

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

In Re: )  
)  
CIGNA HEALTHCARE OF ST. LOUIS ) Market Conduct Exam No. 1003-03-TGT  
(NAIC #95635) )  
)  
)

**ORDER OF THE DIRECTOR**

NOW, on this 16<sup>TH</sup> day of JUNE, 2015, Director John M. Huff, after consideration and review of the market conduct examination report of Cigna Healthcare of St. Louis (NAIC #95635) (hereafter referred to as "Cigna St. Louis"), report number 1003-03-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3) (a)<sup>1</sup> 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 St. Louis 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 St. Louis shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Cigna St. Louis 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.

IT IS FURTHER ORDERED that Cigna St. Louis shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$46,000 payable to the Missouri State School Fund.

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

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 16<sup>th</sup> day of JUNE, 2015.

  
John M. Huff  
Director



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

**In Re:** )  
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**CIGNA HEALTHCARE OF ST. LOUIS** ) **Market Conduct Exam No. 1003-03-TGT**  
**(NAIC # 95635)** )  
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**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) (hereinafter referred to as "Cigna St. Louis"), 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 St. Louis has been 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 St. Louis and prepared report number 1003-03-TGT; and

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

1. In 51 instances, Cigna St. Louis incorrectly denied chiropractic service claims for exceeding a 26 visit limit in violation of §375.1007 (1) (3) and (4) and §376.1230<sup>1</sup>;
2. In 4 instances, Cigna St. Louis failed to pay interest on denied chiropractic service claims that it reprocessed more than 45 days after receipt of the claim in violation of §375.1007 (3) and (4) and §376.383.5;
3. In several instances, Cigna St. Louis 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;

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

4. Cigna St. Louis 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);

5. Cigna St. Louis 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);

6. In 8 instances, Cigna St. Louis 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);

7. In 1 instance, Cigna St. Louis 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);

8. In several instances, Cigna St. Louis failed to maintain adequate documentation in claim files in violation of §374.205.2 (2) and 20 CSR 100-8.040 (3) (B) 1;

9. In 5 instances, Cigna St. Louis was late in responding to 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis 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 St. Louis’ remittance advice; and (4) requires a provider audit and corrective action when Cigna St. Louis 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 St. Louis** agrees to create audit procedures to assure that third party vendors comply with the requirements of §376.384.1 (3);

6. **Cigna St. Louis**, if it has not already done so, will remediate the claimant on claim number 6511300712590 in the amount of \$121.18 plus interest at the rate of 9% per annum pursuant to §408.020.

C. **Compliance.** **Cigna St. Louis** 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 St. Louis** agrees, voluntarily and knowingly, to surrender and forfeit the sum of \$46,000, 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 St. Louis**, other than those agreed to in this Stipulation, for the conduct found in Market Conduct Examination 1003-03-TGT.

F. **Waivers.** **Cigna St. Louis**, 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

**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**

**NAIC # 95635**

**MISSOURI EXAMINATION # 1003-03-TGT**

**NAIC EXAM TRACKING SYSTEM # MO341-M8**

**June 12, 2015**

**Home Office**  
**231 S Bemiston Ave, Ste. 500**  
**St. Louis, MO 63105**



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## FOREWORD

This is a targeted market conduct examination report of Cigna Healthcare of St. Louis (NAIC Code # 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:

- “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 St. Louis;
- “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 office:

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 Missouri on May 2, 1985. During the time period of the examination, the Company's service area encompassed the Missouri counties of Franklin, Jefferson, St. Charles, St. Louis City, and St. Louis County, and the Illinois counties of Madison, Monroe, and St. Clair.

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 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 incorrectly calculated copayment amounts;
- 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 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 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 include 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 any underwriting and rating errors observed 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 discovered no issues or concerns.

## **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 141 claim lines (representing 47 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 47 claim numbers were then requested and reviewed for errors in claim processing.

Field Size:	141
Type of Sample	Census
Number of Errors:	32
Error Ratio:	22.7%

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 26<sup>th</sup>, 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.

In reviewing the data and the claim files, the examiners noted many instances where a claim line had been denied with the Remark Code "39." The text given on the EOPs and EOBs for this Remark Code was: "NUMBER OF UNITS ALLOWED BY YOUR PLAN HAVE BEEN EXCEEDED." Since this denial reason appeared to be inconsistent with §376.1230, the examiners inquired as to the Company's standard process for processing chiropractic service claims after the 26th visit. The Company responded that it had a process in place 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. This process 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(1), (3) and (4). The examiners noted 32 claim lines for claim numbers 1706010906461, 1706010906463, 1706010906464, 1706110900448, 1709280900492, 1709280900493, 1709280900494 and 1709280900496 that were denied for this reason.

Reference: §375.1007(1), (3) and (4), RSMo, and §376.1230, RSMo Supp. 2012



2. Upon learning of the Company's process for handling chiropractic claims submitted after the 26th visit, the examiner's requested copies of the quarterly reports generated for 2009. The examiners reviewed the reports and noted claim lines related to six claim numbers (1706010906461, 1706010906463, 1706110900448, 1709280900492, 1709280900493, and 1709280900496) that also appeared in the denied claims sample. The remaining 24 claim lines for claim numbers 1705280902278, 1706040908384, 1707270473193 and 2211030970329 did not appear in the denied claims sample. It is unclear why these 24 claim lines/four claim numbers did not appear in the sample since: (1) the dates of service, dates of receipt and processing dates for claim numbers 1705280902278, 1706040908384 and 2211030970329 all occurred during the time period of the data request for this examination, and (2) the processing date for claim number 1707270473193 occurred during the time period of the data request even though the date of service and date of receipt were indicated as occurring in 2004. Because these 24 claim lines/four claims numbers were not in the sample, they are not included in the number of errors and error ratio for this review. They are noted here as additional errors, however, since the Company appears to have incorrectly processed these claims in the same manner as the claims cited as errors above.

Reference: §375.1007(1), (3) and (4), RSMo, and §376.1230, RSMo Supp. 2012

3. The examiners also noted that the Company failed to pay interest on the chiropractic service claims that it reprocessed as a result of the quarterly reports even though the claims were paid more than 45 days after receipt. In response to Examiner Finding 11, the Company agreed that it had incorrectly failed to pay interest on two claim numbers the examiners criticized (1706110900448 and 1709280900492) and supplied the examiners with a spreadsheet listing 40 claim numbers the Company had reviewed and upon which interest had been paid as a result of the examiners' criticism. Three of the claim numbers listed in this spreadsheet (1706010906461, 1706010906463 and 1706110900448) were chiropractic claims that also appeared in the denied claims sample. It is unclear why claim number 1709280900492 was not also included in the spreadsheet, but the Company did furnish the examiners with separate proof of interest payment as part of its response to Examiner Finding 11. Although the failure to pay interest on these four chiropractic claim numbers constituted errors in the processing of these claims, these additional errors are not included in the number of errors and error ratio above since all four claim files have already been counted as being in error for the purposes of this review.

Reference: §375.1007(3) and (4), RSMo, and §376.383.5, RSMo Supp. 2009

#### **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 3 claim lines (representing 3

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 3 claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

**C. Unfair Claims Practices – Application of Deductibles**

Examiners extracted 15 claim lines (representing 9 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 9 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 45 claim lines (representing 10 claims 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 10 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 105 claim lines (representing 38 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 38 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 4 different claim numbers, which the examiners reviewed for errors in claim processing.

The examiners found no exceptions during their review.

**G. Unfair Claims Practices –Pap Screening Claims**

Section 376.1250.1(1), RSMo, requires health carriers to provide benefits for pelvic examination and Pap smear in accordance with current American Cancer Society guidelines. Examiners extracted 12 claim lines (representing 12 claim numbers) from the data supplied by the Company that were identified in the data as being “denied” or “paid” at \$0.00 where the CPT code was related to Pap smears. 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.

**H. Unfair Claims Practices –Mammography Screening Claims**

Section 376.782, RSMo, requires health carriers to provide benefits for low-dose mammography screenings. Examiners extracted 3 claim lines (representing 2 claim numbers) from the data supplied by the Company that were identified in the data as being “denied” or “paid” at \$0.00 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.

**I. 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 23 claim lines (representing 22 claim numbers) from the data supplied by the Company that were identified in the data as being “denied” or “paid” at \$0.00 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.

**J. Unfair Claims Practices – Copayments**

Field Size:	231
Type of Sample	Random
Sample Size	35

Number of Errors:	26
Error Ratio:	74.3%

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 copayments.” 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 260 claim lines for 231 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 231, 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, 14 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 three claims in Examiner Finding 14 (172090511707057, 172091111065077, and 222081224098072) where the Company's claim processors, in manually processing the claims to recalculate the copayment, permitted the odd penny to be applied to the members, resulting in the members' copayments 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 49 claims in addition to the three identified above, and 23 of these 49 claims had incorrectly allocated the odd penny to the member. Although these 23 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 nine claims in Examiner Finding 14 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 members had paid copayments that exceeded the 50% limitation, the Company's claim files did not appear to be "maintained so as to show clearly the inception, handling, and disposition of each claim," nor did the files 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)

#### **K. 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).

#### **L. Unfair Claims Practices - 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 50 claim numbers (representing 84 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 50 claim numbers.

Field Size:	50
Type of Sample	Census
Number of Errors:	8
Error Ratio:	16%

The examiners noted the following errors during their review:

When the Company denies a claim for services from an out-of-network provider, it provides a Remark Code and explanation for the denial on the EOB sent to the member and the EOP sent to the provider. The Remark Code provided to the member

and provider is “MU,” and the explanation for this Remark 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 50 claims, examiners found the following 8 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. All of the providers in these 14 claims were participating in the Company’s network as either specialists or PCPs, but 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 8 claims were initially denied with a Remark Code of “MU.”

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1702250905247	1708040904596	1708140903863
1708240906435	1709290907073	6508270905739
1703310903574	1706250970782	

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

#### **M. 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 43 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:	43
Type of Sample	Census
Number of Errors:	2
Error Ratio:	4.7%

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, AIM Healthcare Services, Inc., requested a refund of \$121.18 on claim 6511300712590 more than one year after the date of the payment.

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 vendors were purged, and it could not retrieve the refund request letter for claim 682070914590051. 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).

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.

#### **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 17 complaints. Examiners reviewed all complaints filed with DIFP and all complaint files maintained by CIGNA which were 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**

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	13	100%
Received outside time-limit, incl. any extensions	0	0%
<u>No Response</u>	<u>0</u>	<u>0 %</u>
Total	13	100 %

##### **B. Formal Request Time Study**

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
Received w/in time-limit, incl. any extensions	44	90%
Received outside time-limit, incl. any extensions	5	8%
<u>No Response</u>	<u>1</u>	<u>2%</u>
Total	49	100 %

Of the 49 Formal Requests sent to the Company during the course of the examination, the Company was late in responding to Formal Requests 17, 22, 40, 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)

