF MISSOURI

In Re:	)	
	)	
CIGNA HEALTHCARE OF ST. LOUIS	)	**Market Conduct Exam No. 1003-02-TGT**
f/k/a Cigna Healthcare of Ohio d/b/a	)	
Cigna Healthcare of Kansas/Missouri	)	
(NAIC # 95209)	)	
	)	

ORDER OF THE DIRECTOR

NOW, on this 16th day of June, 2015, Director John M. Huff, after consideration and review of the market conduct examination report of Cigna Healthcare of St. Louis f/k/a Cigna Healthcare of Ohio d/b/a Cigna Healthcare of Kansas/Missouri (NAIC #95209) (hereafter referred to as "Cigna Ohio"), report number 1003-02-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3) (a)[1], and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation"), does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such report are deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4).

This order, issued pursuant to §374.205.3(4), §374.280 RSMo (Cum Supp. 2012), and §374.046.15. RSMo (Cum. Supp. 2012), is in the public interest.

IT IS THEREFORE ORDERED that Cigna Ohio and the Division of Insurance Market Regulation having agreed to the Stipulation, the Director does hereby approve and agree to the Stipulation.

IT IS FURTHER ORDERED that Cigna Ohio shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Cigna Ohio in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

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1 All references, unless otherwise noted, are to Missouri Revised Statutes 2000 as amended.

IT IS FURTHER ORDERED that Cigna Ohio shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $94,800 payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 16th day of June, 2015.

John M. Huff
Director

IN THE DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION STATE OF MISSOURI

In Re:	)	
	)	
CIGNA HEALTHCARE OF ST. LOUIS	)	**Market Conduct Exam No. 1003-02-TGT**
f/k/a Cigna Healthcare of Ohio d/b/a	)	
Cigna Healthcare of Kansas/Missouri	)	
(NAIC # 95635)	)	
	)	

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter "the Division") and Cigna Healthcare of St. Louis (NAIC #95635), as the surviving corporation of a merger with and successor in interest to Cigna Healthcare of Ohio d/b/a Cigna Healthcare of Kansas/Missouri (NAIC #95209) (hereinafter collectively referred to as "Cigna Ohio"), as follows:

WHEREAS, the Division is a unit of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereinafter, "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, Cigna Ohio was granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Division conducted a Market Conduct Examination of Cigna Ohio and prepared report number 1003-02-TGT; and

WHEREAS, the report of the Market Conduct Examination revealed that:

1. In 736 instances, Cigna Ohio used unapproved forms containing language that did not comply with Missouri law in violation of §354.405.4 RSMo[1], §354.430, 20 CSR 400-7.010, §376.426 (16) and 20 CSR 400-7.030 (15) (B);

2. In 19 instances, Cigna Ohio misrepresented to claimants the reason for the denial of

1 All references, unless otherwise noted, are to Missouri Revised Statutes, as amended.

coverage and failed to provide a reasonable and accurate explanation for the denial of claims in violation of §375.1007 (1), (3) and (12);

3. In 1 instance, Cigna Ohio processed a claim inconsistent with policy provisions related to COB in violation of §375.1007 (3) and (4);

4. In several instances, Cigna Ohio charged a co-payment in excess of 50% in violation of §354.410.1 (2), §375.1007 (1) (3) and (4), and 20 CSR 400-7.100;

5. Cigna Ohio failed to adopt and implement a process to ensure and document that excessive co-payments are not imposed on members in violation of §375.205.2 (2), 20 CSR 100-8.040 (3) (B), and §375.1007 (3) and (4);

6. Cigna Ohio failed to send EOB's to members for all claims in violation of §375.1007 (3) and (4) and 20 CSR 100-1.050 (1) (A);

7. In 19 instances, Cigna Ohio incorrectly denied claims filed by participating providers using the remark code for non-participating providers in violation of §375.1007 (1) and 20 CSR 100-1.020 (1) (A);

8. In 1 instance, Cigna Ohio requested a refund on a claim more than 1 year after the date of the claim payment in violation of §375.1007 (3) and (4) and §376.384.1 (3);

9. In 7 instances, Cigna Ohio was late in responding to the examiner's findings or formal requests and in 1 instance failed to respond entirely to a portion of a formal request in violation of §374.205.2 (2) and 20 CSR 100-8.040 (6).

WHEREAS, the Division and Cigna Ohio have agreed to resolve the issues raised in the Market Conduct Examination Report as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent that no promise, inducement or agreement not herein expressed has been made, and acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** Cigna Ohio agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those remedial actions at all times, to reasonably assure that the errors noted in the above-referenced market

conduct examination report do not recur. Such remedial actions shall include, but not be limited to, the following:

1. Cigna Ohio agrees to review all denied chiropractic claims from January 1, 2006 to the date of the order closing this exam to determine if any claims were improperly denied. If a claim was improperly denied prior to January 1, 2011, Cigna Ohio must pay restitution to the claimant, and if the claim was denied 46 or more days after receipt, include payment of interest at the rate of 1% per month as required by §376.383, RSMo Supp. 2009. If a claim was improperly denied from January 1, 2011 to the date of the order closing this exam, Cigna Ohio must pay restitution to the claimant, and if the claim was denied 46 or more processing days after receipt, include payment of interest at the rate of 1% per month and payment of a penalty of 1% per day as required by §376.383, RSMo Supp 2013. Either a letter or an EOB, must be included with the payment indicating that "as a result of a Missouri Market Conduct Examination" it was found that additional payment was owed on the claim.

2. Cigna Ohio agrees that it will not impose co-payments exceeding 50% of the total cost of providing any single service to its members in violation of §374.1005 and/or 20 CSR 400-7.100.

3. Cigna Ohio agrees that it will review all claims from January 1, 2006 to the date of the order closing this exam with a member co-payment to determine if any co-payments exceeded 50% of the total cost of providing any single service to its members. If a member paid a co-payment in excess of 50% of the cost of providing any single service, Cigna Ohio must pay restitution to the member, including the payment of interest at the rate of 9% per annum as required by §408.020. Payment of restitution by Cigna Ohio is only required if the cumulative amount paid in excess of 50% for all claims by the member equals or exceeds $5.00. Either a letter or an EOB must be included with the payment indicating that "as a result of a Missouri Market Conduct Examination" it was found that the member was entitled to a refund of moneys paid on the claim.

4. Cigna Ohio agrees to develop a process that: (1) requires its network providers to collect copayments from members that do not exceed the 50% limitation set forth in 20 CSR 400-7.100; (2) facilitates providers' ability to calculate and collect correct copayments at the time of service; (3) requires providers to make refunds to members of any copayments erroneously collected

in excess of the 50% limitation set forth in 20 CSR 400-7.100 within 30 days of receipt of Cigna Ohio's remittance advice; and (4) requires a provider audit and corrective action when Cigna Ohio receives information that a provider may not be complying with the Company's administrative requirements for compliance with the 50% limitation on copayments set forth in 20 CSR 400-7.100.

5. Cigna Ohio agrees to create audit procedures to assure that third party vendors comply with the requirements of §376.384.1 (3).

C. **Compliance.** Cigna Ohio agrees to file documentation with the Division within 90 days of the entry of a final order of all remedial action taken to implement compliance with the terms of this stipulation and to document the payment of restitution required by this Stipulation.

D. **Voluntary Forfeiture.** Cigna Ohio agrees, voluntarily and knowingly, to surrender and forfeit the sum of $94,800, such sum payable to the Missouri State School Fund, in accordance with §374.049 and §374.280, RSMo Supp. 2013.

E. **Other Penalties.** The Division agrees that it will not seek penalties against Cigna Ohio, other than those agreed to in this Stipulation, for the conduct found in Market Conduct Examination 1003-02-TGT.

F. **Waivers.** Cigna Ohio, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, and review or appeal by any trial or appellate court, which may have otherwise applied to the above referenced Market Conduct Examination.

G. **Changes.** No changes to this stipulation shall be effective unless made in writing and agreed to by all signatories to the stipulation.

H. **Governing Law.** This Stipulation of Settlement and Voluntary Forfeiture shall be governed and construed in accordance with the laws of the State of Missouri.

I. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation of Settlement and Voluntary Forfeiture.

J. **Effect of Stipulation.** This Stipulation of Settlement and Voluntary Forfeiture shall not become effective until entry of a Final Order by the Director of the Department of Insurance,

Financial Institutions and Professional Registration (hereinafter the "Director") approving this Stipulation.

K. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation of Settlement and Voluntary Forfeiture and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: 6/12/2015

Angela L. Nelson
Director, Division of Insurance
Market Regulation

DATED: 6/12/2015

Stewart Freilich
Senior Regulatory Affairs Counsel
Division of Insurance Market Regulation

DATED: 6/9/2015

Frank A. Monahan
President
Cigna Healthcare of St. Louis f/k/a
Cigna Healthcare of Ohio d/b/a
Cigna Healthcare of Kansas/Missouri

STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

FINAL MARKET CONDUCT EXAMINATION REPORT
of the Health Maintenance Organization Business of

Cigna Healthcare of Ohio Inc. d/b/a
Cigna Healthcare of Kansas / Missouri

NAIC # 95209

MISSOURI EXAMINATION # 1003-02-TGT

NAIC EXAM TRACKING SYSTEM # MO341-M1

June 12, 2015

Home Office
900 Cottage Grove Rd
Hartford, CT 06152-1149

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FOREWORD

This is a targeted market conduct examination report of Cigna Healthcare of Ohio, Inc. d/b/a Cigna Healthcare of Kansas/Missouri, (NAIC Code # 95209). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- "ACL®" refers to Audit Command Language – proprietary software;
- "COB" refers to Coordination of Benefits as defined and described in 20 CSR 400-2.030;
- "Company" or "Cigna" refers to Cigna Healthcare of Ohio Inc. d/b/a Cigna Healthcare of Kansas/Missouri;
- "CPT" refers to "Current Procedural Terminology." CPT codes are used to identify medical procedures and are published by American Medical Association;
- "CSR" refers to the Missouri Code of State Regulations;
- "DIFP" or "Department" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "Director" refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "EOP", refers to Explanation of Payment. A document, also known as a remittance advice, submitted to a healthcare provider to explain the amount of payment and/or how a claim is resolved;
- "EOB" refers to Explanation of Benefits. A document submitted to an insured or member to explain the amount of payment and/or how a claim is resolved;
- "HMO" refers to Health Maintenance Organization as defined and described in chapter 354;
- "ICD-9" refers to the International Classification of Diseases, Ninth Revision;
- "NAIC" refers to the National Association of Insurance Commissioners;
- "PCP" refers to Primary Care Physician;
- "Remark Code" refers to codes placed on a remittance advice or an explanation of benefits to convey information important to understanding the payment or denial of a claim; and
- "RSMo" refers to the Revised Statutes of Missouri. All citations are to RSMo 2000, unless otherwise specified.

SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§354.465.1, 374.110, 374.190, 374.205, 375.445, 375.938, 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and regulations and to consider whether the Company's operations are consistent with the public interest. Unless otherwise noted, the primary period covered by this review is January 1, 2006, through December 31, 2009. Errors uncovered outside the examination time period, may also be included in the report. The examination was a targeted examination, limited in scope to health contracts involving the following business functions:

- Underwriting
- Claims handling
- Complaints

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook.* As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews applying a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, the examiners only reviewed specific segments of the Company's practices, procedures, products and files. Therefore, some noncompliant practices, procedures, products and files may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

This market conduct examination was performed as a desk audit at the following DIFP offices:

Harry S Truman State Office Building
301 W. High Street
Jefferson City, MO 65101

COMPANY PROFILE

The Company is licensed by the DIFP under Chapter 354, RSMo, to operate as a Health Maintenance Organization (HMO) as set forth in its Certificate of Authority.

The Company was incorporated as a for-profit corporation under the laws of the state of Ohio on August 16, 1985, and it was first licensed to operate as a HMO in Missouri on January 9, 1996. During the time period of the examination, the Company's service area encompassed the Missouri counties of Andrew, Barry, Buchanan, Cass, Christian, Clay, DeKalb, Greene, Jackson, Jasper, Lafayette, Lawrence, Newton, Platte, Polk, Ray, Webster, Stone, and Taney, and the Kansas counties of Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Miami, Osage, and Shawnee.

On September 30, 2011, Cigna Healthcare of Ohio d/b/a Cigna Healthcare of Kansas/Missouri completed a merger with Cigna of St. Louis with Cigna of St. Louis being the surviving corporation.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Cigna. The examiners found the following principal areas of concern:

- The Company used a form not approved by the DIFP;
- The Company limited chiropractic benefits to 26 visits;
- The Company failed to adopt and implement reasonable standards for an investigation and settlement before denying chiropractic claims;
- The Company failed to accurately reflect the dates of receipt on claim forms;
- The Company incorrectly denied claims by stating on its EOBs that services were provided by out-of-network providers, when the providers were contracted with the Company;
- The Company incorrectly denied a COB claim for Emergency Room benefits;
- The Company incorrectly calculated copayment amounts;
- The examiners found the Company did not maintain proper documentation to verify its members received copayment refunds;
- The Company did not audit provider contracts for verification of copayment collections or refunds;
- The Company did not send EOBs to members for all claims;
- The Company requested a refund of payment to a provider over a year after the original payment;
- In some instances, the Company failed to respond to examiners' requests for information within the time frame prescribed by law;
- In some instances, the Company failed to provide all books and records requested by examiners within the time frame prescribed by law;

Examiners requested the Company make refunds concerning underwriting premium overcharges, claim underpayments and or interest uncovered during the examination, if any were found.

Various noncompliant practices were identified, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the Missouri insurance statutes and regulations. When applicable, corrective action for other jurisdictions should be addressed.

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report is designed to provide a review of the Company's underwriting and rating practices. These practices included the use of policy forms, adherence to underwriting guidelines, assessment of premium, and procedures to decline or terminate coverage.

An error can include, but is not limited to, any miscalculation of the premium based on the information in the file, an improper acceptance or rejection of an application, misapplication of the Company's underwriting guidelines, incomplete file information preventing the examiners from readily ascertaining the Company's rating and underwriting practices, and any other activity indicating a failure to comply with Missouri statutes and regulations.

The examiners did not conduct specific reviews for compliance with Missouri statutes and regulations regarding underwriting and rating practices in this targeted examination of the Company, but noted the following underwriting and rating errors in the course of conducting other reviews.

A. Forms and Filings

As a part of the review of the Company's complaint files, the examiners conducted a limited review of the member benefit forms contained in the files to determine the Company's compliance with Missouri statutes and regulations regarding the filing, approval, and content of HMO benefit forms. The examiners found the following errors during their review:

1. The Company filed member benefit form "GSA-ENRL (01) KM-C" with the DIFP on October 10, 2007. This member benefit form was an insert page for the "Group Service Agreement" (GSA) utilized by the Company in Missouri. When combined with a schedule of benefits, the GSA constitutes the evidence of coverage issued by the Company to its Missouri members. In response to the filing, the DIFP Life & Healthcare Section requested the Company remove the word "retardation" from the dependent "Enrollment and Effective Date of Coverage" section of the member benefit form on the basis that it was inconsistent with Missouri law. On November 5, 2007, the Company advised the DIFP Life & Healthcare Section it agreed to the change and submitted a revised version of the form removing "retardation." The DIFP Life & Healthcare Section then approved the revised form on November 9, 2007. When the Company subsequently began issuing the revised GSA to members, however, it failed to use the version of form "GSA-ENRL (01) KM-C" with the approved language. According to the Company's response to Formal Request number 37, 736 members were issued form "GSA-ENRL (01) KM-C" with the unapproved language.

Reference: §354.405.4, RSMo Supp 2012, §354.430, RSMo, and 20 CSR 400-7.010

2. In accordance with the findings of the DIFP Life & Healthcare section, form "GSA-ENRL (01) KM-C", as issued, does not appear to comply with Missouri law.

   Reference: §376.426(16), RSMo, and 20 CSR 400-7.030(15)(B)

II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed the Company's claims handling to determine the timeliness, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, examiners used ACL® to extract specific populations of claim lines from the claims data provided by the Company. Examiners then requested entire claim files for claim lines extracted. The review consisted of claims submitted, reviewed or processed between January 1, 2009, through December 31, 2009.

A claim file, as a sampling unit, is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g., §§375.1000 – 375.1018 and 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%). Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to the law. Errors indicating a failure to comply with laws that do not apply the general business practice standard are separately noted as errors and are not included in the error rates.

A claim error includes, but is not limited to, any of the following:

- An unreasonable delay in the acknowledgement of a claim;
- An unreasonable delay in the investigation of a claim;
- An unreasonable delay in the payment or denial of a claim;
- A failure to calculate claim benefits correctly; or
- A failure to comply with Missouri statutes and regulations regarding claim settlement practices.

Missouri statutes and regulations require the Company to disclose to first-party claimants all pertinent benefits, coverage or other provisions of an insurance policy under which a claim is presented. Claim denials explaining the reason for disallowing a payment request must be given to the claimant in writing, and the Company must maintain a copy of all pertinent documentation in its claim files.

A mandated health benefit, such as chiropractic visits, must be included in the certificate of coverage. A required policy provision, such as coordination of benefits, is a regulatory requirement similar to a mandate. The person or policyholder buying the insurance coverage cannot choose to leave either benefit out of a contract.

Examiners requested separate samples of denied or closed without payment claims related to health care benefits and policy provisions mandated by Missouri law as well as certain types of paid claims. Populations of mandated health benefits were identified by using ACL® to identify claims with specific claim characteristics, such as CPT codes, ICD-9 codes or provider type codes. While examiners reviewed the separate claim

samples for compliance with the benefits mandated by law, they also reviewed Cigna's standard operating procedures and claim processing manuals.

A. Unfair Claims Practices – Denied Chiropractic Claims

Section 376.1230 requires benefits for chiropractic services to be provided in health benefit plans. Examiners extracted 139 claim lines (representing 34 claim numbers) from the data provided by the Company that were indicated in the data as either being "denied" or "paid" at $0.00 and where the provider code was designated as "chiropractor." Copies of the claim files for the 34 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	139
Type of Sample	Census
Number of Errors:	19
Error Ratio:	13.6%

The examiners noted the following errors during their review:

1. Section 376.1230, RSMo Supp. 2012, requires health carriers to provide their members with up to 26 office visits for chiropractic services without a prior authorization. For visits after the 26th, the statute allows a health carrier to require "prior authorization or notification" so that it may make a determination as to medical necessity, but the statute does not permit the limitation of benefits to 26 visits if proof of medical necessity is provided.

   Claim number 6505100770510 contained 34 claim lines for chiropractic services delivered on 34 different dates. The Company denied these 34 claim lines giving different reasons for the denials on the EOB sent to the member. All of the claim lines gave as a "Remark Code" and "Explanation of Remarks" the reason of "UC3 MEMBER IS NOT LIABLE FOR CHARGES OVER THE MEMBER RESPONSIBILITY. IF BILLED OVER THIS AMOUNT PLEASE CONTACT MEMBER SERVICES." One claim line, however, was denied with the additional "Remark Code" and "Explanation of Remarks" of "028 BENEFIT LIMIT REACHED OR EXCEEDED" and 18 of the claim lines were denied with the additional code and reason of "039 NUMBER OF UNITS ALLOWED BY YOUR PLAN HAVE BEEN EXCEEDED."

   Examiner Finding 11 criticized the Company for its handling of the 19 claims with multiple denial reasons noted above on the basis that (1) the denial of these claims limited chiropractic benefits in a manner inconsistent with the requirements of §376.1230, and (2) the claims were processed in a manner prohibited by §375.1007. In response to Examiner Finding number 11, the Company explained that the non-payment of these claims should not be considered contrary to §376.1230, RSMo, because the provider was a non-participating provider, and out-of-network chiropractic services were not covered under the member's HMO plan. While this may be true, the participation status

of the provider was not conveyed to the member as a reason for denial of benefits. Limitation of plan benefits was the reason given the member for the claim denial. Failing to provide a reasonable and accurate reason for claim denial appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (12).

Reference: §375.1007(1), (3) and (12), RSMo

Had the claim lines for claim number 6505100770510 noted above been from a network chiropractor, however, it appears to the examiners that the claims lines would still not have been processed correctly based upon the Company's standard procedure for processing chiropractic claims. During the scope of the examination, the Company maintained a process of automatically denying claims for chiropractic services after the 26th visit, subsequently running quarterly reports to identify such denied claims and reprocessing the identified claims for payment without interest even if the payment was made more than 45 days after the date of claim receipt. Although the examiners did not discover any claims that had been denied due to this process, it does not appear to comply with the requirements for providing chiropractic benefits in §376.1230, and processing claims in this manner appears to be the type of conduct prohibited by §§375.1007 and 376.383.

B. Unfair Claims Practices – Denied Emergency Room Claims

Section 376.1367, RSMo, requires health carriers to provide benefits for emergency services in managed care plans. Examiners extracted 14 claim lines (representing 12 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT code was related to emergency room visits. Copies of the claim files for the 11 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	14
Type of Sample	Census
Number of Errors:	1
Error Ratio:	7.1%

The examiners noted the following error during their review:

Examiners found claim number 6506150970553 was processed inconsistently with policy provisions related to COB and 20 CSR 400-2.030. The Company received a claim from a health care provider that included an EOB from another carrier. The EOB showed that the other health carrier (as the primary plan for COB purposes) had paid all but $17.64 of the charges for the provider's services. Rather than paying the $17.64 as the secondary plan, the Company denied the claim on the basis that the emergency services, which were covered under the plan regardless of the provider's status, were provided by a non-participating provider even though the Company paid

emergency claims for two other members on the same "Explanation of Payment" on which it denied this claim. In response to Examiner Finding 1, the Company agreed that it had incorrectly denied this claim, and it reprocessed and paid the claim, with interest, during the course of the examination.

Reference: §375.1007(3) and (4), RSMo and 20 CSR 400-2.030

C. Unfair Claims Practices – Application of Deductibles

Examiners extracted 21 claim lines (representing 12 claim numbers) from the data provided by the Company that were identified in the data as having deductibles applied to the claims of HMO members. Copies of the claim files for the 12 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

D. Unfair Claims Practices – Denied Childhood Immunization Claims

Section 376.1215, RSMo requires health carriers to provide benefits for immunizations of a child from birth to five years of age. Examiners extracted 78 claim lines (representing 22 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT code was related to childhood immunizations. Copies of the claim files for the 22 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

E. Unfair Claims Practices – Denied Complications of Pregnancy Claims

Section 375.995.4(6), RSMo prohibits health carriers from treating complications of pregnancy differently than any other illness or sickness. Examiners extracted 217 claim lines (representing 37 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT code was related to complications of pregnancy. Copies of the claim files for the 37 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

F. Unfair Claims Practices – Denied Speech and Hearing Claims

Section 376.781, RSMo requires health carriers to offer all group and individual policyholders coverage "for the necessary care and treatment of loss or impairment of speech or hearing" and to provide the coverage if the offer is accepted. Since the examiners were unable to identify such claims in the data provided by the Company, the examiners requested that the Company provide them with copies of the claim files

for any claims for these benefits that had been denied during 2009. The Company provided claim files for 18 different claim numbers, which the examiners reviewed for errors in claim processing.

The examiners found no exceptions during their review.

G. Unfair Claims Practices – Prostate Cancer Screening Claims

Section 376.1250.1(2) RSMo requires health carriers to provide benefits for prostate examination and laboratory tests for cancer. Examiners extracted 7 claim lines (representing 1 claim number) from the data supplied by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT code was related to prostate cancer screening. A copy of the claim file for the 1 claim number was then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

H. Unfair Claims Practices – Colon Cancer Screening Claims

Section 376.1250.1(3), RSMo requires health carriers to provide benefits for colorectal cancer examinations and laboratory tests for cancer. Examiners extracted 2 claim lines (representing 2 claim numbers) from the data supplied by the Company that were identified in the Company supplied data as being "denied" or "paid" at $0.00 and where the CPT code was related to colon cancer screening. Copies of the claim files for the 2 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

I. Unfair Claims Practices –Mammography Screening Claims

Section 376.782, RSMo requires health carriers to provide benefits for low-dose mammography screenings. Examiners extracted 6 claim lines (representing 2 claim numbers) from the data supplied by the Company that were identified in the Company supplied data as being "denied" or "paid" at $0.00 and where the CPT code was related to mammograms. Copies of the claim files for the 2 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

J. Unfair Claims Practices – Mental Health Claims

Section 376.1550, RSMo Supp. 2012, requires health carriers to provide benefits for mental illness and prohibits health carriers from treating applicable illnesses differently than any other illness or sickness. Examiners extracted 95 claim lines (representing 57 claim numbers) from the data supplied by the Company that were

identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes and ICD-9 codes were related to mental health. Copies of the claim files for the 57 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

K. Unfair Claims Practices - Copayments

Field Size:	309
Type of Sample	Random
Sample Size	35
Number of Errors:	9
Error Ratio:	25.7%

As a condition of licensure pursuant to § 354.410.1(2), RSMo, HMOs are required to demonstrate that they "will effectively provide or arrange for the provision of basic health care services . . . except to the extent of reasonable requirements for co-payments." To define what these reasonable requirements should be, the Department promulgated 20 CSR 400-7.100. This regulation provides that HMO copayments may not exceed:

- 50% of the total cost of providing any single service to an enrollee;
- In the aggregate, 20% of the total cost of providing all basic health services; or
- For basic health care services in a calendar year, 200% of an enrollee's total annual premium.

For the purposes of calculating the limitations in the regulation, the total cost of a single basic health care service is the total contracted amount due the provider for the service, consisting of the amount of cost sharing paid by the member and the payment by the HMO. Member copayments exceeding the Company payment amounts do not comply with the 50% rule set forth in 20 CSR 400-7.100.

In order to review the Company's compliance with the 50% limitation, examiners used ACL® to extract from the claims data supplied by the Company those claims for basic health care services where the copayment exceeded 50% of total costs for each claim line. This process generated 359 claim lines for 309 claim numbers. Because multiple claim lines could be included in the service to which a copayment was applicable, the examiners determined testing should be conducted by claim number and randomly selected 35 claim numbers, of the original 309, to review for compliance with the regulation.

The examiners noted the following errors during their review:

1. In instances where the standard copayment for the member's benefit plan exceeds 50% of the cost of providing a particular service, the Company has implemented a process whereby (1) such claims are identified at the time of submission, (2) the copayment is manually recalculated and reduced to 50% of the service cost, and

(3) the provider is advised in the EOP that the copayment has been reduced and the provider should refund any excess amount the provider may have collected. In Examiner Finding 14, however, seven claim numbers were noted where this process had not taken place. This resulted in a copayment in excess of the 50% limitation being imposed on the members and EOPs indicating the excessive copayment was the correct copayment going to the providers. In the Company's response to EF 14, it agreed that it had not processed these claims correctly. The Company subsequently reprocessed the claims during the course of the examination.

Reference: §§354.410.1(2), and 375.1007(1), (3), and (4), RSMo, and 20 CSR 400-7.100

2. When the total cost of a single service is an odd amount, dividing a penny in half is not possible, and the resulting odd penny must be allocated to the Company's portion of the service cost in order to avoid the member paying an amount over 50%. Examiners noted one claim number in the claim sample (222090213070092) where the Company's claim processors, in manually processing the claim to recalculate the copayment, permitted the odd penny to be applied to the member, resulting in the member's copayment exceeding the 50% limitation.

   Reference: §§354.410.1(2), and 375.1007(1), (3), and (4), RSMo, and 20 CSR 400-7.100

   Upon discovering the error above, the examiners asked the Company how many additional claims in 2009 required a recalculation of the 50% copayment and resulted in an odd penny being allocated to either the Company or the member. The Company responded that there were 38 claims in addition to the one identified above, and 10 of these 38 claims had incorrectly allocated the odd penny to the member. Although these 10 claims were processed in error, they are not included in the errors noted above since they were not part of the sample.

3. As noted above, when the Company determined the standard copayment in a member's benefit plan was in excess of 50% of the cost of a single service, the Company's process was to advise the provider to refund any excess amount the provider may have collected by placing a Remark Code of M&1 on the provider's EOP. The M&1 code states, "COPAY REDUCED TO 50% OF COVERED EXPENSES. MEMBER SHOULD BE REIMBURSED ANY AMOUNTS PAID GREATER THAN 50% OF COVERED EXPENSES."

   The Company's contractual agreements with providers include provisions titled "Overpayments"; "Reimbursements of Amounts Collected In Error"; and "Limits on Billing Participants For Your Services." These provider contract provisions limit participating providers from charging or collecting amounts of compensation in excess of applicable copayments and Company reimbursements. In their

review of the claim sample, the examiners noted one claim (6506110903090) where the provider's EOP had the M&1 Remark Code, but the claim file did not contain any documentation as to the amount of copayment collected or refunded by the provider. Since the Company depends upon providers to refund any copayments collected in excess of the 50% limitation, examiners asked the Company how it monitors or audits providers for compliance with these provider contract provisions.

According to procedures and statements by the Company, its current business practice is neither to monitor providers for refunds nor to maintain documentation in its claim files of any excess copayment refunds to its members. Because the examiners could not ascertain from the Company's claims records whether or not this members had paid a copayment that exceeded the 50% limitation, the Company's claim file did not appear to be "maintained so as to show clearly the inception, handling, and disposition of each claim," nor did the file appear to be "sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed." This lack of a process to ensure and document that excessive copayments are not imposed on the Company's members appears to be the type of claims settlement practice prohibited by §375.1007(3) and (4).

Reference: §§374.205.2(2), 375.1007(3) and (4), RSMo, and 20 CSR 100-8.040(3)(B)

L. Unfair Claims Practices - EOBs Not Issued

According to statements and documents provided by the Company, it maintains a business practice of not sending EOBs to members for all claims. The Company's procedure, currently and during the examination period, is to only send an EOB when the member has a liability other than a copayment. Regulation 20 CSR 100-1.050(1)(A) requires the insurer to advise the first-party claimant (which includes an HMO member) of the acceptance or denial of the claim. While the examiners did not conduct any claim testing regarding this issue, such a claims settlement practice does not appear to be consistent with the prohibitions in §375.1007(3) and (4).

M. Unfair Claims Practices – Denied Out-of-Network Claims

Most health benefit plans offered by HMOs are distinguished from plans offered by insurance companies and health services corporations in that the HMO plans only provide benefits for services rendered by network providers, except for emergency services and services outside the HMO's service area. In an effort to test for the accuracy of the Company's denials for out-of-network services, the examiners extracted 89 claim numbers (representing 169 claim lines) from the data provided by the Company that showed the reason for denial as being out-of-network, but where the Company had paid other claim numbers for that same provider. The Company was then requested to provide explanations for its handling of the 89 claim numbers.

Field Size:	89
Type of Sample	Census
Number of Errors:	19
Error Ratio:	21.3%

The examiners noted the following errors during their review:

One type of HMO plan offered by the Company is a plan the Company refers to as an "open access" plan. Under these plans, the member chooses or is assigned a PCP, but the member is allowed to see specialists without a PCP referral. A complicating factor to a member's "open access" to network providers, however, is the Company's practice of contracting with physicians as either a PCP or a specialist. Based upon examiner inquiries and specific claim files, some members perceived any physician in the Company's network was available without a referral or an authorization. If a member obtained services from a physician, who was contracted as a PCP rather than a specialist, claims for services were denied because the physician was not the member's PCP. The Remark Code and explanation provided to the member and provider is "MU." The MU code states: "SERVICES PROVIDED BY NON-PARTICIPATING PROVIDER ARE NOT COVERED SINCE THE MEMBER'S PLAN HAS NO OUT OF NETWORK BENEFITS. MEMBER RESPONSIBLE."

Examiners used ACL® to find the population of claims with remark code MU. Based upon the census of 89 claims, examiners found the following 19 claims were initially denied with Remark Code MU. The use of MU is an incorrect statement on the EOP/EOB because the providers of service for these claims were contracted network providers. The EOBs failed to inform the member they did not follow the proper referral or PCP transfer procedures set forth in their certificate of coverage. Denying benefits to members for services of providers with valid contracts with the Company for not being "in-network" appears to misrepresent policy provisions in claims settlements contrary to provisions of §375.1007(1) and 20 CSR 100-1.020(1)(A). The following 21 claims were initially denied with a Remark Code of "MU."

Claim Number	Claim Number	Claim Number
6504150905979	6506170904115	1004300903634
1006090911738	6501120903128	6502240908179
6503110904259	6504230903454	6505010904040
6505070908494	6506180903217	
	6511160902702	6512040901225
1004220908758	6508200903293	6511250906751
1004130970839	1004150970626	1012230950016

Reference: §375.1007(1), RSMo and 20 CSR 100-1.020(1)(A)

N. Unfair Claims Practices – Refund Requests

As stated in §376.384.1(3), RSMo, an HMO may "not request a refund or off set against a claim more than twelve months after a health carrier has paid a claim except

in cases of fraud or misrepresentation by the health care provider." To test for compliance with this claim handling requirement, the examiners used ACL® to extract 169 claim numbers from the Company-provided claims data that were identified with a processing code (C4) indicating a refund had been requested, and reviewed those claims where the refund appeared to have been requested more than one year after payment.

Field Size:	169
Type of Sample	Census
Number of Errors:	1
Error Ratio:	0.6%

The examiners noted the following errors in this review:

1. Refund Requested Over One Year After Initial Payment

   The Company, through its third party vendor, Viant, requested a refund of $8,180.01 on claim 172090501506001 more than one year after the date of the claim payment. The claim has been subsequently reprocessed, with interest, as a result of this examination.

   Reference: §§375.1007(3) and (4), and 376.384(3), RSMo

2. Record Maintenance

   The Company admitted certain refund demand letters from its third party vendor, Viant, were purged, and it could not retrieve the refund request letter for claim 172090501506001. Failure to maintain books and records for claim files does not appear to comply with the claim recordkeeping requirements of §374.205(2) and 20 CSR 100-8.040(3)(B)1, and the claims processing standards of §375.1007(3). Since this is the second error attributable to this claim file, however, the claim file was only counted as an error once for the purposes of this review.

   Reference: §§375.1007(3) and 374.205(2), RSMo, and 20 CSR 100-8.040(3)(B) 1

III. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

A. Complaint File Review

Section 375.936(3), RSMo, requires companies to maintain a registry of all written complaints received for the last three years. The registry must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company.

The examiners verified the Company's complaint registry, dated January 1, 2007 through December 31, 2009. The registry contained a total of 16 complaints. Examiners reviewed all complaints filed with DIFP and all complaint files maintained by Cigna which it received directly from members or other interested parties.

The review consisted of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint as required by §375.936(3), RSMo, and 20 CSR 300-2.200(3)(D).

The examiners found no exceptions during their review.

IV. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms ("Examiner Findings"). Missouri statutes and regulations require companies to respond to criticisms and formal requests within 10 calendar days. Please note, in the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within the allotted time, the response was not considered timely.

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
Received w/in time-limit, incl. any extensions	15	94%
Received outside time-limit, incl. any extensions	1	6%
No Response	0	0 %
Total	16	100 %

Of the 16 Examiner Findings sent to the Company during the course of the examination, the Company was late in responding to Examiner Finding 9.

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040(6)

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
Received w/in time-limit, incl. any extensions	45	90%
Received outside time-limit, incl. any extensions	6	8%
No Response	1	2%
Total	50	100 %

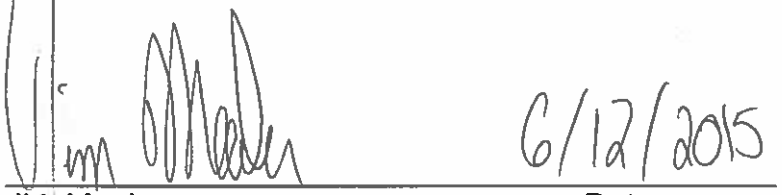
Of the 50 Formal Requests sent to the Company during the course of the examination, the Company was late in responding to Formal Requests 17, 22, 40, 41, 42 and 44,

and the Company failed to respond entirely to a portion of the information requested in Formal Request 45.

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040(6)

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Cigna Healthcare of Ohio d/b/a Cigna Healthcare of Kansas/Missouri (NAIC #95209), Examination Number 1003-02-TGT. This examination was conducted by John Korte, Rita Heimericks-Ash, John Clubb and Mike Woolbright. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated November 14, 2013. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.



6/12/2015

Jim Mealer — Date
Chief Market Conduct Examiner