REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

CIGNA HEALTH AND LIFE INSURANCE COMPANY

AS OF JUNE 30, 2019

Conducted from February 26, 2020

Through

March 31, 2022

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 59-1031071
NAIC: 67369

COMMONWEALTH OF VIRGINIA

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I, Brant Lyons, Principal Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Cigna Health and Life Insurance Company as of June 30, 2019, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's responses to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2024-00064 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 22nd day of August, 2024.

Brant Lyons

Examiner in Charge

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I. PURPOSE & SCOPE OF EXAMINATION

The Target Market Conduct Examination of Cigna Health and Life Insurance Company ("Cigna" or "the Company") was conducted under the authority of § 38.2-1317.1 of the Code of Virginia ("the Code").

The examination included a detailed review of Cigna's fully-insured individual and large group comprehensive major medical, dental, and stop-loss insurance coverage for the period beginning July 1, 2018, through June 30, 2019.

The purpose of this examination was to determine compliance with Virginia insurance statutes and regulations and to determine that the Company's operations were consistent with public interest. The examiners followed internal procedures that are based on the NAIC Market Regulation Handbook to perform this examination.

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. Failure to identify, comment on, or criticize specific Company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

All instances of non-compliance identified during the course of this examination are noted in this Report. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to Cigna during the examination. Cigna was given the opportunity to respond to each finding in this Report.

The Report includes Corrective Action Items and Recommendations for the Company to address. The Company is required to take Corrective Action when restitution is owed to VA consumers or providers, a general business practice is established, or an issue was identified where additional controls must be put in place to ensure compliance going forward. The examiners may decide to make a Recommendation instead of a Corrective Action when non-compliance did not occur with such frequency as to indicate a general business practice but the Company should review its current processes, procedures, and operations to ensure compliance in the future.

II. EXECUTIVE SUMMARY

This Report contains 947 violations and instances of non-compliance. Some issues of significant concern include:

Provider Contracts:

- 188 violations were noted during the Provider Contracts review for the failure to include or comply with required provisions

Provider Claims:

- Failure to pay claims in accordance with the provider contract's fee schedule

Policy Forms:

- Failure to file policy forms for approval
- Approved forms were subsequently modified by Cigna outside of the permitted variability
- Failure to file explanation of benefits (EOB) forms for approval

Cancellations:

- Notices sent to members for past-due premiums included incorrect information regarding the date of cancellation

Complaints, Internal Appeals, and External Review:

- Failure to provide final benefit determinations within a reasonable period of time

Claims:

- 627 violations and instances of non-compliance were noted during the Claims review, involving individual and large group comprehensive major medical claims
- EOBs incorrectly indicated that Cigna's vendor or third-party administrator was the "provider" of services
- Claims were incorrectly underpaid or denied during the initial processing despite necessary information being submitted by the claimant, resulting in the failure to make a prompt, fair and equitable settlement when claims were later reprocessed and paid
- Vendor-processed claim EOBs did not accurately reflect claim submission or processing details
- Cigna's process for reducing claims payments for Medicare-eligible members resulted in EOBs that did not clearly and accurately reflect processing details or member liability, in addition to the failure to pay claims in accordance with policy provisions
- Provider contract documentation reviewed in connection with claims included subrogation language

- Failure to pay required statutory interest
- Cost sharing on vendor-processed claims was calculated on amounts that exceed those paid or payable to the provider
- Failure to provide EOBs and written denials as required for vendor-processed claims that it considered “administrative denials”
- Failure to provide EOBs within 21 calendar days
- Failure to include required information on prescription drug summaries made available to members
- Failure to track, apply, and clearly communicate information to enrollees regarding out-of-pocket maximums

Mental Health Parity:

- Failure to comply with Financial Requirements and Quantitative Treatment Limitations (QTLs)

A Corrective Action Plan (CAP) that must be implemented by Cigna was established to address these issues and others discussed in the Report. Cigna will document completion of each CAP Item to the examiners.

III. COMPANY PROFILE

Cigna Health and Life Insurance Company is a wholly-owned subsidiary of Connecticut General Life Insurance Company and is an indirect subsidiary of CIGNA Corporation. The Company was originally incorporated in Florida in 1963. Cigna was authorized to transact the business of accident and sickness insurance in Virginia in 1980.

The table below shows the Company’s premium volume and approximate market share in Virginia during 2018 and 2019 for the lines of insurance included in this examination.*

YEAR AND LINE	PREMIUM VOLUME	MARKET SHARE
2018 Individual Accident & Health	$572,872,014	11.4%
2019 Individual Accident & Health	$603,244,960	12.9%
2018 Group Accident & Health	$600,408,255	6.9%
2019 Group Accident & Health	$697,939,941	7.8%

* Source: The 2018 and 2019 Annual Statements on file with the National Association of Insurance Commissioners.

IV. STATISTICAL SUMMARY

The files selected for the review were chosen by random and stratified sampling of the populations provided by the Company. The relationship between population and sample is shown in the table below.

The details of the errors will be explained in this Report. General business practices may or may not be reflected by the number of errors shown in the summary.

Area	Population	Sample	Files with Errors	Error Ratio
Provider Contracts	33,973	19	19	100%
Provider Claims *submitted under sample provider contracts	1,855	214	20	9%
Advertising	812	50	2	4%
Agent Appointments	91,150	105	3	3%
Agent Terminations	754	25	1	4%
New Business-Issued	91,150	105	0	0%
New Business-Declined	609	25	0	0%
Reinstatements	1,851	25	0	0%
Renewals	69,686	50	0	0%
Cancellations	42,915	75	7	9%
Complaints, Internal Appeal, & External Review	3,101	97	10	10%
Claims-Paid	3,559,625	361	130	36%
Claims-Denied	729,308	330	125	38%
Claims-Stop Loss	353	10	0	0%
Out-of-Pocket Maximums *enrollees that met the OOP maximum	284,508	25	6	24%
Prior Authorizations	23,336	10	0	0%
MHPAEA	n/a	4	4	100%

V. PROVIDER CONTRACTS REVIEW

The examiners reviewed each sample provider contract to determine compliance with various requirements, including but not limited to the following:

- Section 38.2-510 A 15 of the Code
- Section 38.2-3407.15 of the Code
- Section 38.2-3407.15:1 of the Code
- Section 38.2-3407.15:2 of the Code
- Section 38.2-3407.15:3 of the Code
- Section 38.2-3407.15:4 of the Code

FINDINGS: ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Issue: The Company failed to include required provider contract provisions.

Finding: The review revealed 36 violations of the subdivisions of § 38.2-3407.15 B of the Code. This was determined to be a general business practice under § 38.2-510 A 15 of the Code.

Discussion: The provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	3	PC01-TT
§ 38.2-3407.15 B 2	3	PC02-TT
§ 38.2-3407.15 B 3	2	PC01-TT
§ 38.2-3407.15 B 4	6	PC03-TT
§ 38.2-3407.15 B 5	2	PC02-TT
§ 38.2-3407.15 B 6	2	PC01-TT
§ 38.2-3407.15 B 7	3	PC03-TT
§ 38.2-3407.15 B 8	6	PC13-JM
§ 38.2-3407.15 B 9	6	PC15-JM
§ 38.2-3407.15 B 10	3	PC05-TT

Corrective Action: Cigna will amend its provider contracts to include the provisions required by § 38.2-3407.15 B of the Code and take steps to ensure any required updates are included going forward.

Issue: The Company failed to incorporate the fee schedule used to pay claims into its pharmacy contract. The Company also amended the fee schedule without providing the required notice.

Finding: The review revealed 1 violation each of §§ 38.2-3407.15 B 8 and 38.2-3407.15 B 9 of the Code.

Discussion: While already included in the chart above as part of PC15-JM, the examiners are providing this specific example for clarification. The Company was paying pharmacy claims according to methodology that was documented to the examiners in a spreadsheet. However, a different reimbursement methodology was incorporated into the contract.

Corrective Action: Cigna will take steps to ensure that the fee schedule used to pay pharmacy claims is incorporated into the contract and that required notice is provided for any amendments, as required by §§ 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) and 38.2-3407.15 B 10 (formerly B 9 during the examination time frame) of the Code.

FINDINGS: REQUIRED PROVISIONS IN CARRIER CONTRACTS WITH PHARMACY PROVIDERS

Issue: The Company failed to include required provider contract provisions.

Finding: The review revealed 9 violations of the subdivisions of § 38.2-3407.15:1 B of the Code and 1 violation of § 38.2-3407.15:1 C of the Code.

Discussion: The provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:1 B 1	1	PC01-TT
§ 38.2-3407.15:1 B 2	1	PC01-TT
§ 38.2-3407.15:1 B 3	1	PC01-TT
§ 38.2-3407.15:1 B 4	1	PC01-TT
§ 38.2-3407.15:1 B 5	1	PC01-TT
§ 38.2-3407.15:1 B 6	1	PC01-TT
§ 38.2-3407.15:1 B 7	1	PC01-TT
§ 38.2-3407.15:1 B 8	1	PC01-TT
§ 38.2-3407.15:1 B 9	1	PC01-TT
§ 38.2-3407.15:1 C	1	PC01-TT

Corrective Action: Cigna will amend its provider contracts to include the provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code and take steps to ensure any required updates are included going forward.

FINDINGS: REQUIRED PROVISIONS IN CARRIER CONTRACTS REGARDING PRIOR AUTHORIZATION

Issue: The Company failed to include required provider contract provisions.

Finding: The review revealed 136 violations of the subdivisions of § 38.2-3407.15:2 B of the Code.

Discussion: The provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:2 B 1	17	PC01-JM
§ 38.2-3407.15:2 B 2	17	PC02-JM
§ 38.2-3407.15:2 B 3	17	PC03-JM
§ 38.2-3407.15:2 B 4	17	PC04-JM
§ 38.2-3407.15:2 B 5	17	PC05-JM
§ 38.2-3407.15:2 B 6	17	PC06-JM
§ 38.2-3407.15:2 B 7	17	PC07-JM
§ 38.2-3407.15:2 B 8	17	PC08-JM

Corrective Action: Cigna will amend its provider contracts to include the provisions required by § 38.2-3407.15:2 B of the Code and take steps to ensure any required updates are included going forward.

FINDINGS: REQUIRED PROVISIONS IN CARRIER & INTERMEDIARY CONTRACTS WITH PHARMACY PROVIDERS

Issue: The Company failed to include required provider contract provisions.

Finding: The review revealed 4 violations of the subdivisions of §§ 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code.

Discussion: The provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:3 B 2	1	PC01-TT
§ 38.2-3407.15:3 B 4	1	PC01-TT
§ 38.2-3407.15:3 C 1	1	PC01-TT
§ 38.2-3407.15:3 C 3	1	PC01-TT

Corrective Action: Cigna will amend its provider contracts to include the provisions required by §§ 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code and take steps to ensure any required updates are included going forward.

FINDINGS: REQUIRED PROVISIONS IN CARRIER CONTRACTS REGARDING LIMIT ON COPAYMENT FOR PRESCRIPTION DRUGS; PERMITTED DISCLOSURES

Issue: The Company failed to include required provider contract provisions.

Finding: The review revealed 2 violations of the subdivisions of § 38.2-3407.15:4 C of the Code.

Discussion: The provision, number of violations, and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:4 C 1	1	PC01-TT
§ 38.2-3407.15:4 C 3	1	PC01-TT

Corrective Action: Cigna will amend its provider contracts to include the provisions required by § 38.2-3407.15:4 C of the Code and take steps to ensure any required updates are included going forward.

VI. PROVIDER CLAIMS REVIEW

The examiners reviewed each sample provider claim processed under the sample contract to determine compliance with various requirements, including but not limited to the following:

- Section 38.2-510 A 15 of the Code
- Section 38.2-3407.15 of the Code
- Section 38.2-3407.15:1 of the Code
- Section 38.2-3407.15:2 of the Code

- Section 38.2-3407.15:3 of the Code
- Section 38.2-3407.15:4 of the Code

FINDINGS: ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Issue: The Company failed to pay claims in accordance with the fee schedule.

Finding: The review revealed 20 violations of § 38.2-3407.15 B 8 of the Code. This was determined to be a general business practice under § 38.2-510 A 15 of the Code.

Discussion: Cigna's claims were reimbursed based on a fee schedule that was available to the provider online. However, this online fee schedule was not incorporated into the contract and different reimbursement methodology was incorporated into contract. An example is discussed in Review Sheet PCCL03-JM.

Corrective Actions:

- Cigna will take steps to ensure claims are paid in accordance with the fee schedule incorporated into the contract, as required by § 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) of the Code.

- Cigna will adjust the claims discussed in Review Sheets PCCL03-JM and PCCL11-JM and pay them at the contract rate for all services rendered along with statutory interest owed on the underpaid portion. Include with each check, an explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."

VII. ADVERTISING REVIEW

The examiners reviewed each sample advertisement to determine compliance with:

- Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code
- 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the

overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-90-50)

FINDINGS: ACCIDENT AND SICKNESS INSURANCE ADVERTISEMENTS

Issue: The advertisement failed to set out a required disclosure conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

Finding: The review revealed 1 violation of 14 VAC 5-90-40.

Discussion: A statement was missing a disclosure directing the viewer to the list of sources included several pages later in the advertisement. This is discussed in Review Sheet AD06-LK.

Recommendation: Cigna will take steps to ensure required disclosures are set out conspicuously and in close conjunction with the statements to which the information relates in advertisements, as required by 14 VAC 5-90-40.

Issue: The sample advertisements failed to identify the source of statistics used.

Finding: The review revealed 1 violation of 14 VAC 5-90-90 C.

Discussion: The advertisement was missing a list of sources intended to be included at the end of a slide presentation. This is discussed in Review Sheet AD08-LK.

Recommendation: Cigna will take steps to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C.

VIII. POLICY FORMS REVIEW

The examiners reviewed each policy form contained in the sample files and rate charged to determine compliance with:

- Section 38.2-316 of the Code
- Section 38.2-316.1 of the Code
- Section 38.2-3407.4 A of the Code
- 14 VAC 5-100-50 (3)

FINDINGS: POLICIES

Issue: The Company issued forms that had not been filed and approved prior to issue.

Finding: The review revealed 34 violations of §§ 38.2-316 A and 38.2-316 C 1 of the Code.

Discussion: In some instances, the Company issued policy forms that had not been submitted for approval. In other instances, the Company made revisions to approved forms that were outside of the variability permitted in the filing. An example is discussed in Review Sheet PF03-JA.

Corrective Actions:

- Cigna will take steps to ensure that all policy forms are filed with and approved by the Commission prior to use, and that policy forms are not modified beyond their approved variability, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code.

- Cigna will review all policy forms currently in force and currently being marketed in Virginia and identify any policy forms, including those referenced during the course of this examination, that were not previously filed with the Commission as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking any action, Cigna will submit a remediation plan to the Forms section of the Life and Health Market Regulation division. It is requested that the Company clearly indicate in the letter(s) of transmittal that the submission is a result of Cigna's efforts to comply with this examination's Corrective Action Plan.

FINDINGS: EXPLANATION OF BENEFITS (EOB)

Issue: The Company used EOBs that were not filed and approved prior to use.

Finding: The review revealed 7 violations of § 38.2-3407.4 A of the Code.

Discussion: An example is discussed in Review Sheet PF01-AF.

Corrective Actions:

- Cigna will identify and file for approval all EOB forms currently in use that have not yet been filed with the Commission, as required by § 38.2-3407.4 A of the Code.

- Cigna will take steps to ensure that its EOB forms are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code.

IX. AGENTS REVIEW

The examiners reviewed sample agent termination files, as well as the writing agents or agencies designated in the sample new business files to determine compliance with:

- Section 38.2-1812 of the Code
- Section 38.2-1822 of the Code
- Section 38.2-1833 of the Code
- Section 38.2-1834 of the Code

FINDINGS: AGENT APPOINTMENTS

Issue: The Company accepted an application from an unappointed agent and did not appoint the agent within 30 days of execution of the first application submitted by a licensed but not yet appointed agent. The Company also paid a commission to an unappointed agent.

Finding: The review revealed 1 violation of § 38.2-1812 A of the Code and 3 violations of § 38.2-1833 A 1 of the Code.

Discussion: An example is discussed in Review Sheet AG02-JA.

Corrective Action: Cigna will take steps to ensure compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents.

FINDINGS: TERMINATED AGENT APPOINTMENTS

Issue: The Company terminated the appointment of an agent and failed to notify the agent within 5 calendar days.

Finding: The review revealed 1 violation of § 38.2-1834 D of the Code.

Discussion: This is discussed in Review Sheet AG01-MH.

Recommendation: Cigna will take steps to ensure it notifies agents and agencies within 5 calendar days and the Commission within 30 calendar days of appointment termination, as required by § 38.2-1834 D of the Code.

X. UNDERWRITING REVIEW

The examiners reviewed each new business and renewal sample file to determine compliance with:

- Sections 38.2-500 through 38.2-514 of the Code
- Sections 38.2-600 through 38.2-620 of the Code
- 14 VAC 5-180-10 et seq.

FINDINGS: NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Issue: The Company failed to include a complete description of the required rights regarding personal information and the manner exercised.

Finding: The review revealed that Cigna was in violation of § 38.2-604 B 4 of the Code.

Discussion: While Cigna confirmed that it complied in practice with the requirements of allowing applicants and policyholders to exercise the required rights under §§ 38.2-608 and 38.2-609 of the Code, the Company failed to provide a complete description of these rights in its NIP form. This is discussed in Review Sheet UN01-JA.

Corrective Action: Cigna will take steps to ensure that NIP forms given to applicants and policyholders comply with all requirements set forth in § 38.2-604 of the Code.

XI. REINSTATEMENTS REVIEW

The examiners reviewed each reinstatement sample file to determine compliance with:

- Established internal procedures
- Policy provisions

FINDINGS: INDIVIDUAL REINSTATEMENTS

Issue: The Company failed to provide required termination/reinstatement letters and cancelled coverage prior to the end of the required grace period.

Finding: The review revealed 6 instances of non-compliance with established internal procedures and 2 instances of non-compliance with the policy.

Discussion: An example is discussed in Review Sheet PB04-LK.

Recommendations:

- Cigna will take steps to ensure it follows established internal procedures in generating required termination and reinstatement letters.
- Cigna will take steps to ensure it allows the required grace period in accordance with policy provisions.

XII. CANCELLATIONS REVIEW

The examiners reviewed each cancellation sample file to determine compliance with various requirements, including but not limited to the following:

- Established internal procedures
- Policy provisions
- Section 38.2-3542 of the Code

FINDINGS: INDIVIDUAL CANCELLATIONS

Issue: The Company issued a statement that misrepresented the benefits, advantages, conditions or terms of the policy.

Finding: The review revealed 7 violations of § 38.2-502 (1) of the Code.

Discussion: While Cigna's policy provisions allowed the required 31-day grace period in practice for members not receiving the Advance Premium Tax Credit (APTC), the termination/past-due notice sent to members indicated that the policy would be cancelled effective the day before the start of the grace period (the "paid-through date") in the event of non-payment of past-due premium. An example is discussed in Review Sheet CN01-LK.

Company Response: Cigna disagreed with the examiners' observations. However, the Company made revisions to the content of its termination/past-due letter subsequent to the examination time frame.

Corrective Action: Cigna will revise its past-due notice for individual policies to ensure it provides clear and accurate information about the terms and conditions of the policy and the grace period, so as to prevent misrepresentations, as required by § 38.2-502 (1) of the Code.

Issue: The Company's internal procedures failed to comply with policy provisions.

Finding: The review revealed 1 instance of non-compliance with the policy.

Discussion: Cigna's policy required a 31-day grace period for members not receiving APTC with the cancellation effective date being the last day of the grace period. However, Cigna's internal procedures allowed only a 1-month grace period, which may be less than 31 days depending on the month and required the cancellation to be effective on the "paid-through date," which is the day before the grace period begins. This is discussed in Review Sheet CN13-LK.

Company Response: Cigna disagreed with the examiners' observations. However, the Company made revisions to the content of its termination/past-due letter that is generated based on these procedures subsequent to the examination time frame.

Corrective Action: Cigna will take steps to ensure its internal procedures comply with policy provisions regarding the required grace period for individual policies.

XIII. REVIEW OF COMPLAINTS, INTERNAL APPEALS, & EXTERNAL REVIEW

The examiners reviewed each complaint, internal appeal, and external review sample file to determine compliance with:

- Section 38.2-511 of the Code
- Sections 38.2-3556 through 38.2-3571 of the Code
- Section 38.2-5804 of the Code
- 14 VAC 5-216-10 et seq.

FINDINGS: COMPLAINTS, INTERNAL APPEALS, EXTERNAL REVIEW

Issue: The Company failed to follow its MCHIP complaint system approved by the Commission and failed to notify the covered person of the final benefit determination within a reasonable period of time appropriate to the medical circumstances.

Finding: The review revealed 10 violations each of § 38.2-5804 A of the Code and 14 VAC 5-216-40 E 2.

Discussion: Cigna failed to notify the covered person of the final benefit determination within the required 30-day time frame specified in its approved complaint system and by regulation. An example is discussed in Review Sheet CP01-JA.

Corrective Actions:

- Cigna will take steps to ensure that it follows its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code.

- Cigna will take steps to ensure that it notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 2.

Issue: The Company failed to maintain a complete complaint file.

Finding: The review revealed 1 violation of § 38.2-5804 A 1 of the Code.

Discussion: This is discussed in Review Sheet CP03-JA.

Recommendation: Cigna will take steps to ensure a record of complaints is maintained for no less than 5 years, as required by § 38.2-5804 A 1 of the Code.

XIV. CLAIMS REVIEW

The examiners reviewed each sample individual and large group comprehensive major medical and stop-loss sample claim file to determine compliance with applicable statutes and regulations, as well as the terms of the policy or certificate of coverage (COC) and the insurer's policies and procedures. The examiners also reviewed a sample of insureds who had met their out-of-pocket maximum during the time frame. The findings are outlined below.

FINDINGS: MEDICAL CLAIMS

Issue: The Company issued a statement that misrepresented the benefits, advantages, conditions or terms of the policy.

Finding: The review revealed 137 violations of § 38.2-502 (1) of the Code.

Discussion: Cigna sent EOBs indicating that providers participating in a provider discount arrangement were part of a network, which is prohibited and identified as misleading under Administrative Letter 2016-09. An example is discussed in CL57-AF.

Cigna also sent EOBs incorrectly indicating that the Company's vendor or third-party administrator was the provider of services, which misrepresents claim details including the rendering provider of services. An example is discussed in Review Sheet CL27-JA.

Corrective Actions:

- Cigna will take steps to ensure its EOBs provide clear and accurate information regarding provider discount arrangements, so as to prevent misrepresentations, as required by § 38.2-502 (1) of the Code.

- Cigna will take steps to ensure its EOBs sent in connection with vendor-processed claims provide clear and accurate information about the provider of services, so as to prevent misrepresentations, as required by § 38.2-502 (1) of the Code.

Issue: The Company failed to make a prompt, fair and equitable settlement of claims in which liability has become reasonably clear.

Finding: The review revealed 35 violations of § 38.2-510 A 6 of the Code. This was determined to be a general business practice.

Discussion: Cigna's claims were initially underpaid or erroneously denied due to issues such as providers incorrectly identified as out-of-network, provider load errors, and failure to recognize prior authorizations on file, and these claims were later reprocessed and paid. Although Cigna had the necessary information to correctly pay these claims upon initial receipt, the final correct payment was not made in several cases until over a month after initial receipt. An example is discussed in Review Sheet CL15-AF.

Corrective Action: Cigna will take steps to ensure that it makes prompt, fair and equitable settlements of claims in which liability has become reasonably clear, as required by § 38.2-510 A 6 of the Code.

Issue: The Company provided an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

Finding: The review revealed 161 violations of § 38.2-514 B of the Code.

Discussion: Cigna's EOBs for vendor-processed claims reflected allowed amounts on claim lines that did not match the amounts used as the basis of payment to the provider, billed amounts on claim lines that did not match the amounts submitted by the provider, and denied claim lines that were submitted by the provider but omitted from the EOB altogether. The EOBs also did not correctly reflect the amounts paid to the provider in several instances. An example is discussed in Review Sheet CL03-JA.

The examiners also found that Cigna utilized a process under its individual policies where, if a member was eligible for Medicare due to age but did not enroll, Cigna would estimate Medicare's payment and reduce the Company's payment by that amount. This resulted in EOBs that provided contradictory information regarding the amount paid to the provider, unclear information regarding the methodology of how Medicare was estimated, and unclear information regarding the member liability. An example is discussed in Review Sheet CL66-AF.

In addition, the examiners identified EOBs that included remarks that were potentially misleading to the member, such as incorrectly indicating that the provider was non-participating when the provider was actually participating, indicating that "zero dollars" were billed on claims that had billed amounts, "overpayment" requests that would only be understood by the providers and not by the members, and references to primary carrier payment information or Medicare eligibility when the member had already informed Cigna they were not eligible for Medicare or had no other insurance. An example is discussed in Review Sheet CL116-AF.

Furthermore, the examiners identified situations where the EOB for services performed by a non-participating provider indicated that the member was not responsible for amounts that were unpaid, including the balance between the billed amount and allowed amount as well as provider coding denials. However, this protection was not a benefit provided under the policy and it did not appear that anything would prevent the provider from billing the member for these amounts. An example is discussed in Review Sheet CL54-AF.

Corrective Action: Cigna will take steps to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, billed amounts, allowable amounts, deductibles, coinsurance, and copayments on its EOBs, as well as ensuring that included remarks are not potentially misleading to the member.

Issue: The Company attempted to reduce benefits paid under the health insurance contract because the individual was also eligible for medical expense benefits under a liability insurance contract.

Finding: The review revealed that Cigna was in violation of § 38.2-3405 B of the Code.

Discussion: Upon review of a contract between Cigna's vendor and a chiropractic and rehabilitative services provider to confirm the details of certain claims processing requirements, the examiners found that the contract instructed the provider to seek payment from the third party if the member's condition is related to a third-party liability claim and then seek reimbursement from Cigna's vendor for any balance not reimbursed by the third party. This is discussed in Review Sheet CL25-JA.

Corrective Actions:

- Cigna will remove all subrogation language from Virginia provider contracts entered into through its vendors, in accordance with § 38.2-3405 B of the Code, and contact all such contracted Virginia providers to alert them to cease this practice immediately.

- Cigna will review, reopen, and reprocess all claims for enrollees of plans issued in Virginia by Cigna that potentially involved subrogation associated with vendor provider contract language, for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by §§ 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly."

- Cigna will contact all Virginia providers participating under contracts entered into through vendors to inquire about claims that may not have been submitted to Cigna for payment, for the years 2018, 2019, 2020, 2021, and the current year, in view of the fact that these claims may have been paid by the third party or paid out-of-pocket by the enrollee. If such claims are identified, instruct the providers to submit the claims, accept such claims for adjudication and payment, regardless of any timely filing limits, and review and process such claims. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check, an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly."

Issue: The Company failed to pay required interest on claims.

Finding: The review revealed 29 violations of § 38.2-3407.1 B of the Code.

Discussion: Cigna paid less interest than required by the statute. This was largely caused by Cigna counting interest due in working days once it began accruing. While interest does not begin accruing until 15 working days after receipt of proof of loss, once it begins accruing it does so in calendar days. By continuing to count in working days instead of calendar days, Cigna is consistently undercalculating the amount of interest due. An example is discussed in Review Sheet CL01-LG.

Corrective Actions:

- Cigna will review and consider for re-adjudication all paid claims that took greater than 15 working days to pay for the years of 2018, 2019, 2020, 2021, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. This should include the claims discussed in Review Sheets CL05-AF, CL34-AF, CL50-AF, CL52-AF, CL59-AF, CL61-AF, CL62-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL109-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL129-AF, CL131-AF, CL01-JA, CL09-JA, CL01-LG, and

- CL17-LK. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously."

- Cigna will take steps to ensure the correct payment of interest, as required by § 38.2-3407.1 B of the Code.

Issue: In situations where a subscriber or enrollee was required to pay a coinsurance or deductible, the Company calculated the cost share on an amount that exceeded the total amount actually paid or payable to the provider of such services.

Finding: The review revealed 49 violations of § 38.2-3407.3 A of the Code. This was determined to be a knowing and willful violation based on the requirements of § 38.2-3407.3 B of the Code.

Discussion: For certain claims processed by Cigna's vendors, the Company utilized a process where the provider initially submits the claim to the vendor. The vendor prices the claim and assesses an additional fee for utilization management and other services and submits the claim to Cigna, with an indicated allowed amount that includes the amount the vendor pays to the provider plus the additional fee combined. Cigna then calculates the enrollee's cost sharing based on this allowable amount, resulting in higher cost sharing for enrollees than what is allowed by the Code. An example is discussed in Review Sheet CL02-JA.

Corrective Actions:

- Cigna will review all vendor-processed chiropractic/rehabilitative services, home health/durable medical equipment, radiology, and fertility claims from 2018, 2019, 2020, 2021, and the current year and reimburse enrollees directly for all excess coinsurance and deductible amounts collected for claims that were processed in violation of the calculation of cost sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost sharing amount. Please accept this refund due to you."

- Cigna will take steps to ensure that if the insured is required to pay a specified percentage of the cost of covered services, it shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, as required by § 38.2-3407.3 A of the Code.

Issue: The Company provided an EOB that did not accurately and clearly set forth the benefits payable under the contract.

Finding: The review revealed 12 violations of § 38.2-3407.4 B of the Code.

Discussion: Cigna's policies/COCs list a dollar amount for the individual deductible (for example, $3,000 per person) and a different dollar amount for the family deductible (for example, $6,000 per family). However, for plans with a collective family deductible, the deductible accumulators shown at the bottom of the EOBs indicate that both the individual deductible and the family deductible are the same dollar amount (for example, both the individual deductible and the family deductible are $6,000). An example is discussed in Review Sheet CL40-AF.

Corrective Action: Cigna will take steps to ensure that every EOB provided to an insured, claimant, or subscriber accurately and clearly sets forth the benefits payable under the contract, specifically related to out-of-pocket accumulators, as required by § 38.2-3407.4 B of the Code.

Issue: The Company failed to provide a denial to the claimant in writing.

Finding: The review revealed 101 violations of 14 VAC 5-400-70 A. This was determined to be a general business practice.

Discussion: For claims processed by its vendors, Cigna failed to provide written denials for situations it deemed to be "administrative denials," such as denials related to terms of the provider contract. The examiners clarified that the requirement to provide a claim denial applies to any claim denial. An example is discussed in Review Sheet CL05-TF.

The examiners also found that Cigna issued EOBs where the claim reflected payment amounts of $0.00, but no remark was included to explain that the claim was denied. An example is discussed in Review Sheet CL23-LK.

Corrective Action: Cigna will take steps to ensure that any denial of a claim shall be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial, as required by 14 VAC 5-400-70 A.

Issue: The Company failed to provide a reasonable written explanation of the basis for any claim denial, including a specific reference to a policy provision, condition, or exclusion, if any.

Finding: The review revealed 8 instances of non-compliance with 14 VAC 5-400-70 B. This was not determined to be a general business practice.

Discussion: Cigna denied charges identified as "Miscellaneous" on the EOB, and the only explanation given was "Your plan booklet lists the services and procedures covered

by your plan. The plan will only pay for services listed in the booklet." Without further detail on the EOB, the member would be unable to identify the applicable policy exclusion or basis for denial. An example is discussed in Review Sheet CL04-LG.

The examiners also found that Cigna issued EOBs with the denial reason "we reviewed this claim and this amount is not covered. You will receive a letter explaining why it is not covered and your appeal rights." However, the referenced letter was not sent to the member. An example is discussed in Review Sheet CL13-AF.

Corrective Action: Cigna will take steps to ensure that it provides a reasonable written explanation of the basis for any claim denial and that the written explanation shall provide a specific reference to a policy provision, condition, or exclusion, if any, as required by 14 VAC 5-400-70 B.

Issue: The Company unreasonably refused to pay claims in accordance with the provisions of the policy.

Finding: The review revealed 4 violations of 14 VAC 5-400-70 E that were determined to be a general business practice. The review also revealed an additional 11 instances of non-compliance that were not determined to be a general business practice.

Discussion: As previously mentioned in the discussion regarding § 38.2-514 B of the Code, Cigna utilized a process under its individual policies where, if a member was eligible for Medicare due to age but did not enroll, Cigna would estimate Medicare's payment and reduce the Company's payment by that amount. Cigna's process for estimating Medicare payment involved reducing its payment by the amount Medicare would have paid in addition to reducing payment by any amount Medicare would not have paid, failing to apply a network discount when the patient utilized an in-network provider, and using the Medicare allowable amount instead of Cigna's to determine what Cigna would have paid in the absence of Medicare. None of these details appeared to be supported by the policy, and the process appears to result in significant reduction of payment on claims. An example is discussed in Review Sheet CL66-AF. As this reduction of payment was Cigna's established procedure, this was determined to be a general business practice that resulted in 4 violations.

In addition to the 4 violations related to estimation of Medicare payments, the examiners identified 11 additional instances of non-compliance where Cigna unreasonably refused to pay claims in accordance with policy provisions. The examiners found that Cigna denied claims for timely filing when the amount of time specified in the provider contract had not actually been exceeded and incorrectly denied claims for coverage not being in effect during the date of service when the coverage was actually in effect and benefits should have been approved. An example is discussed in Review Sheet CL13-JA.

Corrective Actions:

- Cigna will take steps to ensure that it pays claims in accordance with the provisions of the policy, as required by 14 VAC 5-400-70 E.

- Cigna will review, reopen, and reprocess all claims under individual policies where payment was reduced due to Medicare estimation in non-compliance with policy provisions for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly."

- Cigna will provide the examiners with documentation substantiating that Cigna has corrected the processing of the claims discussed in Review Sheets CL11-AF, CL65-AF, CL66-AF, CL68-AF, CL77-AF, CL131-AF, CL133-AF, CL03-JA, and CL13-JA, and that Cigna has refunded any monies owed to the members.

Issue: The Company failed to provide to the insured an EOB describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss.

Finding: The review revealed 73 violations of 14 VAC 5-400-100 B. This was determined to be a general business practice.

Discussion: As previously mentioned, for claims processed by its vendors, Cigna failed to provide EOBs for situations it deemed to be “administrative denials.” An example is discussed in Review Sheet CL01-JA.

Corrective Action: Cigna will take steps to ensure that it provides to the insured an EOB describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy, as required by 14 VAC 5-400-100 B.

Issue: The Company failed to make available a summary of prescription drug claims electronically or provide a written summary at the request of the insured that describes the amounts covered under the policy, the amounts denied, and amounts payable by the insured and insurer.

Finding: The review revealed that Cigna was in violation of 14 VAC 5-400-100 C. This was determined to be a general business practice.

Discussion: Cigna’s pharmacy summary provided to the examiners failed to show deductible, coinsurance, and copay amounts, failed to show accumulators to date for

out-of-pocket tracking, and failed to show denied amounts or the reason for denial. Without this information, the member does not have complete claim processing details or information regarding out-of-pocket accumulations. This is discussed in Review Sheet CL15-LK.

Corrective Action: Cigna will take steps to ensure that it makes available a summary of prescription drug claims electronically or provides a written summary at the request of the insured that shall describe the amounts covered under the policy, the amounts denied, and amounts payable by the insured and insurer, as required by 14 VAC 5-400-100 C.

Issue: The Company failed to comply with requirements regarding provider discount arrangements.

Finding: The review revealed 5 instances of non-compliance with Administrative Letter 2016-09.

Discussion: As previously mentioned, Cigna's EOBs referred to its provider discount arrangement as a network. In addition, Cigna's policies/COCs failed to clearly define network providers, non-network providers, and non-network providers that participate in a provider discount arrangement and accurately describe the member's benefits and responsibilities when utilizing each type of provider. An example is discussed in Review Sheet CL44-AF.

Corrective Action: Cigna will take steps to ensure that it does not refer to the providers participating in a provider discount arrangement in any of its forms or advertising materials as being part of a network, and take steps to ensure that policy forms clearly define network providers, non-network providers, and non-network providers that participate in a provider discount arrangement and accurately describe the member's benefits and responsibilities when utilizing each type of provider, as required by Administrative letter 2016-09.

FINDINGS: OUT-OF-POCKET MAXIMUM

*Note: While these violations are already included in the previous findings section for medical claims, this portion of the Report includes additional examples specific to review of a sample of enrollees that met their out-of-pocket maximum during the time frame.

Issue: The Company issued a statement that misrepresented the benefits, advantages, conditions or terms of the policy.

Finding: The review revealed 4 violations of § 38.2-502 (1) of the Code.

Discussion: The accumulators listed at the bottom of Cigna's EOBs indicated the insured had satisfied a higher amount of the out-of-pocket maximum than the amount actually satisfied. An example is discussed in Review Sheet CL06-AF.

The examiners also found that Cigna notified a member on the EOB that the member had satisfied their out-of-pocket maximum when they actually had not, and Cigna continued to collect cost sharing on subsequent claims after sending this notice. An example is discussed in Review Sheet CL01-AF.

Corrective Action: Cigna will take steps to ensure its EOBs provide clear and accurate information regarding out-of-pocket accumulations, so as to prevent misrepresentations, as required by § 38.2-502 of the Code.

Issue: The Company failed to make a prompt, fair and equitable settlement of claims in which liability has become reasonably clear.

Finding: The review revealed 1 violation of § 38.2-510 A 6 of the Code.

Discussion: Cigna initially overcharged an insured's cost sharing on a claim after the insured had met the out-of-pocket maximum. While the Company attempted to make remediation subsequent to the exam time frame, it reprocessed a different claim for a different provider than the claim that had been previously processed incorrectly. The examiners acknowledge Cigna's efforts to correct the claim processing, but the excess out-of-pocket amount was refunded to a provider unrelated to the affected claim with no confirmation that this provider would have passed the refund along to the insured. This is discussed in Review Sheet CL05-AF.

Corrective Action: Cigna will reprocess the claim discussed in Review Sheet CL05-AF to promptly refund any remaining cost sharing payments charged to the insured after the out-of-pocket maximum was reached and ensure the provider of the incorrectly processed claim receives any reimbursement due.

Issue: The Company provided an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

Finding: The review revealed 3 violations of § 38.2-514 B of the Code.

Discussion: Cigna's policies/COCs required a per visit deductible for certain services that does not apply to the annual deductible. Cigna's EOB listed this per visit deductible under the "deductible" field, which is the same field that captures the annual deductible. For insureds that had met their annual deductible but were being charged the per visit deductible on claims, the EOB included a remark at the bottom indicating they had met

the deductible while also listing an amount due under the "deductible" field of the EOB. An example is discussed in Review Sheet CL07-AF.

Corrective Action: Cigna will file a revised EOB for approval to include a separate field for any per visit deductibles, or identify this type of cost sharing as a copay in policy documents going forward to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code.

Issue: The Company unreasonably refused to pay claims in accordance with the provisions of the policy.

Finding: The review revealed 3 instances of non-compliance with 14 VAC 5-400-70 E.

Discussion: Cigna failed to correctly track and apply deductibles and out-of-pocket amounts, resulting in insureds being charged excess cost sharing. An example is discussed in Review Sheet CL05-AF.

Corrective Action: Cigna will review and reopen all claims for all insureds who exceeded their out-of-pocket maximum during the years of 2018, 2019, 2020, 2021, and the current year and promptly refund all cost sharing payments charged to the insured after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the insured. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the out-of-pocket maximum was collected in error. Please accept this refund amount." This should also include the claims referenced in Review sheets CL01-AF and CL02-AF.

XV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) REVIEW

The examiners reviewed responses to the BOI's Mental Health Parity Questionnaire and Data Collection Tool associated with a sample of policies/COCs to determine compliance with Financial Requirements and Quantitative Treatment Limitations (QTLs) under MHPAEA. The examiners also reviewed Cigna's procedures for compliance with MHPAEA disclosure requirements. The findings are outlined below.

FINDINGS: FINANCIAL REQUIREMENTS/QUANTITATIVE TREATMENT LIMITATIONS

Issue: The Company applied financial requirements or treatment limitations to mental health or substance use disorder benefits in classifications that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Finding: The review revealed that Cigna was in violation of § 38.2-3412.1 B of the Code and 45 CFR 146.136(c)(2).

Discussion: The determination of Medical/Surgical (Med/Surg) benefits versus Mental Health/Substance Use Disorder (MH/SUD) benefits must be based on the condition being treated under the requirements of MHPAEA. This means that some services will be both Med/Surg and MH/SUD benefits, such as occupational therapy and nutritional counseling. The Company recognized every service as either Med/Surg benefits or MH/SUD benefits and failed to correctly recognize services that can treat both Medical/Surgical Conditions and Mental Health Conditions/Substance Use Disorders, resulting in expected claim dollar amounts not being accurate and the predominant level not being applied correctly. An example is discussed in Review Sheet MH02-BL.

While the findings for this examination are focused on financial requirements/QTLs, the examiners also note that defining benefits based on the condition or disorder is a foundational piece of MHPAEA and also has implications in other aspects of compliance with this law, such as Nonquantitative Treatment Limitation (NQTL) comparative analysis and disclosure requirements.

Company Response: The Company disagreed with these findings. However, it has begun taking Corrective Actions to correctly define benefits under MHPAEA based on the condition or disorder.

Corrective Action: Cigna will take steps to ensure that MH/SUD benefits and Med/Surg benefits are recognized based on the condition or disorder being treated, including recognizing services that are both Med/Surg benefits and MH/SUD benefits, for purposes of financial requirement/QTL analysis, as required by § 38.2-3412.1 B of the Code and MHPAEA.

COMMENT: NONQUANTITATIVE TREATMENT LIMITATIONS

While the BOI also initially requested documentation of comparative analyses to determine compliance with NQTL requirements, the Consolidated Appropriations Act (CAA) implemented more stringent requirements for the documentation of comparative

analyses effective in 2021, subsequent to the examination time frame. The BOI has decided to carve out the initial NQTL review from the scope of this Report. The BOI has initiated a separate examination to request and review the updated comparative analyses required under the CAA.

XVI. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, Cigna is required to implement the following Corrective Actions. Cigna will:

1. Amend its provider contracts to include the provisions required by § 38.2-3407.15 B of the Code and take steps to ensure any required updates are included going forward;

2. Take steps to ensure that the fee schedule used to pay pharmacy claims is incorporated into the contract and that required notice is provided for any amendments, as required by §§ 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) and 38.2-3407.15 B 10 (formerly B 9 during the examination time frame) of the Code;

3. Amend its provider contracts to include the provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code and take steps to ensure any required updates are included going forward;

4. Amend its provider contracts to include the provisions required by § 38.2-3407.15:2 B of the Code and take steps to ensure any required updates are included going forward;

5. Amend its provider contracts to include the provisions required by §§ 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code and take steps to ensure any required updates are included going forward;

6. Amend its provider contracts to include the provisions required by § 38.2-3407.15:4 C of the Code and take steps to ensure any required updates are included going forward;

7. Take steps to ensure claims are paid in accordance with the fee schedule incorporated into the contract, as required by § 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) of the Code;

8. Adjust the claims discussed in Review Sheets PCCL03-JM and PCCL11-JM and pay them at the contract rate for all services rendered along with statutory interest owed on the underpaid portion. Include with each check, an explanation stating that “As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that this claim was underpaid.”;

9. Take steps to ensure that all policy forms are filed with and approved by the Commission prior to use, and that policy forms are not modified beyond their

approved variability, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;

10. Review all policy forms currently in force and currently being marketed in Virginia and identify any policy forms, including those referenced during the course of this examination, that were not previously filed with the Commission as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking any action, submit a remediation plan to the Forms section of the Life and Health Market Regulation division. It is requested that the Company clearly indicate in the letter(s) of transmittal that the submission is a result of Cigna's efforts to comply with this examination's Corrective Action Plan;

11. Identify and file for approval all EOB forms currently in use that have not yet been filed with the Commission, as required by § 38.2-3407.4 A of the Code;

12. Take steps to ensure that its EOB forms are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code;

13. Take steps to ensure compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;

14. Take steps to ensure that NIP forms given to applicants and policyholders comply with all requirements set forth in § 38.2-604 of the Code;

15. Revise its past-due notice for individual policies to ensure it provides clear and accurate information about the terms and conditions of the policy and the grace period, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

16. Take steps to ensure its internal procedures comply with policy provisions regarding the required grace period for individual policies;

17. Take steps to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;

18. Take steps to ensure that it notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 2;

19. Take steps to ensure its EOBs provide clear and accurate information regarding provider discount arrangements, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

20. Take steps to ensure its EOBs sent in connection with vendor-processed claims provide clear and accurate information about the provider of services, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

21. Take steps to ensure that it makes prompt, fair and equitable settlements of claims in which liability has become reasonably clear, as required by § 38.2-510 A 6 of the Code;

22. Take steps to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, billed amounts, allowable amounts, deductibles, coinsurance, and copayments on its EOBs, as well as ensuring that included remarks are not potentially misleading to the member;

23. Remove all subrogation language from Virginia provider contracts entered into through its vendors, in accordance with § 38.2-3405 B of the Code, and contact all such contracted Virginia providers to alert them to cease this practice immediately;

24. Review, reopen, and reprocess all claims for enrollees of plans issued in Virginia by Cigna that potentially involved subrogation associated with vendor provider contract language, for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by §§ 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

25. Contact all Virginia providers participating under contracts entered into through vendors to inquire about claims that may not have been submitted to Cigna for payment, for the years 2018, 2019, 2020, 2021, and the current year, in view of the fact that these claims may have been paid by the third party or paid out-of-pocket by the enrollee. If such claims are identified, instruct the providers to submit the claims, accept such claims for adjudication and payment, regardless of any timely filing limits, and review and process such claims. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check, an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

26. Review and consider for re-adjudication all paid claims that took greater than 15 working days to pay for the years of 2018, 2019, 2020, 2021, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. This should include the claims discussed in Review Sheets CL05-AF, CL34-AF, CL50-AF, CL52-AF, CL59-AF, CL61-AF, CL62-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL109-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL129-AF, CL131-AF, CL01-JA, CL09-JA, CL01-LG, and CL17-LK. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously.";

27. Take steps to ensure the correct payment of interest, as required by § 38.2-3407.1 B of the Code;

28. Review all vendor-processed chiropractic/rehabilitative services, home health/durable medical equipment, radiology, and fertility claims from 2018, 2019, 2020, 2021, and the current year and reimburse enrollees directly for all excess coinsurance and deductible amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you.";

29. Take steps to ensure that if the insured is required to pay a specified percentage of the cost of covered services, it shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, as required by § 38.2-3407.3 A of the Code;

30. Take steps to ensure that every EOB provided to an insured, claimant, or subscriber accurately and clearly sets forth the benefits payable under the contract, specifically related to out-of-pocket accumulators, as required by § 38.2-3407.4 B of the Code;

31. Take steps to ensure that any denial of a claim shall be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial, as required by 14 VAC 5-400-70 A;

32. Take steps to ensure that it provides a reasonable written explanation of the basis for any claim denial and that the written explanation shall provide a specific reference to a policy provision, condition, or exclusion, if any, as required by 14 VAC 5-400-70 B;

33. Take steps to ensure that it pays claims in accordance with the provisions of the policy, as required by 14 VAC 5-400-70 E;

34. Review, reopen, and reprocess all claims under individual policies where payment was reduced due to Medicare estimation in non-compliance with policy provisions for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

35. Provide the examiners with documentation substantiating that Cigna has corrected the processing of the claims discussed in Review Sheets CL11-AF, CL65-AF, CL66-AF, CL68-AF, CL77-AF, CL131-AF, CL133-AF, CL03-JA, and CL13-JA, and that Cigna has refunded any monies owed to the members;

36. Take steps to ensure that it provides to the insured an EOB describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy, as required by 14 VAC 5-400-100 B;

37. Take steps to ensure that it makes available a summary of prescription drug claims electronically or provides a written summary at the request of the insured that shall describe the amounts covered under the policy, the amounts denied, and amounts payable by the insured and insurer, as required by 14 VAC 5-400-100 C;

38. Take steps to ensure that it does not refer to the providers participating in a provider discount arrangement in any of its forms or advertising materials as being part of a network, and take steps to ensure that policy forms clearly define network providers, non-network providers, and non-network providers that participate in a provider discount arrangement and accurately describe the member’s benefits and responsibilities when utilizing each type of provider, as required by Administrative letter 2016-09;

39. Take steps to ensure its EOBs provide clear and accurate information regarding out-of-pocket accumulations, so as to prevent misrepresentations, as required by § 38.2-502 (1) of the Code;

40. Reprocess the claim discussed in Review Sheet CL05-AF to promptly refund any remaining cost-sharing payments charged to the insured after the out-of-pocket maximum was reached and ensure the provider of the incorrectly processed claim receives any reimbursement due;

41. Revise its EOB to include a separate field for any per visit deductibles, or identify this type of cost sharing as a copay in policy documents going forward to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code;

42. Review and reopen all claims for all insureds who exceeded their out-of-pocket maximum during the years of 2018, 2019, 2020, 2021, and the current year and promptly refund all cost-sharing payments charged to the insured after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the insured. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the out-of-pocket maximum was collected in error. Please accept this refund amount." This should also include the claims referenced in Review sheets CL01-AF and CL02-AF; and

43. Take steps to ensure that MH/SUD benefits and Med/Surg benefits are recognized based on the condition or disorder being treated, including recognizing services that are both Med/Surg benefits and MH/SUD benefits, for purposes of financial requirement/QTL analysis, as required by § 38.2-3412.1 B of the Code and MHPAEA.

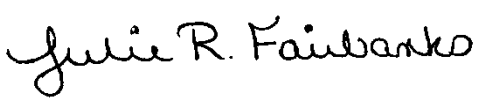
Cigna shall provide a detailed outline of the steps that it will take to comply with each corrective action item listed above and propose a timeline for completion.

XVII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by Cigna's officers and employees during the course of this examination is gratefully acknowledged.

Brant Lyons, MCM, Julie Atkins, MCM, AIRC, Jarod Mentzer, MCM, Laura Klanian, AMCM, HIA, PHIAS, Larry Gibson, MCM, APIR, Tiffany Fontenot, MCM, PIR, Heather Webb, MCM, APIR, and Melissa Hayes of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,



Julie Fairbanks, CIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XVIII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 3 violations, PC01-TT, PC02-TT, PC05-TT
§ 38.2-3407.15 B 2, 3 violations, PC01-TT, PC02-TT, PC05-TT
§ 38.2-3407.15 B 3, 2 violations, PC01-TT, PC02-TT
§ 38.2-3407.15 B 4, 6 violations, PC01-TT, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT
§ 38.2-3407.15 B 5, 2 violations, PC01-TT, PC02-TT
§ 38.2-3407.15 B 6, 2 violations, PC01-TT, PC02-TT
§ 38.2-3407.15 B 7, 3 violations, PC01-TT, PC02-TT, PC03-TT
§ 38.2-3407.15 B 8, 6 violations, PC13-JM, PC14-JM, PC15-JM, PC05-TT, PC06-TT, PC07-TT
§ 38.2-3407.15 B 9, 6 violations, PC15-JM, PC01-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT
§ 38.2-3407.15 B 10, 3 violations, PC01-TT, PC02-TT, PC05-TT
Provider Claims
§ 38.2-3407.15 B 8, 20 violations, PCCL03-JM (10), PCCL04-JM, PCCL11-JM (9)
REQUIRED PROVISIONS IN CARRIER CONTRACTS WITH PHARMACY PROVIDERS
§ 38.2-3407.15:1 B 1, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 2, 1 violation, PC01-TT

§ 38.2-3407.15:1 B 3, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 4, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 5, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 6, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 7, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 8, 1 violation, PC01-TT
§ 38.2-3407.15:1 B 9, 1 violation, PC01-TT
§ 38.2-3407.15:1 C, 1 violation, PC01-TT
REQUIRED PROVISIONS IN CARRIER CONTRACTS REGARDING PRIOR AUTHORIZATION
§ 38.2-3407.15:2 B 1, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 2, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 3, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 4, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT

§ 38.2-3407.15:2 B 5, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 6, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 7, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
§ 38.2-3407.15:2 B 8, 17 violations, PC01-JM, PC02-JM, PC03-JM, PC04-JM, PC05-JM, PC06-JM, PC07-JM, PC08-JM, PC09-JM, PC10-JM, PC11-JM, PC02-TT, PC03-TT, PC05-TT, PC06-TT, PC07-TT, PC09-TT
REQUIRED PROVISIONS IN CARRIER & INTERMEDIARY CONTRACTS WITH PHARMACY PROVIDERS
§ 38.2-3407.15:3 B 2, 1 violation, PC01-TT
§ 38.2-3407.15:3 B 4, 1 violation, PC01-TT
§ 38.2-3407.15:3 C 1, 1 violation, PC01-TT
§ 38.2-3407.15:3 C 3, 1 violation, PC01-TT
REQUIRED PROVISIONS IN CARRIER CONTRACTS REGARDING LIMIT ON COPAYMENT FOR PRESCRIPTION DRUGS; PERMITTED DISCLOSURES
§ 38.2-3407.15:4 C 1, 1 violation, PC01-TT
§ 38.2-3407.15:4 C 3, 1 violation, PC01-TT

ADVERTISING
14 VAC 5-90-40, 1 violation, AD06-LK
14 VAC 5-90-90 C, 1 violation, AD08-LK
POLICY AND OTHER FORMS
§ 38.2-316 A, 34 violations, PF02-JA, PF03-JA, PF10-JA, PF11-JA, PF12-JA, PF13-JA, PF14-JA, PF15-JA, PF16-JA, PF17-JA, PF18-JA, PF19-JA, PF20-JA, PF21-JA, PF22-JA, PF23-JA, PF24-JA, PF25-JA, PF26-JA, PF27-JA, PF29-JA, PF30-JA, PF31-JA, PF32-JA, PF33-JA (9), PF34-JA
§ 38.2-316 C 1, 34 violations, PF02-JA, PF03-JA, PF10-JA, PF11-JA, PF12-JA, PF13-JA, PF14-JA, PF15-JA, PF16-JA, PF17-JA, PF18-JA, PF19-JA, PF20-JA, PF21-JA, PF22-JA, PF23-JA, PF24-JA, PF25-JA, PF26-JA, PF27-JA, PF29-JA, PF30-JA, PF31-JA, PF32-JA, PF33-JA (9), PF34-JA
§ 38.2-3407.4 A, 7 violations, PF01-AF (2), PF02-AF (2), PF03-AF (2), CL15-LK
AGENTS
§ 38.2-1812 A, 1 violation, AG02-JA
§ 38.2-1833 A 1, 3 violations, AG02-JA, AG04-JA (2)
§ 38.2-1834 D, 1 violation, AG01-MH
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-604 B 4, violation, UN01-JA

CANCELLATIONS/NONRENEWALS
Subsection 1 of § 38.2-502, 7 violations, CN01-LK, CN07-LK, CN08-LK, CN09-LK, CN10-LK, CN11-LK, CN12-LK
COMPLAINTS, INTERNAL APPEALS, & EXTERNAL REVIEW
§ 38.2-5804 A, 10 violations, CP01-JA (2), CP03-JA, CP01-TT, CP02-TT (4), CP03-TT (2)
§ 38.2-5804 A 1, 1 violation, CP03-JA
14 VAC 5-216-40 E 2, 10 violations, CP01-JA (2), CP03-JA, CP01-TT, CP02-TT (4), CP03-TT (2)
CLAIM PRACTICES
Subsection 1 of § 38.2-502, 137 violations, CL01-AF, CL05-AF, CL06-AF, CL07-AF, CL44-AF, CL56-AF, CL57-AF, CL113-AF, CL03-JA (25), CL26-JA, CL27-JA, CL28-JA, CL29-JA, CL30-JA, CL31-JA, CL32-JA, CL33-JA, CL34-JA, CL35-JA, CL36-JA, CL37-JA, CL38-JA, CL39-JA, CL40-JA, CL41-JA, CL42-JA, CL43-JA, CL44-JA, CL45-JA, CL46-JA, CL47-JA, CL48-JA, CL49-JA, CL50-JA, CL16-LK (2), CL17-LK, CL18-LK (22), CL21-LK, CL22-LK, CL23-LK, CL24-LK, CL25-LK, CL26-LK, CL27-LK, CL28-LK, CL29-LK, CL30-LK, CL31-LK, CL32-LK, CL33-LK, CL34-LK, CL35-LK, CL36-LK, CL37-LK, CL38-LK, CL39-LK, CL40-LK, CL41-LK (2), CL42-LK (2), CL43-LK, CL44-LK, CL45-LK, CL46-LK, CL47-LK, CL48-LK, CL49-LK, CL01-TF, CL02-TF (9), CL04-TF (13)

§ 38.2-510 A 6, 35 violations, CL05-AF, CL15-AF, CL20-AF, CL52-AF, CL63-AF, CL65-AF, CL70-AF, CL78-AF, CL81-AF, CL86-AF, CL87-AF, CL88-AF, CL92-AF, CL93-AF, CL95-AF, CL96-AF, CL99-AF, CL100-AF, CL108-AF, CL110-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL119-AF, CL129-AF, CL131-AF, CL01-JA, CL08-JA, CL09-JA, CL14-JA, CL18-JA, CL19-JA, CL01-LG, CL49-LK
§ 38.2-514 B, 161 violations, CL04-AF, CL06-AF, CL07-AF, CL09-AF, CL10-AF, CL11-AF, CL13-AF, CL14-AF, CL34-AF, CL37-AF, CL45-AF, CL46-AF, CL49-AF, CL54-AF, CL63-AF, CL64-AF, CL65-AF, CL66-AF, CL68-AF, CL70-AF, CL72-AF, CL73-AF, CL77-AF, CL78-AF, CL79-AF, CL84-AF, CL88-AF, CL89-AF, CL94-AF, CL95-AF, CL96-AF, CL97-AF, CL99-AF, CL101-AF, CL104-AF, CL105-AF, CL106-AF, CL109-AF, CL110-AF, CL112-AF, CL114-AF, CL116-AF, CL117-AF, CL119-AF, CL120-AF, CL121-AF, CL122-AF, CL123-AF, CL124-AF, CL125-AF, CL126-AF, CL127-AF, CL129-AF, CL130-AF, CL131-AF, CL132-AF, CL134-AF, CL135-AF, CL141-AF, CL143-AF, CL144-AF, CL03-JA (25), CL26-JA, CL27-JA, CL28-JA, CL29-JA, CL30-JA, CL31-JA, CL32-JA, CL33-JA, CL34-JA, CL35-JA, CL36-JA, CL37-JA, CL38-JA, CL39-JA, CL40-JA, CL41-JA, CL42-JA, CL43-JA, CL44-JA, CL45-JA, CL46-JA, CL47-JA, CL48-JA, CL49-JA, CL50-JA, CL16-LK (2), CL17-LK, CL18-LK (22), CL23-LK, CL49-LK, CL01-TF, CL02-TF (9), CL04-TF (13)
§ 38.2-3405 B, violation, CL25-JA
§ 38.2-3407.1 B, 29 violations, CL05-AF, CL34-AF, CL50-AF, CL52-AF, CL59-AF, CL61-AF, CL62-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL109-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL129-AF, CL131-AF, CL01-JA, CL09-JA, CL01-LG, CL17-LK

§ 38.2-3407.3 A, 49 violations, CL02-JA (16), CL51-JA (12), CL19-LK (12), CL02-TF (4), CL04-TF (5)
§ 38.2-3407.4 B, 12 violations, CL39-AF, CL40-AF, CL41-AF, CL42-AF, CL43-AF, CL53-AF, CL55-AF, CL111-AF, CL04-JA, CL36-JA, CL01-TF, CL04-TF
14 VAC 5-400-70 A, 101 violations, CL122-AF, CL01-JA, CL03-JA (18), CL06-JA, CL07-JA, CL08-JA, CL09-JA, CL10-JA, CL11-JA, CL12-JA, CL13-JA, CL14-JA, CL15-JA, CL16-JA, CL17-JA, CL18-JA, CL19-JA, CL20-JA, CL21-JA, CL22-JA, CL23-JA, CL24-JA, CL37-JA, CL48-JA, CL20-LK (25), CL23-LK, CL28-LK, CL29-LK, CL31-LK, CL32-LK, CL33-LK, CL35-LK, CL37-LK, CL38-LK, CL41-LK (2), CL43-LK, CL44-LK, CL46-LK, CL02-TF (7), CL04-TF (11), CL05-TF (3)
14 VAC 5-400-70 B, 8 instances of non-compliance, CL13-AF, CL34-AF, CL96-AF, CL133-AF, CL142-AF, CL03-LG, CL04-LG, CL49-LK
14 VAC 5-400-70 E, 4 violations, CL11-AF, CL65-AF, CL66-AF, CL68-AF
14 VAC 5-400-70 E, 11 instances of non-compliance, CL01-AF, CL02-AF, CL05-AF, CL77-AF, CL96-AF, CL114-AF, CL121-AF, CL131-AF, CL133-AF, CL03-JA, CL13-JA
14 VAC 5-400-100 B, 73 violations, CL15-AF, CL31-AF, CL32-AF, CL33-AF, CL34-AF, CL50-AF, CL52-AF, CL63-AF, CL65-AF, CL66-AF, CL67-AF, CL69-AF, CL86-AF, CL87-AF, CL92-AF, CL95-AF, CL98-AF, CL99-AF, CL108-AF, CL110-AF, CL111-AF, CL119-AF, CL123-AF, CL131-AF, CL134-AF, CL01-JA, CL06-JA, CL07-JA, CL08-JA, CL09-JA, CL10-JA, CL11-JA, CL12-JA, CL13-JA, CL14-JA, CL15-JA, CL16-JA, CL17-JA, CL18-JA, CL19-JA, CL20-JA, CL21-JA, CL22-JA, CL23-JA, CL24-JA, CL20-LK (25), CL05-TF (3)
14 VAC 5-400-100 C, violation, CL15-LK

Non-Compliance with Administrative Letter 2016-09, 5 instances, CL44-AF, CL56-AF, CL57-AF, CL113-AF, CL118-AF
MENTAL HEALTH PARITY FINANCIAL REQUIREMENTS & QUANTITATIVE TREATMENT LIMITATIONS
§ 38.2-3412.1 B & MHPAEA, violation, MH01-BL, MH02-BL, MH01-HW, MH01JM, MH01-TT

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
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October 26, 2022

SENT VIA ELECTRONIC MAIL

Ms. Jessica Kearney
Market Conduct, Legal Compliance Senior Manager
Cigna Enterprise Compliance & Regulatory

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Kearney:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Cigna Health and Life Insurance Company for the period of July 1, 2018, through June 30, 2019. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of Cigna Health and Life Insurance Company, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you disagree, giving your specific reasons for disagreement and attach supporting documentation. Please do not include any personally identifiable information in the response.

For the corrective action items with which you agree, provide an outline of your intended method of compliance with each and a proposed timeline for completion in the response. If restitution payments are required to be made to insureds or providers, a spreadsheet will be provided to document those payments with all required details.

Please note that Cigna's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will respond noting any justified revisions to the Report and any areas where we maintained our position. At that time, we will request a detailed outline of Cigna's intended method of compliance with all corrective action items in the report and a timeline for completion.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks

Julie R Fairbanks
BOI Manager
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9785

JRF:mhh
Enclosure
cc: Julie Blauvelt

Jessica Kearney
Legal Compliance Senior Manager

November 30, 2022

Jessica.Kearney@Cigna.com
Telephone: 859.339.6252

VIA EMAIL

Julie R. Fairbanks, BOI Manager
Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219

RE: Cigna Health and Life Insurance Company, Inc.
Market Conduct Examination Exposure Draft Report

Dear Ms. Fairbanks:

In response to the recent market conduct examination of Cigna Health and Life Insurance Company, Inc. (Cigna, CHLIC, the Company) and the issuance of the Exposure Draft Report by the Virginia Bureau of Insurance, please find attached the Company's written response. Cigna has provided response to each corrective action listed within the Exposure Draft Report. The Company has included supporting documentation for the items with which it continues to disagree. Supporting documentation and evidence of correction can also be provided for corrective actions already implemented if needed.

Please note, for responses #28 and #29 we are requesting additional time to submit the corrective action plan detail and an explanation is provided in our response. We would be happy to discuss with the Bureau the reason for the request in greater detail.

If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Jessica Kearney
Legal Compliance Senior Manager

Enclosures: VA BOI Draft Report of CHLIC_Cigna Response
Appendix A: Supporting Documentation

Copy to: Julie Blauvelt
Brant Lyons

Market Conduct Examination Report
Response to Corrective Action Plan
Cigna Health and Life Insurance Company (CHLIC)

Please find below Cigna's responses to each of the corrective actions included in the draft report for Cigna Health and Life Insurance Company (Cigna/CHLIC/the Company).

1. Amend its provider contracts to include the provisions required by § 38.2-3407.15 B of the Code and take steps to ensure any required updates are included going forward;

   Cigna Response: Cigna has amended its provider contracting processes to ensure that the provisions of § 38.2-3407-15 B of the Code and any required updates are included going forward.

   Behavioral Provider Contracting
   The Company's Behavioral Health Provider Administrative Guide, which is incorporated into contracts by reference, was updated on September 1, 2021 and now contains all necessary language in order to be compliant with § 38.2-3407-15 B of the Code.

   Cigna reviews the Provider Administrative Guide content at least bi-annually, and makes updates as needed based on changes in federal and states laws/regulations. This content will continue to be maintained appropriately in the future.

   Medical Provider Contracting
   The required provisions of § 38.2-3407.15 B of the Code were added to Cigna's medical provider contracting tool and templates on June 3, 2021. Contracts originating and/or updated since that date are compliant with § 38.2-3407.15 B of the Code.

   Dental Provider Contracting
   Cigna dental provider contracting intends to comply with the observations of the Commonwealth via updates to the Dental Office Reference Guide upon its next scheduled release and an updated filing of the provider contract with prescriber notices by December 31, 2022.

   Pharmacy Provider Contracting
   Cigna's PBM relationship with OptumRx terminated in 2019. The last day that Cigna utilized OptumRx pharmacy contracts was July 12, 2019. On July 13, 2019 all pharmacy claims began processing utilizing Express Scripts (ESI) pharmacy contracts.

   ESI provider agreements have been reviewed and confirmed to contain the provisions outlined in § 38.2-3407.15(B) of the Code and are therefore in compliance with this requirement.

2. Take steps to ensure that the fee schedule used to pay pharmacy claims is incorporated into the contract and that required notice is provided for any amendments, as required by §§ 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) and 38.2-3407.15 B 10 (formerly B 9 during the examination time frame) of the Code;

   Cigna Response: Cigna's PBM relationship with OptumRx terminated in 2019. The last day that Cigna utilized OptumRx pharmacy contracts was July 12, 2019. On July 13, 2019 all pharmacy claims began processing utilizing Express Scripts (ESI) pharmacy contracts.

ESI provider agreements have been reviewed and confirmed that provider agreements and policies/procedures for issuing amendments are in compliance with §§ 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) and 38.2-3407.15 B 10 (formerly B 9 during the examination time frame) of the Code.

3. Amend its provider contracts to include the provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code and take steps to ensure any required updates are included going forward;

   Cigna Response: Cigna's PBM relationship with OptumRx terminated in 2019. The last day that Cigna utilized OptumRx pharmacy contracts was July 12, 2019. On July 13, 2019 all pharmacy claims began processing utilizing Express Scripts (ESI) pharmacy contracts.

   ESI provider agreements have been reviewed and confirmed to include the provisions outlined in §§ 38.2-3407.15:1(B) and 38.2-3407.15:1(C) of the Code and are therefore in compliance with this requirement.

4. Amend its provider contracts to include the provisions required by § 38.2-3407.15:2 B of the Code and take steps to ensure any required updates are included going forward;

   Cigna Response: Cigna has amended its provider contracting processes to ensure that the provisions of § 38.2-3407.15:2 B of the Code and any required updates are included going forward.

   <u>Behavioral Provider Contracting</u>
   The Company's Behavioral Health Provider Administrative Guide, which is incorporated into contracts by reference, was updated on September 1, 2021 and now contains all necessary language in order to be compliant with § 38.2-3407.15:2 B of the Code.

   Cigna reviews the Provider Administrative Guide content at least bi-annually, and makes updates as needed based on changes in federal and states laws/regulations. This content will continue to be maintained appropriately in the future.

   <u>Medical Provider Contracting</u>
   The required provisions of § 38.2-3407.15:2 B of the Code were added to Cigna's medical provider contracting tool and templates on June 3, 2021. Contracts originating and/or updated since that date are compliant with § 38.2-3407.15:2 B of the Code.

   <u>Dental Provider Contracting</u>
   Cigna dental provider contracting intends to comply with the observations of the Commonwealth via updates to the Dental Office Reference Guide upon its next scheduled release and an updated filing of the provider contract with prescriber notices by December 31, 2022.

5. Amend its provider contracts to include the provisions required by §§ 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code and take steps to ensure any required updates are included going forward;

Cigna Response: Cigna's PBM relationship with OptumRx terminated in 2019. The last day that Cigna utilized OptumRx pharmacy contracts was July 12, 2019. On July 13, 2019 all pharmacy claims began processing utilizing Express Scripts (ESI) pharmacy contracts.

ESI provider agreements have been reviewed and confirmed to include the provisions outlined in §§ 38.2-3407.15:3(B) and 38.2-3407.15:3(C) of the Code and are therefore in compliance with this requirement.

6. Amend its provider contracts to include the provisions required by § 38.2-3407.15:4 C of the Code and take steps to ensure any required updates are included going forward;

   Cigna Response: Cigna's PBM relationship with OptumRx terminated in 2019. The last day that Cigna utilized OptumRx pharmacy contracts was July 12, 2019. On July 13, 2019 all pharmacy claims began processing utilizing Express Scripts (ESI) pharmacy contracts.

   ESI provider agreements have been reviewed and confirmed to include the provisions outlined in § 38.2-3407.15:4(C) of the Code and are therefore in compliance with this requirement.

7. Take steps to ensure claims are paid in accordance with the fee schedule incorporated into the contract, as required by § 38.2-3407.15 B 9 (formerly B 8 during the examination time frame) of the Code;

   Cigna Response: Cigna utilizes the appropriate fee schedule agreed upon during the contract negotiation to pay claims. As noted in previous exam responses, this fee schedule is available to the provider anytime through the Cigna for Healthcare Provider website.

8. Adjust the claims discussed in Review Sheets PCCL03-JM, PCCL04-JM, and PCCL11-JM and pay them at the contract rate for all services rendered along with statutory interest owed on the underpaid portion. Include with each check, an explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid.";

   Cigna Response: Cigna respectfully disagrees with the violations noted in Review Sheets PCCL03-JM, PCCL04-JM, and PCCL11-JM. Cigna has researched the referenced provider claims and has validated that the billed services were paid according to the appropriate fee schedules.

9. Take steps to ensure that all policy forms are filed with and approved by the Commission prior to use, and that policy forms are not modified beyond their approved variability, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;

   Cigna Response: Cigna is taking steps to ensure that all policy forms are filed with and approved by the Commission prior to use, and that policy forms are not modified beyond their approved variability, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code.

   For the Individual & Family Plan (IFP) policy language related to PF02-JA, the language was remediated in subsequent year policy filings submitted to the Commission for approval. To further prevent this from happening, Cigna provided guidance regarding the requirements of §§

38.2-316 A and 38.2-316 C 1 of the Code to the policy drafter in March of 2022. In addition, the IFP team implemented a system in January of 2021 that automates the filed/approved versions of the policies and schedules of benefits into the final member versions of the plans. This automation reduces the manual work to convert each individual schedule of benefits into the full policy one by one and therefore reduces the risk of human error.

Cigna is remediating the issues cited in PF03-JA and is working with its vendor to update the specification page format to align to the filed and approved version. Updates are expected to be complete during the first quarter of 2023. Once remediation is complete, new members that purchase a Cigna IFP policy after the remediation date will get the approved Specification page. In November of 2022 the IFP team established a process whereby the policy filing team will ensure that the final approved Specification page is sent to a designated person directly on the operations team so that the most current version of that page will be populated and sent out with the issuance of each policy to members. This will ensure that any changes that are needed are facilitated properly and software updates are vetted vs. relying on an internal repository for the necessary updates to be completed.

Related to the large group documents, the Company will conduct a full audit of all customer policy forms and certificate documents marketed in Virginia. The Company will submit the remediation plan to the VA Bureau of Insurance no later than March 31, 2023, to include a report of applicable forms that will require a remediation filing based on our full review and audit. Once the Bureau approves our remediation plan, the Company will file the forms through SERFF shortly after for approval. The Company has compliance controls in place so that only approved language from the form filing is included in customer policies and certificates. We will also implement new compliance controls going forward so that any minor wording edits or formatting changes, for example, updating our company name from “CIGNA” to “Cigna” are not made unless there is an approved form filing from the Commissioner.

10. Review all policy forms currently in force and currently being marketed in Virginia and identify any policy forms, including those referenced during the course of this examination, that were not previously filed with the Commission as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking any action, submit a remediation plan to the Forms section of the Life and Health Market Regulation division. It is requested that the Company clearly indicate in the letter(s) of transmittal that the submission is a result of Cigna’s efforts to comply with this examination’s Corrective Action Plan;

    Cigna Response: The Individual & Family Plan (IFP) policy team reviewed all policy forms currently in force and currently being marketed in Virginia. With respect to the issues identified by the state in PF02-JA, the Individual & Family policy team did not find any policy forms that were not previously filed with the Commission as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. For such policy forms identified by the state in PF02-JA, the IFP policy team submitted all forms for current Plan Year 2022 and upcoming plan Year 2023 to the state for review prior to issuing the plans to member. The IFP team also performs a year over year review and have not identified any other issues for subsequent years. Cigna has not reissued the policies for the 2019 plan year because it is concerned that it will result in customer confusion since the discrepancy on the policy form occurred nearly four years ago. Additionally, the policy forms are no longer in use because the IFP plans file the full policy annually. Also, we believe since the text that appeared on the issued form identified by the state in the Market Conduct Exam does not materially misrepresent the benefit that was referenced in PF02-JA, reissuing the policies would be unnecessary.

With respect to the issues identified by the state in PF03-JA, the IFP policy team did find that the identified issues persisted to present day. As indicated in earlier responses, the IFP team is working with the IFP operations team to remediate the discrepancies in the product specification pages to align with the language that was approved by the state and anticipates that this remediation will be complete in the first quarter of 2023. However, the changes that are necessary to align with the state-approved language are not substantive, and the errors did not misstate or misrepresent that customer's benefit. For instance, Cigna IFP's use of the term "insured" in place of the approved language of "policyholder" does not change or otherwise misrepresent the customer's benefit. Given these factors, we believe that reissuing these forms to customers at this time for past product years and for the current product year would cause unnecessary customer confusion.

Related to the large group documents, Cigna will conduct a full audit of all customer policy forms and certificate documents marketed in Virginia. The Company will submit the remediation plan to the VA Bureau of Insurance no later than March 31, 2023, to include a report of applicable forms that will require a remediation filing based on our full review and audit. Once the department approves our remediation plan, the Company will file the forms through SERFF shortly after for approval. The Company has compliance controls in place so that only approved language from the form filing is included in customer policies and certificates. We will also implement new compliance controls going forward so that any minor wording edits or formatting changes, for example, updating our company name from "CIGNA" to "Cigna" are not made unless there is an approved form filing from the Commissioner.

11. Identify and file for approval all EOB forms currently in use that have not yet been filed with the Commission, as required by § 38.2-3407.4 A of the Code;

    Cigna Response: Cigna is in the process of identifying all EOB forms currently in use that have not yet been filed with the Commission, and will file any such EOB forms for approval as required by § 38.2-3407.4 A of the Code. The Company will include any identified EOBs not yet filed and approved by the Commission in the remediation plan referenced in corrective action #10, to be submitted to the VA Bureau of Insurance no later than March 31, 2023.

12. Take steps to ensure that its EOB forms are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code;

    Cigna Response: Cigna is taking steps to implement processes to ensure that its EOB forms are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code. Implementation of the new processes is expected to be completed no later than March 31, 2023.

13. Take steps to ensure compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;

    Cigna Response: Proactive monitoring of appointment timing was implemented by Cigna, beginning July 2022 and continuing on a quarterly basis, to ensure timely appointment of agents and to identify and address root cause issues in compliance with §§ 38.2-1812 A and 38.2-1833 A 1.

To ensure compliance with § 38.2-1833 A 1 Cigna has also implemented Auditing processes, updated its Standard Operating Processes and Appointment Guide, and provides periodic retraining to employees. With the actions already implemented, Cigna has fully remediated this issue.

14. Take steps to ensure that NIP forms given to applicants and policyholders comply with all requirements set forth in § 38.2-604 of the Code;

    Cigna Response: Based on the recommendation of the Virginia Bureau of Insurance during the exam, Cigna updated its Notice of Insurance Information Practices (NIP) in November 2020 to comply with all requirements set forth in § 38.2-604 of the Code. The updated NIP has been in use and available on Cigna.com since November 2020, fully remediating this issue.

15. Revise its past-due notice for individual policies to ensure it provides clear and accurate information about the terms and conditions of the policy and the grace period, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

    Cigna Response: Cigna has remediated its termination for nonpayment process in the state of Virginia to correspond with the filed policy on March 21, 2020 in order to ensure that customers have a grace period that corresponds with the policy provisions.

    Cigna's past due notices will also not reflect the remediated cancelation date at the end of the grace period where applicable to provide clear and accurate information about the terms and conditions of the grace period and policy.

16. Take steps to ensure its internal procedures comply with policy provisions regarding the required grace period for individual policies;

    Cigna Response: Cigna has remediated its termination for nonpayment process in the state of Virginia to correspond with the filed policy on March 21, 2020 in order to ensure that customers have a grace period that corresponds with the policy provisions.

    Cigna's past due notices will also not reflect the remediated cancelation date at the end of the grace period where applicable to provide clear and accurate information about the terms and conditions of the grace period and policy.

17. Take steps to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;

    Cigna Response: Process improvement teams have been added to review and address root causes for Cigna to ensure compliance with § 38.2-5804 A of the Code. The Appeals Submission Identification Improvement Process Workgroup kicked off on March 6, 2020 to move the manual process to electronic. The Quality team met with the Correspondence team to review QCQS workflows in June 2020. The Appeals team continues to monitor the Electronic Mailroom (EMR) process. The Appeals team and Quality team receive a daily report of Daily Appeals Inventory to assist in monitoring any backlog. Actions taken by Cigna have fully remediated this issue.

18. Take steps to ensure that it notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 2;

    Cigna Response: Violations of 14 VAC 5-216-40 E 2 noted within the examination were a result of a backlog of inventory. Cigna took steps in December 2019 to begin increasing the number of staff to address the delay in completion of cases. Additional training classes for staff were also added in 2022 to ensure Cigna notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 2.

19. Take steps to ensure its EOBs provide clear and accurate information regarding provider discount arrangements, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

    Cigna Response: The Company has set forth multiple actions to address the findings in the related Review Sheets. The deductible/accumulator issue for the External Prosthetic Appliance (EPA) specific deductible has a proposed solution addressed in CAP 41. The issue related to Administrative Letter 2016-09 was fixed in May 2021 when the EOB/EOP language was corrected to remove "network" and replace it with "discount".

    The Company will modify the vendor-processed claims to accurately display the names of the participating providers of service within an IT project implementing Q4 2023. Cigna will also modify the vendor-processed claims to reflect the accurate member liability by removing the administration fees from the claim submission. This work will be accommodated in the Q4 2023 IT implementation.

20. Take steps to ensure its EOBs sent in connection with vendor-processed claims provide clear and accurate information about the provider of services, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

    Cigna Response: Cigna is taking steps to ensure EOBs sent in connection with vendor-processed claims provide clear and accurate information about the provider of services, so as to prevent misrepresentations, as required by § 38.2-502 of the Code, as noted in the Company's response to corrective action #19.

21. Take steps to ensure that it makes prompt, fair and equitable settlements of claims in which liability has become reasonably clear, as required by § 38.2-510 A 6 of the Code;

    Cigna Response: Cigna is taking appropriate steps to ensure its compliance with § 38.2-510 A 6 of the Code. Cigna will communicate and ensure necessary training is provided to the claim processors adjudicating claims according to benefit provisions. Training will be completed during Q1 2023, no later than February 28, 2023. Feedback and retraining of the claims teams to ensure claims are paid within 15 business days for VA will also be provided during this time.

    Please note Cigna's continued disagreement with the findings noted in CL71-AF, CL83-AF, and CL85-AF as referenced in Appendix A.

22. Take steps to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by §

38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, billed amounts, allowable amounts, deductibles, coinsurance, and copayments on its EOBs, as well as ensuring that included remarks are not potentially misleading to the member;

Cigna Response: Cigna is taking steps to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code. Specific findings related to Medicare estimation processes were updated and effective on April 1, 2022; the individual violations were corrected. Inaccurate LPI calculation processes were updated to reflect accurate LPI in October 2022 via a system upgrade. The Deductible/accumulator issue for the External Prosthetic Appliance (EPA) specific deductible has a proposed solution addressed in corrective action #41. The following items will be addressed with a current IT Project with a projected implementation date of Q4 2023: EOB rounding percent issue, Provider Discount field, Proclaim code editing for member liability, Amount not covered for saving achieved, and the zero billed line items. All other findings related to this corrective action were manual claim processor errors and were addressed during the exam.

23. Remove all subrogation language from Virginia provider contracts entered into through its vendors, in accordance with § 38.2-3405 B of the Code, and contact all such contracted Virginia providers to alert them to cease this practice immediately;

Cigna Response: As specifically identified in CL25-JA, the subrogation language has been removed from Virginia provider contracts in accordance with 38.2-3405 B of the Code. Contracted Virginia providers were notified the subrogation language was removed on October 14, 2022 (Rehabilitative Service Providers) and November 2, 2022 (Chiropractors).

24. Review, reopen, and reprocess all claims for enrollees of plans issued in Virginia by Cigna that potentially involved subrogation associated with vendor provider contract language, for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by §§ 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

Cigna Response: After further review of the findings identified in CL25-JA, Cigna's claim vendor, ASH, does not have any claims on file that potentially involved subrogation; therefore, there are no claims to review, reopen or reprocess. ASH did not enforce the subrogation clause prior to removal of the subrogation language. Contracted providers were not obligated to seek reimbursement from a third party prior to seeking reimbursement from ASH. Due to the contractual relationship with Cigna, ASH does not assert liens on Cigna’s behalf and did not seek reimbursement from a contracted provider after a third party liability claim was settled.

25. Contact all Virginia providers participating under contracts entered into through vendors to inquire about claims that may not have been submitted to Cigna for payment, for the years 2018, 2019, 2020, 2021, and the current year, in view of the fact that these claims may have been paid by the third party or paid out-of-pocket by the enrollee. If such claims are identified, instruct the providers to submit the claims, accept such claims for adjudication and payment, regardless of any timely filing limits, and review and process such claims. Send checks for the proper contractual benefits,

plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check, an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

Cigna Response: Related to the findings specifically identified in CL25-JA, ASH will contact all contracted Virginia providers pursuant to the request, above. The target mailing date will be January 15, 2023.

Additionally, new remark codes have been requested to accommodate the state prescribed language to be included with each check. Cigna's Proclaim claim system can include exactly what the state has outlined, however, Cigna's Facets claim system has a much more restrictive limitation on characters. For any Facets claim requiring remediation for the examination findings, Cigna proposes the following language: *"A Market Conduct Exam by Virginia State Corporation Commission's Bureau of Insurance determined that this claim was processed incorrectly."*

26. Review and consider for re-adjudication all paid claims that took greater than 15 working days to pay for the years of 2018, 2019, 2020, 2021, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. This should include the claims discussed in Review Sheets CL05-AF, CL34-AF, CL50-AF, CL52-AF, CL58-AF, CL59-AF, CL60-AF, CL61-AF, CL62-AF, CL71-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL100-AF, CL109-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL119-AF, CL129-AF, CL131-AF, CL01-JA, CL09-JA, CL01-LG, and CL17-LK. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously.";

Cigna Response: Cigna is currently analyzing its data to prepare for the remediation of all paid claims that took greater than 15 working days to pay for the past five (5) years (2018-current) and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Due to the potential high volume of claims for a 5-year audit period, Cigna anticipates the analysis will be completed by March 31, 2023, at which time the remediation can be scheduled for implementation.

Cigna has made efforts to correct the interest payments for the claims discussed in Review Sheets CL05-AF, CL34-AF, CL50-AF, CL52-AF, CL59-AF, CL61-AF, CL62-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL109-AF, CL111-AF, CL112-AF, CL113-AF, CL118-AF, CL129-AF, CL131-AF, and CL01-LG prior to the receipt of the Exposure Draft Report. Please see Appendix A Corrective Action #26 for additional details and supporting documentation regarding the corrected processing of the claims discussed in the Review Sheets noted above.

Additionally, new remark codes have been requested to accommodate the state prescribed language to be included with each check for any future required payments. Cigna's Proclaim claim system can include exactly what the state has outlined, however, Cigna's Facets claim system has a much more restrictive limitation on characters. For any Facets claim requiring remediation for the examination findings, Cigna proposes the following language: *"A Market Conduct Examination by Virginia Bureau of Insurance determined that interest had not been paid previously."*

Please note Cigna's continued disagreement with the findings noted in CL58-AF, CL60-AF, CL71-AF, CL100-AF, and CL119-AF, as referenced in Appendix A.

27. Take steps to ensure the correct payment of interest, as required by § 38.2-3407.1 B of the Code;

Cigna Response: Cigna has taken steps to ensure the correct payment of interest, as required by § 38.2-3407.1 B of the Code. The Company's LPI tool used to manually issue LPI was updated to the correct VA State calculation on July 28, 2022. The Facets claim system cannot accommodate a combination of working and calendar day LPI calculations. Since the VA State calculation cannot be accommodated, the company has set the Facets claim system to calculate at 21 calendar days. This will over comply when the system calculates the total time to process and pays the LPI. This change was implemented on June 24, 2022.

28. Review all vendor-processed chiropractic/rehabilitative services, home health/durable medical equipment, radiology, and fertility claims from 2018, 2019, 2020, 2021, and the current year and reimburse enrollees directly for all excess coinsurance and deductible amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you.";

Cigna Response: Cigna acknowledges the Bureau's concerns regarding compliance with the State's cost-sharing requirements. However, at this time, we are unable to fully meet the Corrective Actions proposed by the Bureau due to extensive operational challenges related to remediation of these findings. Among other things, corrective actions will require extensive engagement and support from third parties. For example, Cigna does not have ready access to our third party vendors' confidential and proprietary contract information. Additionally, our arrangement with CareCentrix (one of the third-party vendors applicable to these findings) terminated nearly two years ago (January 31, 2021), and the services are now being managed through Cigna's affiliate, eviCore. The relationships that would support corrective actions have been impacted by turnover and subsequent corporate restructurings at CareCentrix. This necessary reliance on third parties, combined with the inherent complexities of a five-year claims review, significantly increase the effort and time required to develop effective corrective actions.

Notwithstanding, we have already taken some steps to support the Bureau's position and requested corrective actions. Specifically, Cigna has made recent changes to the reimbursement structure and method to calculate cost share with respect to certain services provided to its members, notably home health, durable medical equipment, chiropractic, and radiology services. With these changes, if the insured is required to pay a specified percentage of the cost of the aforementioned services, Cigna will calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the rendering provider, as contemplated by § 38.2-3407.3 A of the Code.

We respectfully request until January 13, 2023 to respond to these proposed Corrective Actions. We remain committed to resolving these issues and appreciate the Bureau's consideration of this request.

29. Take steps to ensure that if the insured is required to pay a specified percentage of the cost of covered services, it shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, as required by § 38.2-3407.3 A of the Code;

    Cigna Response: Cigna acknowledges the Bureau's concerns regarding compliance with the State's cost-sharing requirements. However, at this time, we are unable to fully meet the Corrective Actions proposed by the Bureau due to extensive operational challenges related to remediation of these findings. Among other things, corrective actions will require extensive engagement and support from third parties. For example, Cigna does not have ready access to our third party vendors' confidential and proprietary contract information. Additionally, our arrangement with CareCentrix (one of the third-party vendors applicable to these findings) terminated nearly two years ago (January 31, 2021), and the services are now being managed through Cigna's affiliate, eviCore. The relationships that would support corrective actions have been impacted by turnover and subsequent corporate restructurings at CareCentrix. This necessary reliance on third parties, combined with the inherent complexities of a five-year claims review, significantly increase the effort and time required to develop effective corrective actions.

    Notwithstanding, we have already taken some steps to support the Bureau's position and requested corrective actions. Specifically, Cigna has made recent changes to the reimbursement structure and method to calculate cost share with respect to certain services provided to its members, notably home health, durable medical equipment, chiropractic, and radiology services. With these changes, if the insured is required to pay a specified percentage of the cost of the aforementioned services, Cigna will calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the rendering provider, as contemplated by § 38.2-3407.3 A of the Code.

    We respectfully request until January 13, 2023 to respond to these proposed Corrective Actions. We remain committed to resolving these issues and appreciate the Bureau's consideration of this request.

30. Take steps to ensure that every EOB provided to an insured, claimant, or subscriber accurately and clearly sets forth the benefits payable under the contract, specifically related to out-of-pocket accumulators, as required by § 38.2-3407.4 B of the Code;

    Cigna Response: The Company will remediate the display of the EOB accumulators with its vendor to accurately reflect the correct amount. This work will be completed in the Q4 2023 IT implementation.

31. Take steps to ensure that any denial of a claim shall be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial, as required by 14 VAC 5-400-70 A;

    Cigna Response: Cigna has determined that the referenced findings were related to not receiving all denied lines from its claims vendors. The Company will work with its vendors to acquire the denied lines and accurately display the information on the EOBs as required by 14 VAC 5-400-70 A. This action will be completed in the Q4 2023 IT implementation.

32. Take steps to ensure that it provides a reasonable written explanation of the basis for any claim denial and that the written explanation shall provide a specific reference to a policy provision, condition, or exclusion, if any, as required by 14 VAC 5-400-70 B;

    Cigna Response: Cigna has determined that the referenced findings were related to not receiving all denied lines from its claims vendors. The Company will work with its vendors to acquire the denied lines and accurately display the information on the EOBs as required by 14 VAC 5-400-70 B. Cigna will remediate with the same actions communicated in proposed corrective action #31, to be completed in the Q4 2023 IT implementation.

33. Take steps to ensure that it pays claims in accordance with the provisions of the policy, as required by 14 VAC 5-400-70 E;

    Cigna Response: Cigna is taking appropriate steps to ensure that it pays claims in accordance with the provisions of the policy, as required by 14 VAC 5-400-70 E. The Company will communicate and ensure necessary training is provided to the claim processors adjudicating claims according to benefit provisions. Training will be completed during Q1 2023, no later than February 28, 2023.

    Specifically for violations related to Medicare eligibility, Cigna has updated its process for investigation to pend claims instead of estimating secondary for those customers in the instance of both 65+ and ESRD diagnosis. The updated process went into effect for all customers with date of service of April 1, 2022 and forward to ensure Cigna's compliance with 14 VAC 5-400-70 E. Relevant policies and Standard Operating Procedures (SOPs) have been updated to reflect these changes in Cigna’s process.

    Please note Cigna's continued disagreement with the findings noted in CL71-AF and CL01-LK, as referenced in Appendix A.

34. Review, reopen, and reprocess all claims under individual policies where payment was reduced due to Medicare estimation in non-compliance with policy provisions for the years 2018, 2019, 2020, 2021, and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code, to the enrollees. Include with each check an explanation stating that, "As a result of a Target Market Conduct Inquiry by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly.";

    Cigna Response: As of April 1, 2022, Cigna updated its processes to no longer estimate Virginia claims for Medicare eligible individuals. The Company is currently in the auditing phase of its remediation efforts which will identify all claims that were adjudicated using the prior estimation process. Cigna's targeted completion date of all auditing activities is January 30, 2023. Following our auditing activities, we will establish a full remediation plan around the volume of claims that need to be remediated.

    Additionally, new remark codes have been requested to accommodate the state prescribed language to be included with each check. Cigna's Proclaim claim system can include exactly what the state has outlined, however, Cigna's Facets claim system has a much more restrictive limitation on characters. For any Facets claim requiring remediation for the examination findings, Cigna proposes the following language: *“A Market Conduct Exam by Virginia State*

Corporation Commission's Bureau of Insurance determined that this claim was processed incorrectly."

Please note Cigna's continued disagreement with the findings noted in CL71-AF and CL01-LK, as referenced in Appendix A.

35. Provide the examiners with documentation substantiating that Cigna has corrected the processing of the claims discussed in Review Sheets CL11-AF, CL65-AF, CL66-AF, CL68-AF, CL71-AF, CL77-AF, CL131-AF, CL133-AF, CL03-JA, and CL13-JA, and that Cigna has refunded any monies owed to the members;

    Cigna Response: Please see Appendix A, Corrective Action #35 for supporting documentation regarding the corrected processing of the claims discussed in Review Sheets CL11-AF, CL65-AF, CL66-AF, CL68-AF, CL77-AF, CL131-AF, CL133-AF, CL03-JA, and CL13-JA, and any refunded monies owed to the members.

    Please note Cigna's continued disagreement with the findings noted in CL71-AF, as referenced in Appendix A.

36. Take steps to ensure that it provides to the insured an EOB describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy, as required by 14 VAC 5-400-100 B;

    Cigna Response: Cigna received some of the claims noted in the related Review Sheets from Medicaid. Because Medicaid is always the payer of last resort, the Company paid Medicaid for claims they had paid to a provider. Cigna does not view this as a claim, rather it is accepted as a subrogation request. The Company does not hold Medicaid to the state requirements since they are not claims submitted by the provider or customer, but rather a subrogation request.

    Most of the remaining findings relate to the Company not having the denied claims lines to send the EOB. As noted above, the Company will remediate this issue with the proposed corrective action #31 to be completed in the Q4 2023 IT implementation.

37. Take steps to ensure that it makes available a summary of prescription drug claims electronically or provides a written summary at the request of the insured that shall describe the amounts covered under the policy, the amounts denied, and amounts payable by the insured and insurer, as required by 14 VAC 5-400-100 C;

    Cigna Response: Cigna has taken steps to ensure that it makes available a summary of prescription drug claims electronically or provides a written summary at the request of the insured as required by 14 VAC 5-400-100 C. Pharmacy claims are processed at Point of Sale, therefore, EOBs are only available for paper claims submissions. Mycigna.com maintains two years of claims data for customers to review online. Historical EOBs are available upon request, to include up to eight (8) years of pharmacy claims.

38. Take steps to ensure that it does not refer to the providers participating in a provider discount arrangement in any of its forms or advertising materials as being part of a network, and take steps

to ensure that policy forms clearly define network providers, non-network providers, and non-network providers that participate in a provider discount arrangement and accurately describe the member's benefits and responsibilities when utilizing each type of provider, as required by Administrative letter 2016-09;

Cigna Response: Cigna has taken steps to ensure that providers participating in a provider discount arrangement are not referred to as being part of a network. Cigna has also taken steps to ensure compliance with the requirements of Administrative letter 2016-09. In May 2021, the EOB/EOP language was corrected to remove the term "network" and replaced with "discounts".

39. Take steps to ensure its EOBs provide clear and accurate information regarding out-of-pocket accumulations, so as to prevent misrepresentations, as required by § 38.2-502 (1) of the Code;

Cigna Response: Cigna is taking steps to ensure its EOBs provide clear and accurate information regarding out-of-pocket accumulations and comply with the requirements of § 38.2-502 (1) of the Code.

Specific to Review Sheet CL01-AF, the findings noted were corrected during the exam by updating the deductible and out-of-pocket maximum (OOP). Impacted claims were adjusted and corrected; documentation was provided to the examiner in November 2020. For Review Sheet CLO6-AF, it will align accumulators for External Prosthetic Appliance (EPA) when certificate language is updated to reflect the EPA deductible upon state filing approval and plan document updates upon renewals post state filing approval. It will take approximately 1.5 years after the Commission approves the plan document for the updates to cycle through all renewals as noted below in response to corrective action #41.

40. Reprocess the claim discussed in Review Sheet CL05-AF to promptly refund any remaining cost-sharing payments charged to the insured after the out-of-pocket maximum was reached and ensure the provider of the incorrectly processed claim receives any reimbursement due;

Cigna Response: Cigna reprocessed the claim discussed in Review Sheet CL05-AF in November 2020. Please see Appendix A Corrective Action #40 for supporting documentation regarding the corrected processing of the claim.

41. Revise its EOB to include a separate field for any per visit deductibles, or identify this type of cost sharing as a copay in policy documents going forward to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code;

Cigna Response: Cigna will update the policy document language to change the EPA deductible to copay going forward to ensure that its EOBs clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by § 38.2-514 B of the Code. Once the Commission approves the filing change, Cigna will provide the updated Certificates of Coverage upon renewal and this cycle will be completed approximately 1.5 years after the language change has been approved by the Commission.

42. Review and reopen all claims for all insureds who exceeded their out-of-pocket maximum during the years of 2018, 2019, 2020, 2021, and the current year and promptly refund all cost-sharing payments charged to the insured after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the insured. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the out-of-pocket maximum was collected in error. Please accept this refund amount." This should also include the claims referenced in Review sheets CL01-AF and CL02-AF; and

    Cigna Response: Cigna is currently analyzing its data to prepare for the required remediation of claims for insureds who exceeded their out-of-pocket maximum. Due to the potential high volume of claims for a 5-year audit period (2018-current), Cigna has established a phased review approach, as noted below.

    - Phase 1: Identify potentially impacted clients – Completed November 14, 2022
    - Phase 2: Identify potentially impacted customers – Estimated Completion November 30, 2022
    - Phase 3: Identify potentially impacted overages – Estimated Completion December 23, 2022
    - Phase 4: Review of 2021 impacted claims – Estimated Start Date December 26, 2022
    - Phase 5: Review of 2022 impacted claims – Depending on completion of Phase 4
    - Phase 6: Review of 2018-2020 impacted claims – Depending on completion of Phase 5

    Please note, estimated completion and start dates are variable based upon the prior phase completion. Upon completion of Phase 6, approximately 60 days post report will be required in order for Cigna to complete the analysis to begin remediation. We anticipate to have volume timelines by end of Q2 2023.

    Also note, 2018-2021 impacted claims may be delayed in Proclaim due to system availability for claims older than 2 years. While the required data is still available, it does require a longer time to access and review the claims.

    Additionally, new remark codes have been requested to accommodate the state prescribed language to be included with each check. Cigna's Proclaim claim system can include exactly what the state has outlined, however, Cigna's Facets claim system has a much more restrictive limitation on characters. For any Facets claim requiring remediation for the examination findings, Cigna proposes the following language: *"A Market Conduct Examination by Virginia Bureau of Insurance determined that the out-of-pocket was collected in error, this is your refund."*

43. Take steps to ensure that MH/SUD benefits and Med/Surg benefits are recognized based on the condition or disorder being treated, including recognizing services that are both Med/Surg benefits and MH/SUD benefits, for purposes of financial requirement/QTL analysis, as required by § 38.2-3412.1 B of the Code and MHPAEA.

    Cigna Response: As indicated in Cigna's last response to the Virginia Bureau of Insurance (the Bureau) on March 22, 2022, in order to expeditiously resolve this matter consistent with the Bureau's expectations, and without accepting the legal conclusions offered by the Bureau as to the application of the parity laws to Cigna's cost-share testing and administration practices, Cigna has revised its policies and procedures in accordance with the Bureau's stated positions. Specifically, Cigna has implemented and completed work with respect to plans that Cigna offers

in the individual market in Virginia that updates Cigna's policies and procedures so that inpatient and outpatient services in the relevant benefit classification (or, as applicable, sub-classifications) that are commonly performed to treat medical/ surgical conditions but may be appropriate to treat an MH/SUD condition to be treated as MH/SUD benefits when rendered to treat an MH/SUD condition. For this purpose, Cigna considers a claim to constitute an MH/SUD benefit when the claim is submitted with an ICD-10 diagnosis associated with an MH/SUD condition in the primary position. Cigna is using this assumption when identifying the claims data set used to test Cigna's individual plan designs.

Cigna emphasizes that its testing for the individual market plans offered in the state required an intensive, entirely manual effort, as Cigna typically uses an automated cost-share testing tool. However, the manual testing process using this approach was sufficient to test all plans offered in the individual market in the state for the 2023 plan year, consistent with the Bureau’s expectations for 2023 individual market plan filings.

Jessica Kearney
Legal Compliance Senior Manager

January 13, 2023

Jessica.Kearney@Cigna.com
Telephone: 859.339.6252

VIA EMAIL

Julie R. Fairbanks, BOI Manager
Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219

RE: Cigna Health and Life Insurance Company, Inc.
Market Conduct Examination Exposure Draft Report

Dear Ms. Fairbanks:

On November 30, 2022, Cigna Health and Life Insurance Company, Inc. (Cigna, CHLIC, the Company) provided written response to the Exposure Draft Report issued by the Virginia Bureau of Insurance related to the recent market conduct examination of CHLIC. The Company's written response respectfully requested until January 13, 2023 to respond to proposed Corrective Actions #28 and #29. The Company appreciates the additional time granted to CHLIC by the Bureau to provide the written response for these items.

Please find attached, CHLIC's written response to the Virginia Bureau of Insurance proposed Corrective Actions for items #28 and #29.

If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Jessica Kearney
Legal Compliance Senior Manager

Enclosures: VA BOI Draft Report of CHLIC_Cigna Response_CAPs 28_29

Copy to: Julie Blauvelt
Brant Lyons

Market Conduct Examination Report
Response to Corrective Action Plan
Cigna Health and Life Insurance Company (CHLIC)

Please find below Cigna's responses to corrective actions #28 & #29 included in the draft report for Cigna Health and Life Insurance Company (Cigna/CHLIC/the Company).

28. Review all vendor-processed chiropractic/rehabilitative services, home health/durable medical equipment, radiology, and fertility claims from 2018, 2019, 2020, 2021, and the current year and reimburse enrollees directly for all excess coinsurance and deductible amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you.";

    Cigna Response: Cigna will review the chiropractic/rehabilitative services, home health/durable medical equipment, radiology and fertility claims arranged through third-party vendors of these services from 2018, 2019, 2020, 2021 and 2022.

    Cigna will estimate the rate for the vendors' sub-contracted providers for the impacted claims; as stated previously, Cigna does not have ready access to our third party vendors' confidential and proprietary contract information. Cigna will therefore estimate the sub-contracted rate, based on analyzing data and documents that Cigna may have in its possession, such as MLR reporting and through calculating the difference between allowed amounts and estimated subcontracted rates. Finally, Cigna will calculate cost-sharing obligations for each impacted enrollee based on the estimated sub-contracted rate and the cost-sharing provisions of the enrollee's health plan benefits. Based on those calculations, Cigna will distribute appropriate reimbursement to the impacted enrollees. Additionally, the communication with the Bureau's requested language will be provided to impacted enrollees. The target date for compliance with this Corrective Action is end of Q3 2023.

29. Take steps to ensure that if the insured is required to pay a specified percentage of the cost of covered services, it shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, as required by § 38.2-3407.3 A of the Code;

    Cigna Response: As referenced in our November 2022 response, in recent years, Cigna implemented changes to the reimbursement structure and method to calculate cost share with respect to certain services provided to its enrollees through third-party vendors, notably home health, durable medical equipment, chiropractic and radiology services. With these changes, if the enrollee is required to pay a specified percentage of the cost of the aforementioned services, Cigna calculates such cost-sharing amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider with which the vendor subcontracted to provide the service. For the remaining services, changes to the reimbursement structure will be completed no later than January 1, 2024.

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

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RICHMOND, VIRGINIA 23218

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March 2, 2023

VIA EMAIL

Jessica Kearney
Market Conduct, Legal Compliance Senior Manager
Cigna Enterprise Compliance & Regulatory

RE: Response to the Draft Examination Report
Cigna Health and Life Insurance Company (Cigna)

Dear Ms. Kearney:

The examiners have received and reviewed Cigna's November 30, 2022, response and Cigna's additional January 13, 2023, response to the Draft Report. The BOI is providing the following attachments:

1. **The BOI's Response**

   In this response, the examiners have addressed Cigna's disagreements with the Report findings. The examiners have also addressed places where additional information is needed or where the examiners have concerns regarding Cigna's proposed method of compliance with the required corrective actions. The response also notes where changes have been made to the Report.

2. **Restitution Spreadsheets**

   For CAP Item Numbers 8, 25, 26, 28, 34, 35, 40, and 42, Cigna is required to make restitution. Upon completion of restitution, Cigna must complete and provide each of the attached spreadsheets listed below. Please note that some of the spreadsheets have an additional tab to track remediation associated with specific Review Sheets.

   a. **CAP Item Number 8** - Additional Fee Schedule Payments

   b. **CAP Item Number 25** – Payment of Claims Not Yet Submitted Due to Subrogation

   c. **CAP Item Number 26** – Payment of Interest

   d. **CAP Item Number 28** – Refund Excess Coinsurance and Deductibles

e. **CAP Item Number 34** – Additional Payments for Medicare Estimation Claims

f. **CAP Item Number 35** – Payment of Claims Not Paid in Accordance with Policy

g. **CAP Item Numbers 40 and 42** – Refund Excess Out-of-Pocket Amounts

Cigna may include additional fields in these spreadsheets as needed for clarification, but the attached spreadsheets specify the minimum information that must be included.

3. A Revised Copy of the Report

The revised Report reflects places where the examiners made revisions to reflect findings that have been removed or other corrections. Please note that revisions are noted by the word "REVISED" included on the footer of the applicable pages.

In response to the BOI's correspondence, Cigna must provide the following on or before March 17, 2023:

- Acknowledgement that the entire corrective action plan will be completed no later than June 30, 2023.

- A chart that includes each individual CAP Item Number, the required corrective action, Cigna's method of compliance, and the completion date (anticipated date if not yet completed). For CAP Items that do not require restitution, Cigna should outline the steps taken or to be taken to comply with each CAP Item, including procedural changes, system changes, personnel training, implementing controls, oversight processes, etc.

On or before June 30, 2023, Cigna must provide the following:

- Documentation of all completed CAP Items.

- Completed CAP restitution spreadsheets, as referenced in Number 2 above.

The update provided by Cigna on or before March 17, 2023, and the documentation provided on or before June 30, 2023, should address the BOI's concerns and requests for additional information referenced in the BOI's response (Number 1 above).

If you have any questions or need any additional information, please do not hesitate to contact me.

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Market Conduct Examination Report
BOI Response
Cigna Health and Life Insurance Company (Cigna)

The examiners have received and reviewed Cigna's November 30, 2022, response and Cigna's additional January 13, 2023, response to the Draft Report, along with the documentation provided in Cigna's Appendix A. The BOI acknowledges Cigna's cooperation to implement corrective actions and the steps the Company has already taken. This response addresses Cigna's concerns and proposed corrective actions for each area of review in the same order as presented in the Draft Report. Please note that this response only addresses situations where Cigna has expressed disagreement with the findings in the Draft Report or where the examiners have comments or concerns regarding Cigna's responses.

SECTION V. PROVIDER CONTRACTS REVIEW

CAP Item Numbers 1, 3, 4, 5, and 6 (Required Contract Provisions)

Behavioral Health

Please provide documentation of the update made to the Behavioral Health Provider Administrative Guide on September 1, 2021, including a copy of the Provider Administrative Guide with the required provisions highlighted and an example of the notification given to the providers.

Medical

Please provide documentation of the updates added to the medical provider contracting tool and templates on June 3, 2021, including a copy of the templates with the required provisions highlighted. In addition, please confirm that this update has been incorporated into all existing medical contracts and provide an example of the notification given to the providers.

Please also explain how Cigna will ensure any required updates are included in these contracts going forward.

Dental

Please provide documentation of the updates to the Dental Office Reference Guide and the updated filing of the provider contract with prescriber notices that was anticipated to take place by December 31, 2022, including copies of these documents with the required provisions highlighted and an example of the notification given to the providers.

Please also explain how Cigna will ensure any required updates are included in these contracts going forward.

Pharmacy

Please explain how Cigna will ensure any required updates are included in these contracts going forward.

CAP Item Number 2 (Pharmacy Fee Schedules)

The BOI acknowledges the termination of Cigna's relationship with OptumRx and that pharmacy claims now process utilizing Express Scripts (ESI) pharmacy contracts. However, please explain how Cigna and ESI ensure that its fee schedules are incorporated into the contracts and that required notice is provided for any amendments.

SECTION VI. PROVIDER CLAIMS REVIEW

CAP Item Number 7 (Fee Schedule Payments)

The BOI continues to disagree with Cigna's position. Cigna was cited for 20 violations for the failure to pay claims in accordance with the fee schedules incorporated into the provider contracts. The provider contracts included one set of methodology, but the claims in question were not paid in accordance with this methodology. Cigna provided spreadsheets to document how the claims were reimbursed and stated that this methodology is available to the provider any time, but Cigna failed to include any documentation showing that the methodology in these spreadsheets was made part of the provider contracts. Cigna's response to the Report also fails to include any new documentation of its assertion, and the examiners would also note that Cigna agreed with 9 of these violations during the examination.

Cigna must explain how it will take steps to ensure claims are paid in accordance with the fee schedule incorporated into the contract.

CAP Item Number 8 (Adjusting Underpaid Provider Claim Review Sheets)

The BOI continues to disagree with Cigna regarding the reimbursement of the Provider Claims referenced in Review Sheets PCCL03-JM, PCCL04-JM, and PCCL11-JM. Cigna needs to provide documentation of how these claims were paid according to the appropriate fee schedule if it wishes for its argument to be considered. This documentation should include a step-by-step breakdown of any reimbursement methodology incorporated into the contract and applied to each claim, and Cigna is advised that it will need to demonstrate that the exact dollar amount or specific calculation is incorporated into the contract. The examiners also note that Cigna agreed with observations in Review Sheet PCCL11-JM during the examination.

Based on the provided response from Cigna, no changes to the Report are necessary, and Cigna must adjust and pay the claims in question according to the fee schedule incorporated into the contract with required interest.

SECTION VII. POLICY FORMS REVIEW

CAP Item Number 9 (Policy Forms Filed and Approved)

Individual Business

Please provide documentation of the guidance that was provided to the policy drafter in March of 2022, the system that was implemented in January of 2021 to automate the filed/approved forms, and the process that was established in November of 2022 to ensure changes are facilitated properly.

Regarding the policy specifications page update that is expected during the first quarter of 2023, please provide documentation of this update.

While Cigna's response references Review Sheets PF02-JA and PF03-JA, Cigna also needs to confirm that the changes completed and anticipated will resolve any other issues with individual policies being modified beyond the permitted variability, including but not limited to the issues identified in Review Sheets PF10-JA and PF11-JA.

Large Group Business

Please document the compliance controls Cigna currently has in place to ensure that only approved language is included in its policies. Cigna will also need to provide a specific effective date for the new controls it will implement going forward and provide documentation of those controls upon completion.

The BOI will address the proposed remediation plan in its response to CAP Item Number 10.

CAP Item Number 10 (Identify and File Forms for Approval)

Individual Business

The BOI acknowledges the corrective actions taken by Cigna and agrees that individual policies issued during the examination time frame do not need to be reissued.

Large Group Business

The BOI is agreeable to Cigna's proposed solution of performing a full audit and submitting a remediation plan no later than March 31, 2023. Please proceed with this corrective action, and upon submitting any necessary filings Cigna should ensure it responds promptly to any objections or questions from the Forms section of the BOI.

CAP Item Numbers 11 and 12 (Filing and Approval of EOBs)

The BOI is agreeable to Cigna's proposed solution of including any identified EOBs not yet filed and approved by the Commission in the remediation plan referenced in CAP Item Number 10.

In addition to identifying EOBs and filing for approval, Cigna also needs to explain how it will ensure EOBs are filed with and approved by the Commission going forward.

SECTION X. UNDERWRITING REVIEW

CAP Item Number 14 (Required NIP Form Disclosures)

Please provide a copy of the updated NIP form with the corrected language specific to Review Sheet UN01-JA highlighted.

In addition, please explain how Cigna has taken steps to ensure its NIP form(s) comply with all requirements set forth in § 38.2-604 of the Code going forward.

SECTION XII. CANCELLATIONS REVIEW

CAP Item Numbers 15 and 16 (Allowing Required Grace Period)

Please document how Cigna has remediated its termination for nonpayment process and provide a copy of Cigna's past due notice demonstrating how the correct cancellation date will display.

SECTION XIII. REVIEW OF COMPLAINTS, INTERNAL APPEALS, & EXTERNAL REVIEW

CAP Item Number 17 (Follow Approved Complaint System)

Please provide documentation of each of the referenced actions taken by the process improvement teams to ensure that Cigna follows its established complaint system approved by the Commission.

SECTION XIV. CLAIMS REVIEW

CAP Item Number 19 (EOBs for Provider Discount Arrangements)

Regarding the provider discount arrangement EOB issue, please provide documentation of the revised EOB language to reflect "discount" instead of "network."

As Cigna has provided a response to multiple CAP Items that are beyond the scope of CAP Item Number 19, please note the following:

- The BOI will address the Administrative Letter 2016-09 policy forms language issue in our response to CAP Item Number 38.

- The BOI will address the External Prosthetic Appliance EOB issue in our response to CAP Item Number 41.

- The BOI will address the EOB issue regarding displaying the correct provider of service in our response to CAP Item Number 20.

- The BOI will address the administrative fees/member liability EOB issue in our response to CAP Item Number 22.

CAP Item Number 20 (Display Correct Provider on EOBs)

Cigna indicated in its response to CAP Item Number 19 that it will "…modify the vendor-processed claims to accurately display the names of the participating providers of service within an IT project implementing Q4 2023."

The proposed time frame for completing this corrective action in "Q4 2023" is not acceptable, and it does not appear that Cigna would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

CAP Item Number 21 (Prompt, Fair and Equitable Claim Settlement)

The BOI is agreeable to Cigna's proposed solution of providing training to claims processors no later than February 28, 2023 to ensure claims are adjudicated in accordance with policy provisions. Please provide documentation of this training.

The BOI has reviewed the documentation provided in Appendix A, and the violations of § 38.2-510 A 6 of the Code have been removed regarding Review Sheets CL71-AF, CL83-AF, and CL85-AF. The Report has been revised to reflect these changes.

CAP Item Number 22 (EOB Method of Benefit Calculation)

Cigna states in this CAP Item that several items "…will be addressed with a current IT Project with a projected implementation date of Q4 2023: EOB rounding percent issue, Provider Discount field, Proclaim code editing for member liability, Amount not covered for saving achieved, and the zero billed line items."

Cigna stated in CAP Item Number 19 that it "…will also modify the vendor-processed claims to reflect the accurate member liability by removing the administration fees from the claim submission. This work will be accommodated in the Q4 2023 IT implementation."

The proposed time frame for completing this corrective action in "Q4 2023" is not acceptable, and it does not appear that Cigna would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

Regarding the Medicare estimation issue, please explain and document the specific findings that were updated and effective April 4, 2022. In addition, Cigna must confirm that it is no longer estimating Medicare for individual plans, as this provision was removed from Cigna's policy forms for plans issued on January 1, 2023.

CAP Item Number 25 (Subrogation Claims Remediation)

The BOI is agreeable to Cigna's proposed solution of a target mailing date of January 15, 2023 and to the proposed check language. Please provide an example of the notification

sent to the providers, and please provide the amount of time that Cigna intends to give providers to submit these claims.

CAP Item Number 26 (Interest Payments)

The BOI is agreeable to Cigna's proposed solution to identify claims where interest is due by March 31, 2023 and is agreeable to Cigna's proposed check language.

Regarding Cigna's efforts to correct the interest payments in Review Sheets CL34-AF, CL50-AF, CL52-AF, CL59-AF, CL61-AF, CL62-AF, CL76-AF, CL78-AF, CL86-AF, CL87-AF, CL88-AF, CL90-AF, CL91-AF, CL92-AF, CL95-AF, CL96-AF, CL99-AF, CL109-AF, CL111-AF, CL112-AF, CL118-AF, CL131-AF, and CL01-LG, the examiners have reviewed the documentation provided in Appendix A and in Cigna's January 27, 2023, additional email and verified that Cigna has now paid the required interest.

Upon review of the additional documentation provided in Appendix A, it appears that Cigna still owes additional interest on the claims referenced in CL113-AF, and CL129-AF. Cigna must provide step-by-step calculations and supporting documentation for each of these claims.

Regarding CL05-AF, the examiners are unable to determine how the additional interest payment was calculated. Please provide a step-by-step calculation, including clarification of what Cigna considers to be the receipt of proof of loss and an explanation of any supporting documentation provided.

Please also ensure that Cigna pays interest on the claims discussed in Review Sheets CL01-JA, CL09-JA, and CL17-LK, which are not specifically addressed in Cigna's response.

The BOI has reviewed the documentation provided in Appendix A, and the violations of § 38.2-3407.1 B of the Code regarding Review Sheets CL58-AF, CL60-AF, and CL71-AF, and CL119-AF have been removed. The Report has been revised to reflect these changes.

The BOI continues to disagree regarding Review Sheet CL100-AF. It does not appear that any new documentation is included in Appendix A that was not previously provided to the examiners, and Cigna has not provided any additional explanation or context for why the findings should be removed. The Report appears correct as written.

CAP Item Number 27 (Correct Interest Calculation)

The BOI acknowledges Cigna's efforts to update the Facets claim system's interest calculation. Please provide documentation of this update, and document any other steps Cigna has taken to ensure the correct payment of interest going forward.

CAP Item Numbers 28 and 29 (Excess Coinsurance & Deductible Amounts)

Please document the changes Cigna has made to its reimbursement structure and method to calculate cost share for home health, durable medical equipment, chiropractic, and radiology services, as indicated in the Company's initial response to this CAP Item.

The examiners have also reviewed Cigna's additional response provided via email on January 13, 2023. The BOI is agreeable to Cigna's proposed solution to estimate the rate for the vendors' sub-contracted providers for the impacted claims.

However, the BOI is not agreeable to Cigna's proposal that it will complete the remaining pieces of CAP Item Numbers 28 and 29 by "End of Q3 2023" and "no later than January 1, 2024," respectively. These time frames are not acceptable, and it does not appear that Cigna would need this amount of time to remediate issues that the Company was made aware of over a year ago. Cigna must complete these CAP Items by the end of the second quarter of 2023.

CAP Item Number 30 (EOB Deductible & Out-of-Pocket Accumulators)

Regarding Cigna's IT implementation that is anticipated in "Q4 2023," this time frame is not acceptable, and it does not appear that Cigna would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

CAP Item Number 31 (Written Claim Denial)

Regarding the "Q4 2023" IT implementation, this time frame is not acceptable, and it does not appear that Cigna would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

Cigna is also advised that this issue impacted claims other than the ones involving claim lines not being received from the vendors. There were also issues identified where claim lines were listed on the EOB, but they were shown with $0.00 paid and no remark code to explain the denial (refer to Review Sheet CL46-LK as an example). Please also provide Cigna's response for how it plans to address these issues.

CAP Item Number 32 (Reasonable Denial Explanation)

The BOI acknowledges Cigna's efforts to address this issue. However, Cigna's assessment appears to be incorrect. The instances of non-compliance regarding 14 VAC 5-400-70 B were not related to the failure to receive denied lines from Cigna's vendors. Please refer to the list of Review Sheets cited for this regulation and provide a response for how Cigna plans to address these issues.

If Cigna still intends to address this issue as part of the "Q4 2023" IT implementation, please be advised that this time frame is not acceptable, and it does not appear that Cigna would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

CAP Item Number 33 (Payment of Claims in Accordance with Policy)

The BOI is agreeable to Cigna's proposed solution to communicate and ensure necessary training is provided no later than February 28, 2023. Please provide documentation of

this training upon completion.

Regarding Medicare Eligibility, please provide documentation of the updated process. In addition, as the BOI required carriers to remove Medicare estimation language from 2023 individual policies due to recent CMS guidance, please confirm that Cigna no longer estimates Medicare for members that are eligible due to age but not enrolled.

The BOI has reviewed the documentation provided in Appendix A, and the instances of non-compliance regarding 14 VAC 5-400-70 E for CL71-AF and CL01-LK have been removed. The Report has been revised to reflect these changes.

CAP Item Number 34 (Reprocess Medicare Estimation Claims)

The BOI is agreeable to Cigna's proposed solution of identifying claims by January 30, 2023. Cigna will need to provide an anticipated completion date for reprocessings/payments and provide documentation upon completion. The BOI is also agreeable to Cigna's proposed check language.

Please note that CL71-AF and CL01-LK are unrelated to Medicare estimation and were addressed in the BOI's response to CAP Item Number 33.

CAP Item Number 35 (Reprocess Claims in Accordance with Policy)

Regarding Review Sheet CL11-AF, the BOI is agreeable to Cigna's statement in Appendix A that this Review Sheet will be included in the remediation for CAP Item Number 34.

Regarding Review Sheets CL03-JA and CL13-JA, the BOI is agreeable to these Review Sheets being included in the remediation for CAP Item Number 28, as referenced in Cigna's Appendix A.

The BOI has reviewed the documentation provided in Appendix A, and the instance of non-compliance regarding 14 VAC 5-400-70 E for CL71-AF has been removed. No corrective action is needed on this Review Sheet, and the Report has been revised to reflect this change.

CAP Item Number 36 (Ensure EOBs Are Provided Timely)

Cigna has argued that some of the claims in question were received by Cigna from Medicaid. However, Cigna failed to include the names of the Review Sheets it is referring to and failed to include a specific explanation supported by regulation or statute substantiating its position regarding Medicaid. The Report appears correct as written regarding these items.

Cigna is also advised that only some of the claims in question are related to Cigna "not having the denied claim lines," and Cigna will need to refer to the list of Review Sheets cited for 14 VAC 5-400-100 B and explain the corrective action(s) it plans to take.

If Cigna still intends to address this issue as part of the "Q4 2023" IT implementation, please be advised that this time frame is not acceptable, and it does not appear that Cigna

would need this amount of time to remediate an issue that the Company was made aware of over a year ago. Cigna must complete this CAP Item by the end of the second quarter of 2023.

CAP Item Number 37 (Prescription Drug Claims Summary)

Please document the steps Cigna has taken to make the required summary available. This documentation should include copies of the summaries highlighted to show where Cigna has incorporated the elements referenced in Review Sheet CL15-LK.

CAP Item Number 38 (Provider Discount Arrangement EOB & Policy Language)

The BOI acknowledges Cigna's efforts to correct its EOB language. As the BOI addressed this revision in CAP Item Number 19, our response to CAP Item Number 38 will speak to the required policy language.

Please explain how Cigna has addressed the requirements that its policy forms clearly define network providers, non-network providers, and non-network providers that participate in a provider discount arrangement and accurately describe the member's benefits and responsibilities when utilizing each type of provider, as required by Administrative Letter 2016-09.

CAP Item Number 39 (Clear & Accurate Out-of-Pocket Accumulations on EOBs)

The BOI acknowledges Cigna's efforts to correct the findings in CL01-AF.

Regarding the accumulators for External Prosthetic Appliances, please explain why it will take 1.5 years after approval of the plan document for the updates to "cycle through all renewals…." In addition, please provide the anticipated date of the form filing.

CAP Item Number 40 (Refund Excess Out-of-Pocket Amounts for CL05-AF)

The BOI acknowledges Cigna's efforts to reprocess the claim discussed in Review Sheet CL05-AF. Please provide an explanation of the reprocessing, including amounts initially overcharged, the amount paid to the provider during the reprocessing, documentation of the initial claim that was overcharged compared to the reprocessing, and an explanation of how interest was calculated.

CAP Item Number 41 (Clear & Accurate Display of "Per Visit Deductible")

As also referenced in the BOI's response to CAP Item Number 39, please explain why it will take 1.5 years after approval of the plan document for the updates to "cycle through all renewals…." In addition, please provide the anticipated date of the form filing.

CAP Item Number 42 (Refund Excess Out-of-Pocket Amounts)

Regarding Cigna's proposed solution to "have volume timelines by end of Q2 2023" and the statement that "impacted claims may be delayed in Proclaim due to system availability for claims older than 2 years," these time frames are not acceptable. It does not appear that Cigna would need this amount of time to remediate an issue that the Company was

made aware of over a year ago. Cigna must complete this CAP Item and provide all of the required refunds by the end of the second quarter of 2023.

The BOI is agreeable to the proposed check language.

CAP Item Number 43 (MHPAEA Financial Requirements & QTLs)

The BOI acknowledges Cigna's efforts to revise its Financial Requirement/QTL testing for individual plans. Please provide documentation of these changes.

In addition, please explain how Cigna has corrected this issue for its Large Group plans, to include documentation.

Summary

A copy of the entire Report with the revised pages noted is attached for your review, and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that Cigna violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, § 38.2-510 A 6, and § 38.2-514 B of the Code, in addition to 14 VAC 5-90-40 and 14 VAC 5-90-90 C of Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-70 A, 14 VAC 5-400-70 E, 14 VAC 5-400-100 B, and 14 VAC 5-400-100 C of Rules Governing Unfair Claim Settlement Practices.

It also appears that Cigna violated §§ 38.2-316 A, 38.2-316 C 1, 38.2-604 B 4, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.3 A, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15:1 B 1, 38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3, 38.2-3407.15:1 B 4, 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, 38.2-3407.15:1 B 9, 38.2-3407.15:1 C, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 3, 38.2-3407.15:4 C 1, 38.2-3407.15:4 C 3, 38.2-3412.1 B, 38.2-5804 A, and 38.2-5804 A 1 of the Code, in addition to 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review.

Jessica Kearney
Legal Compliance Senior Manager
859.339.6252
Jessica.Kearney@Cigna.com

March 17, 2023

VIA EMAIL

Julie R. Fairbanks, BOI Manager
Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219

RE: Cigna Health and Life Insurance Company, Inc.
Market Conduct Examination Exposure Draft Report

Dear Ms. Fairbanks:

Thank you for the March 2, 2023 response to the Draft Report Responses submitted by Cigna Health and Life Insurance Company, Inc. (CHLIC) on November 30, 2022 and January 13, 2023. The following response addresses only those items where Cigna continues to disagree with the findings and/or corrective action items in the Draft Report.

SECTION VI. PROVIDER CLAIMS REVIEW
CAP Item Number 7 (Fee Schedule Payments)

Cigna continues to respectfully disagree with the alleged violations cited by the Virginia Bureau of Insurance that the Company failed to pay claims in accordance with the fee schedule as required by § 38.2-3407.15 B 8 of the Code.

Review Sheet PCCL03-JM (related to VA BOI Provider Contract Item #6)
As more fully set forth below, the provider's contract explicitly incorporates the Cigna fee schedule by reference.

The Provider Services Agreement states that Cigna will reimburse the provider at the lesser of billed charges or the applicable fee under an identified exhibit. (BOI Item 6, Provider Services Agreement at Section 3 ("Payments for Covered Services will be the lesser of your billed charge or the applicable fee under Exhibit B, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles.")).

Exhibit B contains the reimbursement methodology applicable to this provider, and explicitly incorporates the Cigna fee schedule by reference as part of that methodology. (BOI Item 6, Provider Services Agreement at Ex. B.II ("Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles, and Coinsurance.")).

For the foregoing reasons, Cigna maintains its objection to CAP #7.

Review Sheet PCCL04-JM (related to VA BOI Provider Contract Item #7)
As more fully set forth below, the provider's contract explicitly incorporates the Cigna fee schedule by reference.

The Ancillary Services Agreement states that Cigna will reimburse the provider at the lesser of billed charges or the applicable fee under an identified exhibit. (BOI Item 7, Ancillary Services Agreement at Section 4.1 ("Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A, subject to the Payment Policies and minus any applicable Copayments, Coinsurance and Deductibles.")).

Exhibit A contains the reimbursement methodology applicable to this provider, and explicitly incorporates the Cigna fee schedule by reference as part of that methodology. (BOI Item 7, Amend. Ex. A. ("Provider shall accept as full and final payment for Covered Services provided to Participants the lesser of billed charges or the reimbursement specified in this Exhibit… All other charges will be reimbursed at the lesser of billed charges or Cigna's Maximum Fee Schedule in place at the time of service less applicable Copayments, Deductibles, and Coinsurance.")).

For the foregoing reasons, Cigna maintains its objection to CAP#7.

Review Sheet PCCL11-JM (related to VA BOI Provider Contract Item #5)
As more fully set forth below, the provider's contract explicitly incorporates the Cigna fee schedule by reference.

The Provider Services Agreement states that Cigna will reimburse the provider at the lesser of billed charges or the applicable fee under an identified exhibit. (BOI Item 5, Provider Services Agreement at Section 3.1 ("Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit C, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles.")).

Exhibit C contains the reimbursement methodology applicable to this provider, and explicitly incorporates the Cigna fee schedule by reference as part of that methodology. (BOI Item 5, Provider Services Agreement at Ex. C.II.C ("[S]uch Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles, and Coinsurance.")).

For the foregoing reasons, Cigna maintains its objection to CAP#7.

CAP Item Number 8 (Adjusting Underpaid Provider Claim Review Sheets)

CAP #8 is secondary to CAP #7, with which Cigna continues to respectfully disagree, as stated above.

Cigna has validated the billed services were paid according to the appropriate fee schedules, and therefore Cigna does not agree that the claims should be reprocessed (except for those associated with Review Sheet PCCL11-JM (related to VA BOI Provider Contract Item #5), where Cigna previously partially agreed).

It should also be noted that Cigna's partial agreement in Review Sheet PCCL11-JM that claims were paid incorrectly was due to the billing provider (contracted through a provider group) inadvertently being tied to an incorrect agreement within Cigna's contracting system.

CAP Item Number 26 (Interest Payments)

CL100-AF: Cigna continues to respectfully disagree with the examiner's comments. Additional explanation is being provided with this response; documentation attached (see CAP Item Number 26 Revised Draft Response).

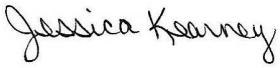
Additionally, as required by the Virginia Bureau of Insurance Response to the Draft Examination Report letter dated March 2, 2023, Cigna acknowledges the request of the Bureau for Cigna to complete all corrective actions by June 30, 2023. All efforts are being put forth to meet the requested

deadline, as noted in the attached chart which includes the CAP Item Number, required corrective action, Cigna's method of compliance, and the completion date or anticipated completion date, if not yet completed.

CHLIC appreciates the opportunity to respond to the market conduct examination Draft Report. If helpful, CHLIC is also willing to discuss further any of the remaining violations or corrective actions included in this response.

If you have any questions regarding information provided with this response, please do not hesitate to contact me.

Best Regards,



Jessica Kearney
Legal Compliance Senior Manager

Enclosures: CAP Item #26_Revised Draft Response
Revised Draft Report_Cigna Response_3.17.23

Copy to: Julie Blauvelt
Brant Lyons

Jessica Kearney
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March 31, 2023

VIA EMAIL

Julie R. Fairbanks, BOI Manager
Market Conduct Section
Life and Health Division
Virginia Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219

RE: Cigna Health and Life Insurance Company, Inc.
Market Conduct Examination Exposure Draft Report

Dear Ms. Fairbanks:

In follow-up to Cigna's March 17, 2023 response to the Revised Draft Report, Cigna respectfully submits the following updates and request, specific to corrective actions items #10, #11, and #43:

Corrective Action Items #10 and #11

As Cigna indicated in its 3/17/23 response pertaining to Corrective Action Item #11, Cigna included Explanations of Benefits (EOBs) identified as not yet filed and approved by the Commission, in the remediation plan referenced in corrective action #10, which was submitted to the Virginia Bureau of Insurance (VA BOI) on March 3, 2023. Cigna submitted via SERFF (SERFF tracking #CCGH-133559553), the EOBs utilized during the time period of the exam and currently in use that had not yet been filed with the Commission, as required by § 38.2-3407.4 A of the Code. The submitted EOBs have been disapproved by the VA BOI.

In efforts to remedy Corrective Action Item #11, Cigna respectfully requests that it be permitted to withdraw the EOBs from the submitted remediation filing, and once all corrections have been implemented for the EOBs as required in Corrective Action Items #19, #20, #22, #30, #31, #32, #36, #39, and #41, Cigna will file for approval its revised EOBs to meet the requirements of Corrective Action Item #11 and the VA BOI EOB checklist requirements.

As noted in Cigna's March 17, 2023 response, Cigna is putting forth all efforts to have the EOB corrections implemented on or before the June 30, 2023 due date.

Corrective Action Item #43

Please see below steps being taken by Cigna to ensure that mental health and/or substance use disorder (“MH/SUD”) benefits and Medical/Surgical benefits are recognized based on the condition or disorder being treated, including recognizing services that are both Medical/Surgical benefits and MH/SUD benefits, for purposes of financial requirement/QTL analysis, as required by § 38.2-3412.1 B of the Code.

Individual market: Cigna initiated a project to implement several corrective actions for its plans offered in the individual market in the state of Virginia, related to the categorization and treatment of

MH/SUD services under these plans. In particular, this project established claims processing guidelines to ensure that a claim for any service that has a primary diagnosis that is MH/SUD will be categorized and treated as MH/SUD, regardless of the service performed. For example, a claim for physical therapy, occupational therapy, or speech therapy may be considered either medical or MH/SUD, depending on the primary diagnosis listed on the claim. Where a claim for a service is considered MH/SUD, the claim will be processed accordingly, subject to the applicable MH/SUD type and level of cost-sharing under the plan. In addition to the correct application of cost-sharing for enrollees under the plan, these efforts include changes to Cigna's MHP cost-share testing tool, which uses claims dollars to perform financial requirements (cost-share) testing on all plans. Since the tool uses medical/ surgical claims in order to determine the permissible type and level of cost-sharing that may be applied to MH/SUD claims, there were updates required in order to ensure claims were appropriately included for testing based on diagnosis.

This project had significant impacts to many different areas of the company, including individual and family plans ("IFP") rate filing, sales and underwriting, pricing, product, contract language, plan automation, service operations (including claims, appeals, calls, contracts, and correspondence), provider reimbursement, medical pricing, and more. It began in April 2022 and was completed in June 2022. The documentation of the project we are submitting includes: (1) an internal project presentation, as well as (2) a detailed technical document that describes Cigna's claims specifications or rules for reconfiguring claims. In short, the presentation sets forth the background and objectives, the scope, and a timeline at the outset of the project; the other document, while technical in nature, is the best description and summary that we have of the final work completed re: updating how claims are adjudicated (as medical/ surgical vs. MH/SUD) based on diagnosis.

Large group market: Cigna initiated a project to implement several corrective actions for its plans offered in the large group market in the state of Virginia, related to the categorization and treatment of mental health and/or substance use disorder ("MH/SUD") services under these plans. The outcome and goals of this project are similar to the individual market/ IFP efforts described above, except that this project is larger in scope, making similar changes across Cigna's entire commercial book of business, including claims for the large group market and not just IFP, and including all states and jurisdictions, not limited to Virginia.

Internally, Cigna has been working to make these changes through its "Mental Health Parity Administration" project, sometimes referred to informally as the MHP "pay by diagnosis" project. These efforts are being managed by an Enterprise Project Delivery Team, targeting implementation to be complete no later than October 2023. The timeline currently has requirements and analysis to be completed in May, templates and decision support tools for cost-sharing configuration to be completed by August 1, 2023 and the technical solution to identify impacted claims by October. Plan documentation and materials, including benefit summaries and SBCs, will be updated for plans renewing during the 2024 plan year. The language updates should be effective for self-funded (ASO) plans for their 2024 renewals; for insured plans, the language must be filed in each state and we are subject to state regulatory approvals before we can use it, but this will be completed as soon as possible, and the claims administration part of the project is projected to be completed before 2024 begins.

We would note that this project is still at an earlier stage and there isn't as robust documentation developed yet. The documentation that we are submitting includes: (1) a slide that outlines the project and timeline; (2) a Program Increment ("PI") document showing the timeline for the project broken down by business unit; and (3) a sample of the language we will be including in our certificates and SBCs, still in draft form right now, but for use for the 2024 plan year.

As previously offered, and if helpful, CHLIC is available to discuss further any of the violations or corrective actions noted in the Revised Draft Report. If you have any questions regarding the updates provided, please contact me at 859.339.6252 or via email at Jessica.Kearney@Cigna.com.

Best Regards,

Jessica Kearney

Jessica Kearney
Legal Compliance Senior Manager

Enclosures: MHPA Pay by Diagnosis
MHPA PI Forecast 2022 – 2023
Plan Document Edits FINAL REVISED 3.24.23
SCTASK3836950 - IFP VA MHSUD overrides
VA IFP Tactical Solution_ Leadership Kickoff_ 7th April2022

Copy to: Julie Blauvelt
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May 10, 2023

VIA ELECTRONIC MAIL

Jessica Kearney
Market Conduct, Legal Compliance Senior Manager
Cigna Enterprise Compliance & Regulatory

RE: Response to the Draft Examination Report
Cigna Health and Life Insurance Company (Cigna)

Dear Ms. Kearney:

The examiners have received and reviewed Cigna's March 17, 2023, correspondence, including the CAP update, documentation, and additional response to the Draft Report, as well as Cigna's additional update and request provided on March 31, 2023. The BOI is providing a revised copy of the Draft Report and the following responses:

COMPANY DISAGREEMENTS

This section of the response addresses Cigna's additional disagreements with the findings or corrective actions for each area of review in the same order as presented in the Draft Report.

SECTION VI. PROVIDER CLAIMS REVIEW

CAP Item Number 7 (Fee Schedule Payments)

The BOI continues to disagree with Cigna's position. Section 38.2-3407.15 B 9 of the Code (formerly B 8 during the examination time frame) requires the provider contract to **attach at the time it is presented** to the provider for execution (i) **the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid** that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) **all material addenda, schedules, and exhibits thereto** and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

The examiners' additional responses regarding how Cigna failed to comply with this requirement in the specific Review Sheets are outlined as follows:

Review Sheet PCCL03-JM (related to VA BOI Provider Contract Item #6)

Cigna has argued that Exhibit B of the provider contract "…contains the reimbursement methodology applicable to this provider, and explicitly incorporates the Cigna fee schedule by reference as part of that methodology." However, Exhibit B includes no information regarding fee schedule reimbursement/methodology other than broad reference that "Covered Services will be reimbursed at…the applicable fee under the Cigna Standard Fee Schedule…." The only fee schedule documented in the contract is on page 29 of the provided PDF, and Cigna reimbursed the claims in question at lower allowable amounts than those specified in this fee schedule. Cigna also stated in its Review Sheet responses that the fee schedule it actually used is merely "shared with the provider during contracting" and "not typically included in the base agreement and subsequent amendments." As the fee schedule used by Cigna is not incorporated into the contract, Cigna has failed to reimburse claims in accordance with the provider contract's fee schedule.

Review Sheet PCCL04-JM (related to VA BOI Provider Contract Item #7)

Cigna has argued that Exhibit A of the provider contract "…contains the reimbursement methodology applicable to this provider, and explicitly incorporates the Cigna fee schedule by reference as part of that methodology." However, Exhibit A states that payment will be based on "the reimbursement specified in this Exhibit" and "Cigna's Maximum Fee Schedule in place at the time of service" for "other charges." For this contract, the exhibit does include a list of CPT codes and allowable amounts. However, the claim in question involved a CPT code not listed on this fee schedule, and Cigna reimbursed this CPT code based on a fee schedule that was not documented in the contract. When asked by the examiners how this fee schedule was incorporated into the contract, Cigna again stated that the fee schedule is merely "shared with the provider during contracting" and "not typically included in the base agreement and subsequent amendments." As the fee schedule used by Cigna is not incorporated into the contract, Cigna has failed to reimburse claims in accordance with the provider contract's fee schedule.

Review Sheet PCCL11-JM (related to VA BOI Provider Contract Item #5)

Cigna has acknowledged in its response for CAP Item Number 8 that the claims in question were paid incorrectly due to being "inadvertently tied to an incorrect agreement within Cigna's contracting system." While the cause of these underpayments is different than the issues discussed in PCCL03-JM and PCCL04-JM, Cigna's processing of these claims is still in violation of § 38.2-3407.15 B 8 of the Code for the failure to reimburse claims in accordance with the provider contract's fee schedule. In addition to correctly incorporating its fee schedules into the contract, Cigna must ensure that it loads its contracts and fee schedules correctly into the system.

Cigna has now been given 4 chances to respond regarding Review Sheets PCCL03-JM and PCCL04-JM and 3 chances to respond regarding PCCL11-JM. Of note, Cigna has failed to provide documentation of its fee schedules that are "available online" being specifically incorporated into or attached to the contract. As Cigna has failed to provide an adequate explanation after multiple attempts, the Report is correct as written and Cigna must take the specified corrective action. Compliance with this CAP Item appears to be as simple as including a link to Cigna's online fee schedule in its contracts, as well as confirming that required notice will be given to the provider when Cigna amends these fee schedules. Cigna will not be given any additional opportunities to respond for reconsideration of the findings.

Cigna must explain how it will take steps to ensure claims are paid in accordance with the fee schedule incorporated into the contract.

CAP Item Number 8 (Adjusting Underpaid Provider Claim Review Sheets)

As described in the CAP Item above, the BOI continues to disagree with Cigna regarding the reimbursement of the Provider Claims referenced in Review Sheets PCCL03-JM, PCCL04-JM, and PCCL11-JM. Cigna must adjust and pay the claims in question according to the fee schedule incorporated into the contract with required interest.

However, as the CPT code in question for the claim in PCCL04-JM was not listed on the fee schedule incorporated into the contract, there is no additional payment owed. The Report has been revised to remove this Review Sheet from CAP Item Number 8, but Cigna still needs to incorporate the fee schedule it uses into this contract as required in CAP Item Number 7.

SECTION XIV. CLAIMS REVIEW

CAP Item Number 26 (Interest Payments)

The examiners have reviewed Cigna's additional explanation in the attachment titled "CAP Item #26 Revised Draft Response," and the violation of § 38.2-3407.1 B of the Code regarding Review Sheet CL100-AF has been removed. The Report has been revised to reflect this change.

ADDITIONAL DOCUMENTATION OF COMPLETED INTEREST REMEDIATION

The examiners have reviewed the additional documentation and explanations provided in Cigna's enclosures, and the information is sufficient for the BOI to confirm that Cigna has now completed restitution for the specific Review Sheets referenced in CAP Item Number 26.

Please ensure that Cigna still includes information regarding these Review Sheets when the Company provides the completed Restitution Spreadsheet for CAP Item Number 26.

UPDATE PROVIDED ON MARCH 17, 2023

The examiners acknowledge that Cigna has agreed to complete the CAP within the specified time frame. The examiners expect Cigna to complete all CAP Items, including CAP Item Number 43, by June 30, 2023, and Cigna must provide periodic updates until the final CAP Item is completed.

In addition, an initial review of Cigna's provided chart of CAP updates appears to show that Cigna has still not addressed all of the requirements of the CAP. For example, the following deficiencies are still present:

- The BOI's response dated March 2, 2023, reminded Cigna to explain how it would ensure any required updates are included in the Medical, Dental, and Pharmacy contracts going forward for CAP Item Numbers 1, 3, 4, 5, and 6 (for example, how are contracts reviewed to ensure new statutory requirements/provisions are incorporated going forward?). However, Cigna's provided chart fails to address this information.

- The BOI's response dated March 2, 2023 required Cigna to provide documentation of the "updated filing of the provider contract" regarding Dental contracts, as referenced by Cigna in its November 30, 2022 response to the Draft Report for CAP Item Numbers 1, 3, 4, 5, and 6. Despite the fact this request was based on terminology provided by Cigna, the Company's provided chart now states "Cigna has not submitted these documents to the Virginia Bureau for review and approval as proposed in the Company's November response; the Company has no record of any such requirement…." It is unclear what Cigna's intended method of compliance is for these CAP Items.

Cigna must provide an updated chart by May 24, 2023, that addresses the bullet points above and the issues addressed in the "COMPANY DISAGREEMENTS" section of this letter. Cigna must also re-review all of the provided information in the chart and update any other deficient responses to ensure that the Company addresses everything in the required CAP Items, as well as the concerns identified BOI's March 2, 2023, response.

UPDATE PROVIDED ON MARCH 31, 2023

Regarding CAP Item Number 11, Cigna has requested that it be permitted to withdraw the EOBs from the submitted remediation filing, and once all corrections have been implemented for the EOBs as required in CAP Item Numbers 19, 20, 22, 30, 31, 32, 36, 39, and 41, Cigna will then file its EOBs to meet the requirements of CAP Item Number 11.

The BOI rejects this request. Cigna cannot continue to use EOBs that have not been filed with and approved by the Commission, and it does not appear that being able to submit the EOB in the required format with variable material bracketed would be dependent upon completion of the other outstanding CAP Items. Cigna must finalize the filing in compliance with the BOI EOB checklist requirements.

If you have any questions or need any additional information, please do not hesitate to contact me.

Very truly yours,

Bryan Wachter, CIE, AIRC, FLMI, MCM
BOI Manager
Health Market Conduct Section
Life and Health Market Regulation Division
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1300 East Main Street
Richmond, VA 23219

RE: Alleged violations of Code of Virginia §§ 38.2-316 A, 38.2-316 C 1, 38.2-604 B 4, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.3 A, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15:1 B 1, 38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3, 38.2-3407.15:1 B 4, 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, 38.2-3407.15:1 B 9, 38.2-3407.15:1 C, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 3, 38.2-3407.15:4 C 1, 38.2-3407.15:4 C 3, 38.2-3412.1 B, 38.2-5804 A, and 38.2-5804 A 1; 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review; the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2 510 A 6 and 38.2-514 B of the Code; 14 VAC 5-90-40 and 14 VAC 5-90-90 C of Rules Governing Advertisement of Accident and Sickness Insurance; and 14 VAC 5-400-70 A, 14 VAC 5-400-70 E, 14 VAC 5-400-100 B, and 14 VAC 5-400-100 C of Rules Governing Unfair Claim Settlement Practices Case No. INS-2024-00064

Dear Ms. Blauvelt:

This will acknowledge receipt of the Bureau of Insurance's ("Bureau") letter dated July 5, 2024, concerning the above-referenced matter.

Cigna Health and Life Insurance Company ("Cigna") wishes to make a settlement offer for the alleged violations cited above. Specifically, we agree to:

1. Enclose with this letter a certified check, cashier's check or money order payable to the Treasurer of Virginia in the amount of $236,900;

2. Comply with, and continue to comply with, the corrective action plan set forth in the examination report;

3. Complete corrective action items 1, 4, 7, 8, 14, 15, 26, 28, 29, 34, 35, 37, 39, 40, and 42 and provide satisfactory documentation of completion thereof to the Bureau by August 1, 2024, or additional penalties may be assessed by the Bureau;

4. Complete corrective action items 22, 30, 31, and 32 and provide satisfactory documentation of completion thereof to the Bureau by December 31, 2024, or additional penalties may be assessed by the Bureau; and,

5. Acknowledge Cigna's right to a hearing before the State Corporation Commission in this matter and waive that right if the State Corporation Commission accepts this offer of settlement.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Sincerely,

Cigna Health and Life Insurance Company

(Signed)

Katie Stewart
(Type or Print Name)

Regional Vice President
(Title)

July 9, 2024
(Date)

Enclosure

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 21, 2024

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CIGNA HEALTH AND LIFE INSURANCE COMPANY,
Defendant

2024 AUG 21 P 2:29

CASE NO. INS-2024-00064

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), the Bureau has alleged that Cigna Health and Life Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia, in certain instances violated §§ 38.2-316 A and 38.2-316 C 1 of the Code of Virginia ("Code") by delivering or issuing for delivery in the Commonwealth insurance policies using application forms that had not been filed with and approved by the Commission; § 38.2-502 (1) of the Code by misrepresenting the benefits, advantages, conditions, or terms of any insurance policy; § 38.2-510 A 6 of the Code by failing to attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear with such frequency as to indicate a general business practice; § 38.2-514 B of the Code by failing to provide to an insured, claimant, subscriber or enrollee, an explanation of benefits which clearly and accurately discloses the method of benefit calculation and the actual amount which has been or will be paid to the provider of services; § 38.2-604 B 4 of the Code by failing to include in the notice required by subsection A of this section, a description of rights established under §§ 38.2-608 and 38.2-609 of the Code and the manner in which those rights may be exercised; § 38.2-1812 A of the Code by paying commission or other valuable

consideration to any person for services as an agent within this Commonwealth that at the time of the transaction out of which arose the right to such commission or other valuable consideration, did not hold a valid license as an agent, for the class of insurance involved; § 38.2-1833 A 1 of the Code by failing to, within 30 calendar days of the date of execution of the first insurance application or policy submitted by a licensed but not yet appointed agent, either reject such application or policy or file with the Commission a notice of appointment in a form acceptable to the Commission; § 38.2-1834 D of the Code by failing to notify the agent of the termination of his/her appointment within five calendar days and the Commission, except as provided in subsection B of this section, within 30 calendar days in a manner acceptable to the Commission; § 38.2-3405 B of the Code by improperly allowing a contract to contain any provision requiring the beneficiary of any such contract or plan to sign any agreement to pay back to any company issuing such a contract or creating a health services plan any benefits paid pursuant to the terms of such contract or plan from the proceeds of a recovery by such beneficiary from any other source; § 38.2-3407.1 B of the Code by failing to pay interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto at the legal rate from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment; § 38.2-3407.3 A of the Code by failing to calculate the insured, subscriber, or enrollee's specified percentage of the cost of covered services based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, subscriber, or enrollee; § 38.2-3407.4 A of the Code by failing to file explanation of benefits forms for approval prior to use; § 38.2-3407.4 B of the Code by failing to provide explanation of benefits that accurately and clearly set forth the benefits payable under the contract; §§ 38.2-3407.15 B 1 - 10 of the Code by failing to include, adhere to, and comply with specific required provisions

related to minimum fair business standards in its provider contracts; §§ 38.2-3407.15:1 B 1 - 9 of the Code by failing to include specific required provisions in carrier contracts with pharmacy providers; § 38.2-3407.15:1 C of the Code by failing to include specific required provisions relating to audits in carrier contracts with pharmacy providers; §§ 38.2-3407.15:2 B 1 - 8 of the Code by failing to include specific required provisions related to prior authorization in its provider contracts; §§ 38.2-3407.15:3 B 2 and 38.2-3407.15:3 B 4 of the Code by failing to include specific required provisions in carrier and intermediary contracts with pharmacy providers; §§ 38.2-3407.15:3 C 1 and 38.2-3407.15:3 C 3 of the Code by failing to include specific required provisions in "[a]ny contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost . . . that require the intermediary or carrier to provide a process for an appeal, investigation, and resolution of disputes regarding maximum allowable cost drug pricing that includes: 1. [a] time period of 14 days from the date of initial claim adjudication for the participating pharmacy provider to file its dispute request . . . [and] 3. [a] telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing dispute requests," §§ 38.2-3407.15:4 C 1 and 38.2-3407.15:4 C 3 of the Code by failing to disclose to an enrollee information relating to the provisions of provider contracts between a health carrier or its pharmacy benefits manager and a pharmacy or its contracting agent and the availability of a more affordable therapeutically equivalent prescription drug and failing to offer and provide direct and limited delivery services to an enrollee as an ancillary service of the pharmacy in accordance with § 54.1-3420.2; § 38.2-3412.1 B of the Code by failing to provide coverage for mental health and substance use disorder benefits in parity with medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008;

§§ 38.2-5804 A and A 1 of the Code by failing to establish and maintain a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints and failing to maintain a record of complaints for no less than five years; as well as 14 VAC 5-90-40 of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* of the Virginia Administrative Code ("Rules"), by failing to disclose required information conspicuously and in close conjunction with the statements to which the information relates and that does not minimize, render obscure, or present in an ambiguous fashion, or intermingle with the context of the advertisement as to be confusing or misleading; Rule 14 VAC 5-90-90 C by failing to identify the source of any statistics used in an advertisement; 14 VAC 5-216-40 E 2 of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.* of the Virginia Administrative Code, by failing to notify the covered person of its post-service claim review final benefit determination decision within 60 days after receipt of the appeal; 14 VAC 5-400-70 A of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.* of the Virginia Administrative Code, by failing to provide a claim denial to a claimant in writing, Rule 14 VAC 5-400-70 E by failing to reasonably pay claims in accordance with the provisions of the policy, Rule 14 VAC 5-400-100 B by failing to provide to an insured, for accident and sickness claims, an explanation of benefits describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy; and Rule 14 VAC 5-400-100 C by failing to make available a summary of prescription drug claims electronically or provide a written summary at the request of the insured, including a description of the amounts covered under the policy, amounts denied, and amounts payable by the insured and insurer.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting or denying any violation of Virginia law, has made an offer of settlement to the Commission. Through its settlement offer, the Defendant has agreed to complete corrective action items 22, 30, 31, and 32 and provide satisfactory documentation of completion thereof to the Bureau by December 31, 2024, or additional penalties may be assessed by the Bureau. The Bureau further notes that the Defendant, through its settlement offer, timely provided documentation currently under review by the Bureau to demonstrate its completion of corrective action items 1, 4, 7, 8, 14, 15, 26, 28, 29, 34, 35, 37, 39, 40, and 42, has tendered to the Treasurer of Virginia the amount of Two Hundred Thirty-Six Thousand and Nine Hundred Dollars ($236,900); and has waived the right to a hearing.

The Bureau has recommended that the Commission accept the Defendant's settlement offer pursuant to the authority granted to the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered this matter, is of the opinion and finds that the Defendant's settlement offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The Defendant's settlement offer is hereby accepted.

(2) The Commission shall retain jurisdiction in this matter for all purposes, including the institution of a show cause proceeding or taking such other action it deems appropriate on account of any failure on the part of the Defendants to comply with the terms of the settlement.

A COPY hereof shall be sent by the Clerk of the Commission by electronic mail to: Jessica Kearney, Market Conduct, Legal Compliance Senior Manager, Cigna Healthcare Legal & Corporate Affairs, jessica.kearney@cignahealthcare.com; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.