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

In Re:	)	
	)	
CIGNA HEALTHCARE OF ST. LOUIS, INC.	)	**Market Conduct Exam No. 1308-17-TGT**
(NAIC #95635)	)	

CURATIVE ORDER OF THE DIRECTOR

NOW, on this 29th day of December, 2016, Director, John M. Huff, (hereafter the "Director"), after consideration and review of the market conduct examination report of Cigna HealthCare of St. Louis, Inc. (NAIC #95635) (hereinafter "Cigna" or the "Company"), report number 1308-17-TGT, conducted by the Division of Insurance Market Regulation pursuant to §374.203.3(3)(a), RSMo[1], does hereby adopt such report as filed. After consideration and review of such 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), RSMo.

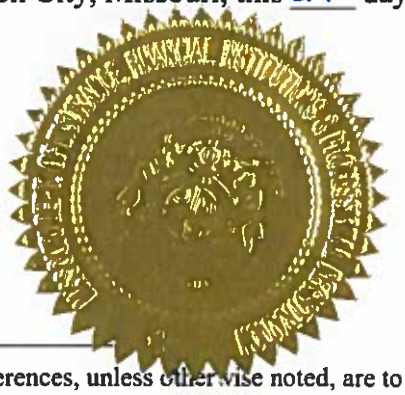
This order, issued pursuant to §374.205.3, RSMo and §374.046.15, RSMo (Cum. Supp. 2013), is in the public interest.

IT IS FURTHER ORDERED that Cigna shall CURE the violations of law, regulations or prior orders revealed in such report and shall take remedial action to bring the Company into full compliance with the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times, including, but not limited to, taking the following actions:

1. Cigna agrees to comply with the requirements of §376.1382 and to take corrective action to assure that the errors noted in the above-referenced market conduct examination report do not recur.

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 29th day of December, 2016.



John M. Huff
Director

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

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 St. Louis, Inc.
NAIC #95635

MISSOURI EXAMINATION #1308-17-TGT

NAIC EXAM TRACKING SYSTEM #MO341-M116

December 27, 2016

Home Office
231 South Bemiston
Clayton, MO 63105

Main Administrative Office
900 Cottage Grove Road
Hartford, CT 06002

TABLE OF CONTENTS

FOREWORD

This is a targeted market conduct examination report of Cigna HealthCare of St. Louis, Inc., (NAIC #95635). 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:

- "Company" refers to Cigna HealthCare of St. Louis, Inc.;
- "CSR" refers to the Missouri Code of State Regulations;
- "Department " or "DIFP" 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;
- "HMO" refers to a Health Maintenance Organization;
- "NAIC" refers to the National Association of Insurance Commissioners;
- "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, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2010, through December 31, 2012, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: claims handling and the handling of complaints for HMO health benefit plan coverage.

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 that applied 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 reviewed some 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.

COMPANY PROFILE

Cigna HealthCare of St. Louis, Inc. 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 is a wholly owned subsidiary of Healthsource, Inc. which is a wholly-owned subsidiary of Cigna Health Corporation, which is an indirect wholly-owned subsidiary of Cigna Corporation.

The Company was incorporated as a for-profit corporation under the laws of the state of Missouri on May 2, 1985. The Company was first issued a certificate of authority as an HMO on January 17, 1986, and it commenced its operations on February 1, 1986.

Effective September 30, 2011, the Company was merged with its affiliate, Cigna Healthcare of Ohio d/b/a Cigna Healthcare of Kansas/Missouri, with the Company being the surviving corporation.

According to the Department's *2010 Missouri Health Maintenance Organization Report*, the Company's service area at the beginning of the examination period encompassed the Missouri counties of Andrew, Barry, Buchanan, Cass, Christian, Clay, Clinton, DeKalb, Franklin, Greene, Jackson, Jasper, Jefferson, Lafayette, Lawrence, Newton, Platte, Polk, Ray, St. Charles, St. Louis, St. Louis City, and Webster, and the Illinois counties of Madison, Monroe, and St. Clair. The Department's *2012 Missouri Health Maintenance Organization Report* indicates the Company had added the Kansas counties of Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Miami, Osage, Shawnee, and Wyandotte to its service area by the end of the examination period.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Cigna HealthCare of St. Louis, Inc. The examiners found the following principal areas of concern:

I. COMPLAINTS

The examiners found three errors in a review of the complaint files for all 17 complaints filed directly with the Company during the examination period. The errors consisted of two instances where the Company failed to send written acknowledgement letters within 10 working days of receipt of a first-level grievance contrary to §376.1382.2(1), RSMo, and 20 CSR 400-7.110(2)(C)1, and one instance where the Company failed to send an appeal decision letter to the member contrary to §376.1382.2(3), RSMo, and 20 CSR 400-7.110(2)(C)3. *(Pages 7-9).*

Various non-compliant 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 laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

EXAMINATION FINDINGS

I. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Included within this review are complaints termed "grievances" or "appeals" under Missouri's utilization review statutes in §§376.1350 to 376.1389, RSMo and Supp. 2013. The examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations. In this review, the examiners also attempted to identify issues indicating possible market conduct trends that would necessitate further examination into other areas of the Company's operations and/or practices within the scope of the examination warrant.

Sections 375.936(3) and 376.1375, RSMo, and regulations 20 CSR 400-7.110 and 20 CSR 100-8.040(3)(D) require HMOs to maintain a registry of all written complaints, grievances and appeals received. 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 for the period January 1, 2010, through December 31, 2012. The registry contained 17 complaint cases sent directly to the Company by the complainant. The examiners requested copies of the complaint files for all 17 complaints and reviewed the files for compliance. The review consisted of a review 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) and 376.1375, RSMo, and regulations 20 CSR 400-7.110 and 20 CSR 100-8.040(3)(D).

A. Complaints Sent Directly to the Company

The examiners reviewed 17 complaints the Company received directly from members or providers in calendar years 2010 through 2012. The examiners noted the following issues of concern in the review:

1. Criticism #02: The member appealed, via telephone, the denial of five claims for physical therapy services. After reviewing the appeal, the Company upheld the original decision based on a maximum benefit limitation provision for "Short-term Rehabilitative Therapy" in the plan's evidence of coverage.

   In reviewing the complaint file, the examiners could not find any evidence that an acknowledgement letter had been sent to the member as required by §376.1382.2(1), RSMo. While a telephone complaint is not included in the definition of "Grievance" in §376.1350, RSMo Supp. 2013, which would ordinarily make §376.1382 inapplicable, the examiners also noted the following provision from the evidence of coverage (entitled "Guide to Your Benefits") that the Company issued to the member:

Appeals Procedure
The Healthplan has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask the Healthplan to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.

By specifically authorizing members to initiate their complaint/grievance by telephone, the examiners believe the Company has waived the requirement for a writing, so the provisions of §376.1382 apply. Consequently, the Company's failure to send a written acknowledgement within 10 working days of receipt of this first-level grievance appeared to the examiners to be contrary to the requirements of §376.1382.2(1) and 20 CSR 400-7.110(2)(C)1 of the HMO regulations.

Reference: §376.1382.2(1), RSMo, and 20 CSR 400-7.110(2)(C)1.

In response to Criticism #02, the Company agreed without further explanation.

2. Criticism #03: The Company initially denied benefits for a provider's services on the basis that the provider was out of network. The provider appealed the denial and provided the Company with medical records to support its appeal. The medical records indicated the member had been initially treated by a different provider who referred the member to the "out of network" provider. Based upon this information, the Company reversed its initial denial and paid the claim.

   In reviewing the complaint file, however, the examiners did not find where a first-level grievance decision letter was sent to the member as required by Missouri law. The Company stated that the decision letter had not been "loaded" in its system, so the Company provided a note from its system stating that "MEMBER WAS UNAWARE LETTER AND EOB SENT" and also provided "Sample Letter Language" from its system to demonstrate what the text of a "MEMBER WAS UNAWARE LETTER" would have been. The examiners interpreted this information as evidence that the Company intended to send the member a written decision letter, but the letter was never sent.

   By failing to send an appeal decision letter to the member, it appeared to the examiners that the Company's handling of this first-level grievance was contrary to the requirements of §376.1382.2(3), RSMo, and 20 CSR 400-7.110(2)(C)3 in the HMO regulations. In addition, the Company's actions appear to be contrary to the "First Level Appeal" provisions on page 30 of the "Guide to Your Benefits" issued by the Company to the member.

Reference: §376.1382.2(3), RSMo, and 20 CSR 400-7.110(2)(C)3.

In response to Criticism #03, the Company agreed without further explanation.

3. Criticism #05: A member appealed the denial of claims for services rendered to his dependent child at an urgent care center while the dependent was away from home attending college. The member explained that the Company had previously provided benefits for services from the same urgent care center. Based upon the member's explanation, the Company reversed its previous denial and paid the claims.

   In reviewing the complaint file, the examiners could not find any evidence that an acknowledgement letter had been sent to the member as required by §376.1382.2(1), RSMo. The Company's failure to send a written acknowledgement within 10 working days of receipt of this first-level grievance appeared to the examiners to be contrary to the requirements of §376.1382.2(1) and 20 CSR 400-7.110(2)(C)1 of the HMO regulations.

   Reference: §376.1382.2(1), RSMo, and 20 CSR 400-7.110(2)(C)1.

   In response to Criticism #05, the Company agreed without further explanation.

B. DIFP Consumer Complaints

Since there were no complaints received from the Department in the Company's complaint data, the examiners reviewed the complaint tracking system utilized by the Department's Division of Consumer Affairs in order to check whether or not the Company had failed to log any Department complaints in its complaint/grievance registry. The system listed 13 records for the Company for calendar years 2010 through 2012. All 13 of these records were marked as "Inquiries" rather than "Complaints" in the system. Of the 13 inquiries, 10 involved administration of self-funded plans by the Company or its affiliates and were outside the regulatory jurisdiction of the Department. The remaining three involved questions answered by consumer services representatives without contacting the Company. Consequently, it did not appear to the examiners that the omission of any of these 13 records from the Company's complaint/grievance registry was in error.

II. CRITICISM AND FORMAL REQUEST 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. Missouri law requires companies to respond to criticisms and formal requests within 10 calendar days unless an extension of time is requested and granted. Please note that in the event an extension 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 that time period, the response was not considered timely.

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
Received w/in time-limit, incl. any extensions	5	100.00%
Received outside time-limit, incl. any extensions	0	0.00%
No Response	0	0.00%
Total	5	100.00%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
Received w/in time-limit, incl. any extensions	3	100.00%
Received outside time-limit, incl. any extensions	0	0.00%
No Response	0	0.00%
Total	3	100.00%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Cigna HealthCare of St. Louis, Inc. (NAIC #95635), Examination Number 1308-17-TGT. This examination was conducted by Bunlue Ushupun, John Clubb, Randy Kemp, and Donald Wilson. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated October 25, 2016. 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.

12/29/2016
Date

Jim Mealer
Chief Market Conduct Examiner