CIGNA HEALTHCARE OF MAINE, INC. AND CIGNA BEHAVIORAL HEALTH, INC.
FREEPORT, MAINE

NAIC GROUP CODE - 0901
NAIC COMPANY CODE – 95447

MARKET CONDUCT REPORT OF EXAMINATION AS OF December 31, 2001

Contents

SUMMARY OF FINDINGS AND CONCLUSIONS

(Note: lack of sequence in the above table of contents is due to several examination cycles being removed from the scope of the examination at the direction of the Maine Bureau of Insurance. A recently completed joint review conducted by the Maine Bureau of Insurance and the Maine Department of Human Services, Bureau of Medical Services included several of the examination areas, accordingly, these areas were removed from the scope of this exam to avoid duplication of effort.)

I hereby certify that the attached report of examination dated December 27, 2002 shows the condition and affairs of CIGNA HealthCare of Maine, Inc. and CIGNA Behavioral Health, Inc. of Freeport, Maine as of December 31, 2001 and has been filed in the Bureau of Insurance as a public document.

This report has been reviewed.

_____
Alessandro A. Iuppa
Superintendent
Bureau of Insurance

This _____day of _____, 2004

FOREWORD

This Market Conduct Examination Report of CIGNA Healthcare of Maine, Inc. and CIGNA Behavioral Health, Inc. is, in general, a report by test. The examiners, in writing this report, cited errors the Companies made. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Maine Bureau of Insurance. Statutory cites are as of the period under examination unless otherwise noted. American Express Tax and Business Services, Inc. provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Maine Bureau of Insurance. All statutory citations, case law or any other legal opinions or interpretation included herein are provided by the Maine Bureau of Insurance for inclusion in this report. Assistance in the preparation of this report was provided by certain American Express Tax and Business Services, Inc. personnel in their capacity as Market Conduct Examiners.

Where used in the report:

- "CHC" or "Company" refers to CIGNA Healthcare of Maine, Inc.;
- “CBH” refers to CIGNA Behavioral Health, Inc.

December 27, 2002

Honorable Alessandro Iuppa
Superintendent of Insurance
State of Maine
Bureau of Insurance
State House Station #34
Augusta, Maine 04333

Dear Superintendent Iuppa:

Pursuant to the provisions of Title 24-A, M.R.S.A., Section 221 and in conformity with your instructions, a market conduct examination has been made of

CIGNA Healthcare of Maine, Inc. and CIGNA Behavioral Health, Inc.

at the home office of CIGNA HealthCare of Maine, Inc. in Freeport, Maine. The following report is respectfully submitted.

SCOPE OF EXAMINATION

This examination covers the period from January 1, 2001 through December 31, 2001. The examination was a full scope examination and consisted of a review of the following areas: Company Operations/Management, Complaint Handling, Grievance Procedures, Marketing and Sales, Network Adequacy (CBH only), Producer Licensing, Policyholder Service, Underwriting and Rating and Claims. The areas of Provider Credentialing, Quality Assessment and Improvement and Utilization Review were omitted from the scope of the examination at the direction of the Maine Bureau of Insurance due to a recently completed examination that addressed these areas. The examination was performed in accordance with examination standards and guidelines as set forth in the National Association of Insurance Commissioner's (NAIC) Market Conduct Examiners Handbook, the rules and regulations prescribed by the State of Maine and procedures developed by the Maine Bureau of Insurance (Bureau of Insurance). The examination was performed under the supervision and direction of the Bureau of Insurance.

Each examination area has standards that were measured by the examination team. Some standards have specific statutory guidance, others have specific Company guidelines, and yet others have contractual guidelines.

Various NAIC databases were reviewed and the information was utilized in our examination to the extent deemed appropriate.

For purposes of this report, comments will be made for each Standard in an area reviewed by the examiners and the results of the review will be reported. Exceptions will be noted as part of the comments for the applicable Standard.

While this report contains errors found in individual files, the primary focus of the examination is on the general business practices of the Companies. In this report, examiners used the National Association of Insurance Commissioners published error tolerance rate of seven percent (7%) for claims practices and ten percent (10%) for all other examination areas. An error rate in excess of this tolerance level may be indicative of a general business practice to engage in that type of conduct.

COMPANY PROFILE

Cigna Healthcare of Maine, Inc. (CHC) is a direct wholly owned subsidiary of Healthsource, Inc. and an indirect wholly owned subsidiary of CIGNA Health Corporation (CIGNA Health). CIGNA Health is a wholly owned subsidiary of CIGNA Corporation (CIGNA Corp.). CIGNA Behavioral Health, Inc. (CBH) is a wholly owned subsidiary of Connecticut General Corporation (CGC) and CGC is a wholly owned subsidiary of CIGNA Corp. CIGNA Corp. is one of the largest publicly traded insurance organizations in the United States with total assets in excess of $88 billion and over $5 billion in shareholder equity.

CIGNA Corp. is one of the major providers of employee benefits across the U.S. and throughout the world. CIGNA Corp. offers various products and services including managed medical and dental products, group indemnity health insurance and related services, group life, accident and disability insurance and retirement and investment products and services.

CHC has been assigned an A.M. Best's rating of A- (Excellent) based on the HMO's strong market presence as well as its positioning as a subsidiary of CIGNA Corp. The excellent rating also reflects the fact that CHC has a well diversified product portfolio, a low risk profile, a large membership base, profitability and the strong operating profile and financial strength of the parent.

CHC is licensed solely in the state of Maine and offers a self funded HMO Plan, a traditional commercial group HMO product as well as an individual HMO product, and a point-of-service (POS) product, which may be offered on either an insured or a self-funded basis. Premiums and fees at CHC increased steadily during the late 1990's (peaking in 1998) due to rate increases coupled with increasing membership. However, due to the decrease in membership during 2001 and 2000, premiums and fees declined from previous year end figures. However, the Company did report a profit in 2001 and 2000, after reporting losses for the prior three years, due to the lower medical loss ratio.

Premiums and membership for the last five years for CHC were as follows (in 000s):

Year	Premium	Membership
2001	$ 158,340	65,104
2000	162,169	68,511
1999	172,415	79,125
1998	161,591	88,843
1997	123,196	74,015

CHC's investments are managed to the nature and duration of the liabilities, liquidity needs and appropriate diversification. Following the CIGNA Corp. strategy, the assets of HMO plans are invested primarily in fixed income securities and short term investments.

During 2001, CHC paid no dividends to its parent, Healthsource, Inc. CHC paid $7.4 million in administrative service fees and fees for other services during 2001 to its affiliate CIGNA Health. This was a decrease from the approximately $18.4 million paid to CIGNA Health for these services in 2000. The allocation of these expenses is based on the ratio of the respective expense category to total expenses at the parent company level. Interest was also paid to CIGNA Health in the amount of $31,489 and $175,447 for 2001 and 2000, respectively.

International Rehabilitation Associates, Inc. d/b/a Intracorp (Intracorp) is an affiliate of CHC. Intracorp receives a capitation fee for utilization management, case management, demand management, disease management, care management and other services provided to CHC members. The expense relating to these services for 2001 and 2000 was $13,539 and $0, respectively.

CHC also pays CIGNA Health for liability insurance. During 2001 the cost for the liability insurance was $2,729. This provided protection against liabilities imposed on CHC from allegations of negligence stemming from the management of health care activities.

CBH is an affiliate of CHC and is paid a capitation fee by CHC to provide mental health and substance abuse services to its members. The expenses relating to this agreement for the years ended December 31, 2001 and December 31, 2000 were $4,194,839 and $4,634,887.

CBH was founded in 1974 and is located in Minneapolis, Minnesota. CBH offers an array of managed behavioral health care benefit management services and work/life and employee assistance programs. CBH delivers services through regional care centers owned and operated by CBH in many major markets. CBH contracts with mental health and substance abuse facilities and licensed, independent providers to complete its network. Providers include psychiatrists; psychologists; master's level social workers; marriage, family, and child counselors; and substance abuse specialists. CBH currently employs over 1,000 individuals and provides mental health and substance abuse services to more than 12 million CIGNA participants nationwide.

CHC enrollees have access to mental health and substance abuse services through CBH's 24 hour, toll free telephone lines staffed by intake specialists. Emergency calls at any time of day or night are handled by clinicians who can arrange for assistance or intervention.

CBH is licensed in the state of Maine as a Third Party Administrator and as a Medical Utilization Review Service.

PERTINENT FACTUAL FINDINGS

A. Company Operations and Management

The Company Operations and Management portion of the examination is designed to provide a view of what the Companies are and how they operate. It is not specifically based upon sampling techniques. It is more concerned with structure. This review is not intended to duplicate a financial examination review, but it is important to provide the market conduct examiners with an understanding of the Companies being examined. Many troubled companies have become so because structural problems existed in the Company and management did not have the processes in place to identify, recognize and address the problems in a timely manner.

The areas considered in this review include:

a. History
b. Profile
c. MGA, GA, TPA oversight
d. Internal audits
e. Antifraud plan
f. Certificates of authority
g. Disaster recovery plan
h. Computer systems

STANDARDS
Company Operations/Management

Standard A-1
The Company has an up-to-date, valid internal or external audit program.

NAIC Market Conduct Examiners Handbook - Chapter XVII Section A, Standard 1

The examiners reviewed the CIGNA HealthCare Corporate Audit Division (CAD) 2001 Internal Audit Work Plan and a summary listing of reports prepared during the calendar year 2001 through the date of fieldwork. A listing of eight audit reports was provided by the Companies as being applicable to the entities under review. From this listing, copies of three reports were selected for review based upon their significance to the market conduct examination areas being reviewed.

The examiners reviewed the audit reports to determine if the function is providing meaningful information to management and also determine how management was using the reports. The examiner reviewed internal audit reports to determine if the Company responds to internal audit recommendations to correct, modify and implement procedures and if accuracy of internal statistical data and information systems is periodically tested by the Company's audit program.

Upon review of the information provided, it was evident that the reports selected did not directly relate to either of the Companies under review. Also, during review of the internal audit plan, it

was noted that the plan is based upon an overall corporate level, and is not specific to CHC or CBH. Reports are sent to Division Heads at the corporate level and each state plan is only contacted when applicable.

Based upon the above information provided to the examiners, it appears that there is an internal audit function in place to detect any structural problems on a corporate wide basis, however, CHC or CBH specifically are not considered due to the size of the companies in comparison with the holding company group. **(Finding #2)**

Standard A-2
The Company has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 2

Appropriate controls, safeguards and procedures for protecting the integrity of computer information are an important part of an effective internal control system. Examiners reviewed documentation provided by the Companies of their internal controls in this area. Follow-up interviews were also conducted to provide further understanding of the control environment.

Based upon this review of the Companies' documentation, it appears that the Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Standard A-3
The Company has an antifraud plan in place.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 3

Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. Appropriate antifraud activity is important for asset protection as well as policyholder protection. Further, the insurer has an affirmative responsibility to report fraudulent activities of which it becomes aware.

Examiners reviewed documentation of the antifraud plan provided by the Companies and noted no significant deficiencies in this area.

Standard A-4
The Company has a valid disaster recovery plan.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 4

A formal disaster recovery plan is an essential part of the Companies' business continuity planning. A detailed plan that includes procedures for continuing operations in the event of a disaster as well as documentation of recent testing of the plan is a requirement.

Examiners were provided with documentation related to disaster recovery and business continuity by the Companies. Based upon this review, it was noted that the Companies have an established plan to minimize the effects of an interruption in business.

Standard A-5
The Company is adequately monitoring the activities of any entity (MGA, GA, and TPA) that contractually assumes a business function or is acting on behalf of the Company.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 5

The objective of this standard is to ensure that the Companies are conducting an appropriate level of oversight of the activities of MGAs and TPAs.

Based upon information provided by the Companies, it was noted that the only significant agreement in place was between CHC and CBH (acting as a TPA). Review of this agreement indicated the following deficiency. The agreement between CHC and CBH has a stipulation that a Statement of Auditing Standards No. 70 (SAS 70) review or other evidence of appropriate internal controls is to be provided on an annual basis. Examiners requested a copy of the current SAS 70 report and were advised that no SAS 70 review has ever been performed for this function. It was also noted that the Company's lack of a SAS 70 review was also commented upon in the last exam. **(Finding #4)**

Standard A-6
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 6

Inadequate, disorderly, inaccessible, or inconsistent records can lead to inappropriate handling of claims, inappropriate underwriting decisions, inappropriate rates and other issues. The Companies' policies and procedures in this area are an important part of the internal control environment.

Examiners reviewed the current record retention policies and procedures of the Companies. It was noted that CBH does not have a formal, written record retention policy, however the Company advised that they do generally keep documents for approximately 10 years. **(Finding #3)**

Maine Statutes Chapter 24-A §3408 states that "Every domestic insurer shall have and maintain its principal place of business and home office in this state, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principals and practices of insurance accounting and record keeping as applicable to the types of insurance transacted by the insurer". In addition, Maine Rule 191, Section 10(B) requires HMOs to maintain records of their affairs and transactions for a period of at least 6 years. During testing, examiners noted several areas where the Companies were not able to

provide complete or adequate documentation. These findings will be noted in the applicable sections of the report.

Standard A-7
The Company is licensed for the lines of business that are being written.

NAIC Market Conduct Examiners Handbook – Chapter XVII, Section A, Standard 7

Examiners reviewed CHC's Maine Certificate of Authority for the period under examination and noted no exceptions.

Standard A-8
The Company cooperates on a timely basis with examiners performing the examination.

NAIC Market Conduct Examiners Handbook – Chapter XVII, Section A, Standard 8

Cooperation with examiners in the conduct of an examination is not only required by statute, but it is conducive to completing the examination in a timely fashion and minimizing cost.

Examiners noted that the Company cooperated with the Examiners performing the examination.

Standard A-9
The Company has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 9

Examiners reviewed the Companies' policies and procedures "Confidentiality of Plan Participant Information," dated 2/22/00; a form notice distributed to members, which discusses handling of confidential information; and an enrollment form containing the "Authorization to Disclose Confidential Information and Fraud Notice" in conjunction with Maine privacy statutes. Based upon this review, it was noted that the Companies appear to have procedures in place to meet the Maine privacy guidelines.

Standard A-10
The Company has developed and implemented written policies, standards and procedures for the management of insurance information.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section A, Standard 10

As noted in Standard A-9 above, Examiners reviewed the Companies' polices and procedures related to the management of insurance information and noted that the Companies have procedures in place to meet the Maine information guidelines.

B. Complaint Handling

The NAIC definition of a complaint is a written communication primarily expressing a grievance (meaning an expression of dissatisfaction). The examiners reviewed the Company's procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

The NAIC definition of a compliant is broader than the NAIC definition of a grievance. If it is determined that a "complaint" meets the definition of a "grievance" as that term is defined and limited by the NAIC Health Carrier Grievance Procedure Model Act, the standards for grievance procedures (Section C) should be applied. Those complaints that do not meet the definition of a grievance should meet the standards of this Section.

Examiners reviewed the laws of the State of Maine applicable to this Section and in relation to Section C on Grievance Procedures. Any occurrences of non-compliance have been noted in the report.

The Examiners requested a copy of the CHC complaint log for 2001. We were provided with two different spreadsheets that had to be combined to get a complete list of complaints received during 2001. The member complaint/PCP changes report (PCP Report) was represented to contain a record of all complaints received by CHC whether by phone, email or regular mail and the HMO reconciliation spreadsheet was represented to contain all complaints received from the Maine Bureau of Insurance (MBOI complaints). Examiners combined the reports and pulled a random sample of 50 items for review. Thirty-two of the items requested for review were from the PCP report and eighteen were from the MBOI complaints. The Company represented that 11 complaints were received related to CBH in 2001. We selected all 11 complaints for testing.

The population and sample size for the Complaint Testing is as follows:

Area Sampled	Population Size	Sample Size	Sample Type
CHC Complaints	227	53**	Random
CBH Complaints	11 ***	11	100%

**During review, it was noted that three complaints handled through the Freeport Office were not logged onto either CHC complaint listing and therefore were not subject to selection in our sample. Examiners requested these files for detailed review and therefore, reviewed a total of 53 files instead of our planned sample size of 50.
*** Population incomplete.

Standards
Complaint Handling

Standard B-1
All complaints are recorded in the required format on the Company complaint register. *NAIC Market Conduct Examiners Handbook - Chapter XVII, Section B, Standard 1*

A review of complaint handling procedures incorporated direct policyholder complaints to the Companies and those complaints filed with the Bureau of Insurance.

The results of testing for this standard are as follows:

Area Sampled	Population Size	Sample Size	Sample Type	Errors Identified	Error Rate
CHC Complaints	227	53	Random	8	15%
CBH Complaints	11	11	100%	0	See Below

CHC was unable to locate one of the thirty-two files requested from the PCP report. **(Finding #7)**

During testing of the CBH complaint area, Examiners requested a copy of the 2001 complaint log for CBH. We received a log of eleven complaints with the last complaint dated 7/17/01. The Company informed the examiners that the complaint log is understated and that CBH is in the process of reengineering the logging of complaints. In addition to being in violation of the Company's own policy, the Company also appears to be in violation of Title 24-A, Section 4211 which requires an annual report detailing the complaint system and total number and disposition of complaints handled be submitted to the Superintendent of Insurance and Maine Regulation Chapter 850 Section 9A which requires the company to maintain an accurate and complete complaint and grievance log. **(Finding #8)**

During review of the complaints received by MBOI during 2001, the Examiners attempted to reconcile information obtained from the MBOI records to the complaint/grievance log/reports provided by the Company. Seven items that were documented on the MBOI records could not be traced to the CHC logs. The Company later researched these seven files and determined that three of them were received directly at and processed through the Freeport office but were not logged onto the MBOI log because they were not sent through the Bloomfield, CT office. The remaining four complaints were for CHC and all the responses sent to the MBOI provided a local contact person in Freeport, Maine to answer any additional questions; however, these four complaints were not included in the Company's log. The Company appears to be in violation of Maine Regulation Chapter 850, Section 9A which requires the Company to maintain an accurate and complete log of complaints and grievances as well as the Company's own policies and procedures. **(Finding #14)**

Examiners also reviewed the 11 complaint files received in the CBH population. No exceptions were noted during this review other than the fact that the population was incomplete as noted above.

The examiners also reviewed and classified the frequency of similar complaints to note any patterns of a specific type of complaints. The examiners reviewed the nature of all complaints, as reported in the log, to determine if any adverse trends exist. No unusual patterns or trends were noted from this review.

Standard B-2
The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section B, Standard 2

The examiners requested documentation from the Companies detailing compliance with Maine Statutes Title 24-A, Subsection 4211 which requires the following:

1. Every HMO shall establish and maintain a complaint system which has been approved by the Superintendent, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services and general operating procedures.
2. Each HMO shall submit to the Superintendent an annual report in a format prescribed by the Superintendent, which shall include:
   A description of the procedures of the complaint system
   1. The total number and disposition of complaints handled through the complaint system and a compilation of causes underlying the complaint filed. Complaints concerning access to chiropractic providers and the results of those complaints must be separately stated.
   2. The number, amount and disposition of malpractice claims settled during the year by the HMO.
3. The HMO shall maintain records of written complaints filed with it concerning other than health services and submit to the Superintendent a summary report at such times and in such format as the Superintendent may require. Such complaints involving other persons shall be referred to such persons with a copy to the Superintendent.

As noted above, CHC appears to be in violation of this section. The Company provided examiners with a memo noting that they were verbally notified by the MBOI in 2000 that the reporting elements outlined above did not need to be provided. The Company could not provide written documentation for examiner review to verify that it did not have to file the information required by this section. As a result of this examination finding, the Company discussed this issue further with the MBOI and noted that HMOs are not exempt from this reporting and must comply. The Companies have advised that they will begin reporting this information in the 2003 filing. **(Finding #18)**

Standard B-3
The Company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section B, Standard 3

Review of the CHC complaint sample revealed the following exceptions when compared to applicable statutes, rules and regulations:

Area Sampled	Population Size	Sample Size	Sample Type	Errors Identified	Error Rate
CHC Complaints	227	53	Random	9	17%
CBH Complaints	11	11	100%	0	0

1. There were six (6) instances where examiners could not determine if the Company's response fully addressed the complaint issue and for the same six files, examiners could not determine what corrective action was taken.
2. There were three (3) exceptions identified when tests were conducted to ensure the Company maintained the file on the complaints for the required duration of time.
3. There were six (6) exceptions relating to testing to determine if the Company's files contained adequate information so as to permit easy retrieval of the entire file. **(Finding #16)**

Standard B-4
The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section B, Standard 4

Review of the CHC complaint sample related to the timeframe standards revealed the following exceptions:

Area Sampled	Population Size	Sample Size	Sample Type	Errors Identified	Error Rate
CHC Complaints	227	53	Random	25	47%
CBH Complaints	11	11	100%	0	0

1. There were fifteen (15) potential exceptions identified when tests were conducted to ensure the company complied with Maine Statutes 24-A Chapter 3, Section 220 that the insured responds to the State Department complaint inquiry within 14 days or the time stated in the letter. For nine (9) of the fifteen noted as the responding date, it should be noted that the Company requested an extension within the timeframe required by the Statute (2 days prior to the due date).
2. There were six (6) potential exceptions identified relating to advising the State the reason for the inability to respond at least two days prior to the due date of the response as

required by Maine Statute Chapter 3, Section 220. The responses appear to be late and for four of the six files, the Company could not locate documentation to determine the member number, date received or date responded and could not calculate the number of days to respond.

3. There were three (3) exceptions relating to the examiners test to ensure the Company complied with internal procedures regarding responses to non-insurance department complaints within 30 days of receipt. These same three files were also exceptions relating to the Company complying with policies to ensure Company response to inquiries or complaints relating to urgent care within 1 calendar day. Because the files were not provided for review, examiners could not determine if the above noted timeframes had been met.
4. There were fourteen (14) exceptions noted in the examiners' test to ensure the Company complied with internal procedures regarding responding to inquiries or complaints involving care/suggestion of malpractice with acknowledgement/resolution letter within 5 days. **(Finding #16)**

C. Grievance Procedures

The Grievance procedures portion of the examination is designed to evaluate how well the Companies handle grievances. The NAIC definition of a grievance is a written complaint submitted by or on behalf of a covered person regarding the:

1. availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review;
2. claims payment, handling or reimbursement for health care services; or
3. matters pertaining to the contractual relationship between a covered person and a health carrier.

Note that this definition may not include all written communications that the companies track as "complaints" under the NAIC definition of a complaint.

Examiners reviewed the laws of the State of Maine applicable to this Section and in relation to Section B on Complaint Handling. Any occurrences of non-compliance have been noted in the report.

Examiners reviewed the companies' procedures for processing grievances. Specific problem areas which may necessitate an overall review of a particular segment of the Companies' operations have been highlighted.

Standard C-1
The health carrier treats as a grievance any written compliant submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the carrier.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 1

Based upon the Examiners review of the Complaint and Grievance areas at the Companies, we have determined that the Companies are using the proper classification of Complaint vs. Grievance as defined in the Handbook.

Standard C-2
The health carrier documents grievances and establishes and maintains grievance procedures in compliance with statute, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 2

Examiners reviewed the following populations of Grievances for 2001:

Area Sampled	Population Size	Sample Size	Sample Type	Errors Identified	Error Rate
CHC:					
1st Level Administrative Grievances	6	6	All	3	50%
1st Level Grievances - Medical	968	42	Random	(A)	(A)
2nd Level Grievances - Medical	86	25	Random	(A)	(A)
2nd Level Grievances - Behavioral Care	50	25	Random	21	84%
Provider Payment Appeals	2280	50	Random	45	90%
CBH:					
1st Level Grievances - Behavioral Care	112	50	Random	26	52%

(A) Twenty -six errors were noted during review of the CHC 1st and 2nd level grievances above - see details below. This resulted in a sample error rate of 39%.

Note: All samples were randomly selected using ACL unless the population was less than 50. If the population was less than 100, a judgmental sample was selected for review. Originally, the 1st and 2nd level CHC grievance populations were combined into one sample of 50 items (41 1st level and 9 2nd level). After Examiners encountered problems with several sample items, the sample sizes were expanded to ensure adequate coverage for both 1st and 2nd level grievances resulting in the sample sizes noted above.

Examiners requested the Companies to provide detailed populations of grievances received during 2001. The above populations were provided and the corresponding sample sizes were selected for review. Based upon this review, the following exceptions were noted.

CHC 1st Level Administrative Grievances

CHC had provided examiners with an administrative appeal log detailing first level administrative appeals (grievances) processed by the PACES unit during 2001. The PACES unit handled all first level administrative appeals for insured's with a plan that was administered on the Power MHS Claim system. All other administrative appeals (grievances) processed through the regular CHC grievance review process were included in the CHC grievance testing. There were six appeals listed on this log and due to the limited number, examiners reviewed them all.

During our review, we noted that one file did not contain an acknowledgement letter that was sent to the member filing the grievance. Accordingly, examiners were unable to perform certain tests. It was noted that CHC had originally received the appeal in a different location (December 7, 2001 date stamp) and did not forward the appeal to the processing unit until December 17, 2001. Once the grievance was received by the unit, a decision was made and the decision letter was sent within one day, however, the acknowledgement letter was not sent within 5 business days of receipt as is required by CHC policies and procedures. It was noted that the grievance was processed within the 20 day time frame required by statute.

It was also noted that CHC's standard acknowledgement letter does not specifically state that the insured cannot attend the first level grievance review as required by Maine Rule 850 (9)(C)(1).

The grievance log provided did not give a general description of the reason for the grievance as required by Maine Rule 850 Section 9A.

For two files, it was noted that it appears CHC did not comply with their own policies and procedures which require that the Company record resolution in the system, verify that actions to resolve the grievance are carried out and verify that the issue files are complete including all mailing and documentation within 15 calendar days. For these two items, it was noted that the decision letter was sent on 12/14/01, but the cases were not closed on the system until 2/5/02 or 51 days later. **(Finding #15)**

CHC 1st and 2nd Level Grievances

The Companies had provided the examiners with two grievance logs which when combined consisted of 1,113 grievance items. Examiners originally used ACL to select a sample of 50 items for review (41 first level and 9 second level). After issues were noted with this sample, and examiners learned that second level Behavioral Care grievances were also included in the population, two additional samples were selected for review. Examiners selected an additional 14 items for CHC second level grievances to bring the total CHC population tested to 25 Medical (non-Behavioral Care) grievances. Examiners also selected a sample of 25 second level Behavioral Care grievances for which CBH had handled the first level grievance. The following exceptions were noted:

1. For one first level grievance and nine second level grievances, a variance was found when the information on the log was traced to the information in the file. Examiners used the information in the file to perform their test work.

2. The grievance log provided does not give the date of the review, resolution or date of the resolution as required by Maine Rule 850 Section 9A.
3. In two cases, a decision letter could not be located in the file. Examiners noted that the file did not appear to contain adequate documentation.
4. In one instance the Company did not send an acknowledgement letter within five days of receipt of the grievance as required by Company policy and procedures.
5. Three violations were noted in regards to the Company policy and procedures relating to a decision being sent via mail within two days if first level and within 5 days if second level.
6. In ten instances, it was noted that the written decision of the first level review was not issued within 20 working days as required by Maine Rule 850 (9)(C)(1)(a).
7. Company policy and procedures state that if not a quality of care issue, investigation of the appeal occurs and the final decision is made by someone independent of the review issue. The decision is to be made and notification sent within 30 calendar days. In ten cases, the notification was not sent within 30 days.
8. In two instances, Examiners could not locate a decision letter in the file and therefore could not determine if the Company issued a written decision after completing the first level review as required by Maine Rule 850 Section 9.C.b.
9. In ten cases, it appears the Company was in violation of Maine Rule 850, Section 8(G)(1)(c). For standard appeals, the health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where the carrier or the carrier's designated URE can establish the 20 day time frame cannot reasonably be met due to the carrier's or designee's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier or the carrier's designated URE shall provide written notice of the delay to the covered person and the attending or ordering provider.
10. In thirteen instances, it appears the Company did not abide by their own policy and procedures which require that the review meeting be scheduled within 30 calendar days of receipt of the appeal request.
11. In twelve cases, it appears that the Company did not abide with Maine Rule 850, Section 9(D)3 which requires that the Company notify the covered person in writing of the date, time and place of the second level review meeting at least 15 working days in advance of the review meeting date.
12. In two cases, it appears the Company did not comply with State of Maine Chapter 850 Section 9(D)3(f) which requires the Company to issue a written decision within five working days of completing the second level review meeting. The written decision is to contain: the names and titles of the reviewers', a statement of the reviewers understanding of the nature of the grievance and all pertinent facts, the reviewers' decision in clear terms and the basis for the decision, if the case involves an adverse determination, the instructions for a written statement of the clinical rationale, including the clinical review criteria used to make the decision per Chapter 850, a reference to the evidence or documentation used as the basis for the decision and notice of the covered person's right to contact the Superintendent's office, including the toll free phone number and the address of the MBOI and notice to the enrollee describing any subsequent external review rights, if required by Title 24-A, Section 4312(3). **(Finding #17)**

CBH 1st Level Administrative Grievances

During our review of the CBH 1st level administrative grievances, the following potential exceptions were noted:

1. In one instance, the grievance request was not date stamped. On the same file, it was also noted that the date on the decision letter was crossed out and a new date was handwritten in.
2. In one instance it was noted that the grievance was never completed. It appears CBH authorized the claim and a decision letter was never sent.
3. In six cases, the date on the letter provided was the date the letter was printed off the system for Examiner review. Company personnel crossed out the incorrect date and wrote the actual date of the letter on the copy. Examiners were then provided with a history screen off the system showing the date the letter was sent per the system.
4. The grievance log provided was incomplete and does not provide the necessary information required by the Maine Rule 850 Section 9A.
5. In four cases, a letter of appeal or decision letter could not be located in the file. Examiners noted that these files did not appear to contain adequate documentation.
6. In four cases, Examiners could not verify that the Company date stamped the request.
7. In two cases, it was noted that the Company did not send a decision letter within 2 days after reviewing the grievance as required by Rule 850 (9)(C)(1)(a).
8. In two cases, it was noted that the file did not contain documentation showing that a written decision was issued within 20 days as required by Maine Rule 850 (9)(C)(1)(a).
9. In two cases, it appears the Company was in violation of Maine Rule 850 8(G)(1)(c). For standard appeals, the health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where the carrier or the carrier's designated URE can establish the 20 day time frame cannot reasonably be met due to the carrier's or designee's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier or the carrier's designated URE shall provide written notice of the delay to the covered person and the attending or ordering provider.
10. In one case, it was noted that the file did not contain documentation showing that a written decision was issued after completing a first level grievance review. **(Finding #26)**

CBH 1st Level Medical Necessity Appeals

During review of the CBH 1st level medical necessity appeals, the following matters were noted:

1. The appeals log provided does not provide the necessary information required by Maine Rule 850, Section 9A. It was also noted that in 14 cases, the log showed a date letter issued date of 2002 when the letter was actually issued in 2001. It was also noted in 14 instances that the date letter issued column per the log did not agree to the actual date on the decision letter per the file.

2. Three violations were noted in regards to whether the Company files contained adequate documentation.
3. Nine violations were noted in regards to the Company policy and procedures relating to a decision not being sent via mail within 2 days if first level review.
4. In seven instances, it was noted that the written decision of the first level review was not issued within 20 working days as required by Maine Rule 850, Section (8)(G)(1)(c).
5. In one instance the acknowledgement letter was not in the file in violation of the Company's policy.
6. Company policies and procedures state that if a request was in writing it would be date stamped. In five instances, Examiners could not verify that the request/chart was date stamped.
7. In seven cases, it appears that the Company is in violation of Maine Rule 850, Section 8(G)1(c) which states, for standard appeals, the health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where the carrier or the carrier's designated URE can establish the 20 day time frame cannot reasonably be met due to the carrier's or designee's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier or the carrier's designated URE shall provide written notice of the delay to the covered person and the attending or ordering provider.
8. In two instances it appears the Company did not abide by their own policy and procedures which required that an acknowledgement letter be sent within 5 days of receiving a grievance.
9. In four cases, it appears that the Company did not abide by Maine Rule 850, which states an adverse decision shall contain: "the names, titles and qualifying credentials of the person or persons evaluating the appeal; a statement of the reviewers' understanding of the reason for the covered person's request for an appeal; the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carriers' position; a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse determination, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. The notice must advise of any subsequent appeal rights, and the procedure and time limitation for exercising those rights." Notice of external review rights must be provided to the enrollee as required by 24-A, M.R.S.A., Section 4312(3). A description of the process for submitting a written request for second level grievance review pursuant to Section 9(D) must include the rights specified in Section 9(D)(3)(c).
10. In one case, it appears the Company did not comply with Maine Rule 850 Section 8(2) which states, the Company has provided reasonable response time, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review. The clinical peer or peers were not involved in the initial determination.

11. In one case, it appears the Company did not comply with Maine Rule 850, Section 8(2)(D) which states, the Company will make a decision and notify the covered person or the provider as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the review is commenced.
    (Finding #29)

CHC 2nd Level Behavioral Care Grievances

During review of the 2nd level Behavioral Care grievance population (for which 1st level grievances had been handled by CBH), the following exceptions were noted:

1. The grievance log provided does not provide the necessary information required by Maine Rule 850, Section 9A.
2. In ten cases, the receipt date on the grievance log is the date the grievance package was received at CHC, not the date all the necessary information was received at CBH. Company policy is that any second level grievances received at CBH are forwarded up to CHC for review. Examiners used the date the information was received at CBH for testing purposes.
3. In one case, the date received per the grievance log was not the date received per the date stamp in the file. Examiners used the date stamp from the file for testing.
4. In one case, it appears that the Company did not abide with their internal policy for date stamping any requests made in writing.
5. In three cases, it appears the Company did not abide by their policy which states that the Company would send an acknowledgement letter within five days of receipt of the grievance request. For one of the three instances, the acknowledgement letter date was hand written on the letter and Examiners could not verify the actual date the acknowledgement letter was sent.
6. In four instances, it appears the Company did not abide by their own policy which required that the review meeting be scheduled within 30 calendar days of receipt of the request.
7. In twelve cases, it appears that the Company did not abide by Maine Chapter 850 Section 9(D)(3)(a), which required the Company to notify the covered person in writing of the date, time and place of the second level review meeting at least fifteen working days in advance of the review meeting date.
    (Finding #30)

Provider Payment Appeals

During review of the Companies' grievance processing, it was noted that the Companies track provider payment appeals separately from the normal member appeals. Accordingly, Examiners selected a separate sample of provider payment appeals for review. During this review, it was noted the provider payment appeals policy provided to Examiners for review did not become effective until August 2002. Prior to August 2002, there was not a formal written policy in place in reference to the handling of provider payment appeals. **(Finding #35)**

Also, during review of the provider payment appeals, the following observations were noted:

1. For the sample reviewed, the median number of business days from receipt of the provider payment appeal to the decision letter being sent was 20.5.
2. For the sample reviewed, the average number of business days from receipt of the provider payment appeal to the decision letter being sent was 23.
3. For fourteen of the files selected for review, the Examiners were not able to trace the information provided on the log to the file.
4. The grievance log provided does not provide a general description of the reason for the grievance, resolution, date of resolution or the name of who filed the grievance.
5. One of the fifty files requested for review could not be provided.
6. For five of the sample items it appeared that the Company did not maintain adequate documentation in the file.
7. In three cases, Examiners could not verify that the Company date stamped the request.
8. In approximately twenty-seven instances, Examiners noted that it appears the Company did not comply with its internal policy, which requires that the Company will conduct a first level review of all submitted provider payment appeals and issue a written decision within 30 calendar days of receiving a provider payment appeal.
9. In three cases, Examiners could not verify that the carrier provided the covered person with the name, address and phone number of a person designated to coordinate the first level grievance review.
10. In three instances, Examiners could not determine that a written decision was issued after completing the first level review.
11. For the twenty-three appeals that had the decision upheld or the decision letter was not provided, Examiners determined that the decision letter did not contain information regarding a second level appeal or give subsequent appeal rights.
12. During our review, it was noted that 74% of the 50 appeals in the sample were related to authorization, precertification or referral and 20% related to timely filing. Of these 50 appeals, 60% of the decisions were overturned during the first level review and 40% were upheld.
    (Finding #36)

Standard C-3

A health carrier files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.
NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 3

As noted in the Complaint review, Standard B-2 above, both CHC and CBH appear to be in violation of this standard.

Standard C-4
The health carrier conducts first level reviews of grievances in compliance with statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 4

During our review of CHC grievances the following trend was noted: Of the first level grievances in the sample (42 sample items reviewed) taken from CHC grievances files, 90% were related to a review of benefits and 10% related to a medical review. Of these 42 files, 71% of the decisions were overturned during the first level review and 29% were upheld. **(Finding #24)**

See exceptions noted during review of the first level grievances in Standard C-2 above.

Standard C-5
The health carrier conducts second level reviews of grievances in accordance with statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 5

During review of the CHC grievances, the following trends were noted: 36% of the second level grievances in the sample (25 sample items reviewed) taken from CHC grievance files were related to prescription denials, 32% related to a denial of service, 24% related to a denial of medical supplies and/or equipment and 8% related to other issues. Of the 25 files reviewed, 80% of the decisions were upheld and 20% were overturned during the second level review. **(Finding #24)**

See exceptions noted during review of the second level grievances in Standard C-2 above.

Standard C-6
The health carrier handles grievances involving adverse utilization review determinations in compliance with statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 6

See exceptions noted during review of the first and second level grievances in Standard C-2 above.

Standard C-7
The health carrier has procedures for and conducts expedited appeals in compliance with statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section C, Standard 7

During review of Companies' grievance registers, it was noted that the logs provided to Examiners did not contain an indicator which showed which grievances were expedited and which were standard. The sample selected by Examiners did not contain any expedited appeals. In discussion with Company personnel it was noted that the majority of the grievances received are standard grievances and this is probably the reason that our sample did not contain any expedited grievances. Since there was no way to determine which of the grievances processed by the Companies during 2001 were expedited, Examiners were unable to select a sample of expedited grievances for review. **(Finding #32)**

D. Marketing and Sales

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the Companies about their products. The areas reviewed include available written and verbal advertising and sales materials including producer sales training materials in order to determine compliance with statutes, rules and regulations.

Examiners reviewed all advertising materials from the population for detail review. The examiners reviewed the advertising and sales materials to ensure that they were in compliance with applicable statutes, rules and regulations.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy should be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive was determined by reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

Standards
Marketing and Sales

Standard D-1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 1

This standard is designed to evaluate the representations made by the Companies about its products. Based upon review of the above sample, the following comments and exceptions were noted:

During review of the advertisement sample, various test steps were developed based upon Maine Rule 140.

Examiners requested all marketing and sales material used by the Companies to market their products during 2001. The preliminary response received from the Company indicated that CHC did not do any local market advertising separate from CIGNA's national advertising. It was also noted that CBH does not market any products and would not be applicable for this Examination Cycle.

After additional follow-up and clarification by the examiners as to the definition of "advertising" we later received materials that the Company provides to producers to show prospective insureds. We also received a list of charitable contributions and sponsorship advertisements in 2001 for fundraising, non-profit organizations and municipalities. CHC stated that the advertisements were all very basic, listing the name of the Company, Company logo, address and

telephone number and provided an example for our review. It was noted that CHC did not retain copies of these advertisements and appears to be in violation of Maine Rule 140, Section 11A. **(Finding #6)**

During review of the information provided by the Company as Advertising, examiners noted the following:

1. Three items reviewed did not appear to adequately define the term pre-existing condition as required by Maine Rule 140, Section 5B.
2. Two items reviewed did not appear to comply with the requirement of Maine Rule 140 that when an advertisement contains an application form to be completed by the applicant and returned by mail, such application form shall contain a statement that reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. **(Finding #9)**

In addition, it was noted that according to Maine Statutes Title 24-A, Section 2736-C 6.A - each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to Subsection 8, to individuals in this State. Based upon our review, the Company's response that they do not engage in any local advertising and the limited amount of advertising information provided by the Company, it appears that the Company is violation of this statute. **(Finding #6)**

During review of the Companies' Internet web sites, examiners reviewed the two sites utilized by the Companies and noted no unusual items.

Standard D-2
Company internal producer training materials are in compliance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 2

This standard is designed to evaluate the representations the Companies use to instruct its sales force about the Companies' products.

Examiners performed a review of the producer oversight and training performed by CHC. It was noted that the Company requires that producers be licensed and appointed by CHC prior to any business being written. When a new producer wants to sell CHC's products, a new business manager meets with the producer to review information about CHC and the potential client specific proposal. Examiners were also advised that during 2001, producers were also trained and educated about the Company's products and services through a breakfast seminar as well as through articles published in an online newsletter.

CHC provided examiners with an example which detailed the possible sale of a group product to a Company but no documentation was provided which would allow examiners to determine how producers are trained on selling individual business.

Per review of applicable Maine Statutes examiners note that the insurer is responsible for training and supervision of its producers. Based on our review, it does not appear that the Company is adequately documenting the training provided to producers. Examiners were unable to determine what training is given to new producers to ensure that they accurately represent the Company's products. Also, due to the lack of documentation provided for examiner review, examiners were unable to determine if the Company is adequately training the producers. This appears to be a violation of Maine Statute Chapter 16 - Section 1445.
(Finding #11)

Standard D-3
Company communications to producers are in compliance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 3

This standard is designed to evaluate the representations the Companies make to its sales force about the Companies' products.

See comments under Standard D-2 above.

Standard D-4
Company rules on replacements are in compliance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 4

Because the State of Maine has no statutes, rules or regulations relating to replacement requirements and based upon the nature of the products written by the Company in Maine, this standard would not be applicable.

Standard D-5
Outline of coverages are in compliance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 5

Examiners reviewed the Company's Outlines of Coverage to determine if they were in compliance with Maine statutes, rules and regulations and NAIC guidelines. Examiners reviewed the three Outlines of Coverage (OOCs) provided by the Company for the products they offer: Group HMO, Group POS and Direct Enrollment (individual).

Examiners discussed with the Company the process to verify that the OOCs had been authorized by the Company and approved by the appropriate person within the Company (NAIC Standard 5 - Step 2 & 3). It was noted that The OOCs for the group HMO and POS plans are reviewed at the corporate level and there was no evidence to prove it had been approved by the appropriate person. The Direct Enrollment OOC had been carried forward from Healthsource and a formalized review and approval process had not been documented.

Examiners could not verify that the following was adequately disclosed in the OOCs as required by NAIC Standard D-5:

1. The extent to which premium rates for an individual and dependents are established or adjusted based upon rating characteristics;
2. The carrier's right to change premium rates, and the factors, other than claim experience, that affect changes in premium rates;
3. The provisions relating to renewability of policies and contracts;
4. Any provisions relating to any preexisting condition provision; and
5. All individual health benefit plans offered by the carrier, the prices of the plans if available to the eligible person, and the availability of the plans to the individual

It was noted that the term pre-existing condition was used and that the term pre-existing condition was not adequately defined as required by Maine Chapter 140.

According to NAIC Standard D-5, examiners were required to ensure the outlines of coverage accurately represent the applicable consumer protections and minimum standards required by HIPAA which may include:

1. Limits on pre-existing condition exclusions
2. Prohibitions on discrimination based on health status and related factors;
3. Guaranteed issue for small groups of 2 to 50;
4. Guaranteed renewability for all policies, with certain exceptions;
5. Expansion of COBRA entitlement;
6. Portability for eligible individuals leaving group coverage, with certain exceptions;
7. Minimum maternity benefits when maternity is covered by the plan;
8. Mental health parity requirements;
9. Limits on the factors that can be used to establish and change premium rates;
10. Descriptive information about all available health benefit plans.

Based on our review, examiners could only determine that the limits on pre-existing condition exclusions #1 and minimum maternity benefits #7 were accurately reflected in the OOCs. The other areas tests 2 - 10 (excluding #7) noted above were not clearly stated on the OOCs. **(Finding #10)**

Standard D-6
Company has suitability standards for its products when required by applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section D, Standard 6

Based upon the types of products written by the Company, this standard would not be applicable.

E. Network Adequacy

The network adequacy portion of the examination is designed to assure that companies offering managed care plans maintain service networks that are sufficient to assure that all services are accessible without unreasonable delay. The standards require companies to assure the adequacy, accessibility, and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include company access plans and other measures used by the companies to analyze network sufficiency, contracts with participating providers and intermediaries, and on-going oversight and assessment of access issues.

The MBOI focused this Network Adequacy review on the network of CBH only in relation to their support of the CHC membership. Any comments included in this section relate to CBH only. The CHC network was not reviewed.

Using the roster of providers and facilities provided by the Company, examiners requested a sample of specific provider contracts for review. CBH advised that their network of contracted providers in Maine was comprised of 1,125 providers which included 107 MD psychiatrists, 183 psychologists and 835 licensed master level therapists. In addition, the Company had 124 providers in the credentialing process. Finally, due to many geographically remote locations in Maine, the Company maintained a full continuum of outpatient providers and facilities, which were utilized on an ad hoc basis pursuant to Single Case Agreements. CBH had 759 available ad hoc outpatient providers during 2001. A random sample of 50 provider contracts was selected for review. The sample was selected from the three populations based upon the following table:

Provider Type	Number of Providers	Percent of Total Population	Sample Size
Contracted Providers	1,125	56%	28
Provider in Credentialing Process	124	6%	3
Ad Hoc Outpatient Providers	759	38%	19
Total	2008	100%	50

Standard E-1
The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 1

See comments under Standard E-2 below.

Standard E-2
The health carrier files an access plan with the commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing

managed care plan The carrier makes the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties absent proprietary information upon request.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 2

Examiners requested a copy of the Company's access plan filings for 2001. The Company provided the 2001, 2000 and 1999 updates as well as the original filing from 1998. Based upon review of these filings, it appears that the Company has made the required access plan filings.

Standard E-3
The health carrier files with the commissioner all required contract forms, and any material changes to a contract, proposed for use with its participating providers and intermediaries.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 3

Examiners reviewed sample contracts and provider agreements during review of the claims files and noted that these agreements appear to be in compliance with Maine Statutes.

Standard E-4
The health carrier ensures covered persons have access to emergency services twenty-four (24) hours per day, seven (7) days per week within its network and provides coverage for emergency services outside of its network pursuant to [cite appropriate section of state law that corresponds to the NAIC Utilization Review Model Act, Section 13].

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 4

Examiners noted that the Company Access Plan does cover 24 hour emergency services both within and outside its network. Also, in conjunction with the Company's access plan review, during review of the complaints and grievances, examiners did not note any unusually high occurrences of inquiries related to the Company's access plan or coverage issues.

Standard E-5
The health carrier executes written agreements with each participating provider that are in compliance with statutes, rules, and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 5

Examiners reviewed provider contracts during claims testing and noted that the Company had written agreements with each of the providers included in the sample.

Standard E-6
The health carrier's contracts with intermediaries are in compliance with statutes, rules, and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 6

Examiners reviewed the Company's contracts with CBH during review of Company Operations and Management Cycle. This contract appears to be in compliance with Maine requirements.

Standard E-7
The health carrier's arrangements with participating providers comply with statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 7

See comments under Standard E-5 above.

Standard E-8
The health carrier provides at enrollment a Provider Directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section E, Standard 8

During review of the Access Plan, examiners were provided with a copy of the Company's current Provider Directory. Upon review, examiners requested a copy of the Directory in effect during 2001. The Company responded that they do not maintain historical copies of the directory. A current directory is provided to each new member upon enrollment and an updated version of the current directory is available on the Company's website.

The Company also provided a listing of all CBH providers during 2001 at the request of the examiners. This listing was then sorted by zip code and seven provider sample items were randomly selected for further review. During this review, examiners attempted to tie the providers listing in the CBH provider file to the CIGNA HealthCare Provider Directory dated Winter 2001/2002 which had been provided to the examiners. Based upon this review, the following exceptions were noted:

1. 9 providers were included in the CHC Provider Directory, but were not listed under the town (zip code) noted on the CBH provider file.
2. 8 providers were included in the CHC Provider Directory, but were not listed in the CBH provider file.
3. 28 providers from the CBH provider files were not listed in the CHC Provider Directory. **(Finding 28)**

F. Producer Licensing

The producer-licensing portion of the examination is designed to test a Company's compliance with state producer licensing laws and rules. The focus of the review relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

The examiner reviewed and compared information obtained from the Bureau of Insurance and Company records pertaining to licenses held by individuals or entities soliciting business on behalf of the Companies.

We tested licensed producers by randomly selecting a sample of producers from various sources as noted in the following table:

Review Summary

Source	Population Size	Sample Size	Sample Type	Errors Discovered	Error Rate
2001 Individual Producers (Active)	102	10	Random	0	0%
2001 Producer Firms (Active)	29	5	Random	0	0%
2001 New Business - Large Group	36	5	Random	0	0%
2001 New Business - Small Group	196	20	Random	0	0%
2001 Brokers	91	10	Random	2	20%
Total	454	50			

Standards
Producer Licensing

Standard F-1
Company records of licensed and appointed (if applicable) producers agree with department of insurance records.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section F, Standard 1

Examiners compared the Companies' list of agents selected from the samples selected above, to the list of agents licensed by the State of Maine Bureau of Insurance. The following exceptions were noted:

Two agents were noted as the producer on two policies written during 2001, but license records at the MBOI indicated that these two agents were not licensed until May of 2002. It was noted that these two agents were both CIGNA producers. It appears that these two agents would be in violation of the Maine Statute Section 1411 and the Company's own internal producer licensing guidelines. **(Finding 13)**

Standard F-2
Producers are properly licensed and appointed (if required by state law) in the jurisdiction where the application was taken.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section F, Standard 2

See comments relating to Standard F-1 above.

Standard F-3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section F, Standard 3

The Company advised that they had not terminated any producers during 2001, accordingly, examiners were unable to review this standard.

Standard F-4
The Company's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section F, Standard 4

This standard is concerned with potential geographical discrimination through the insurer's selection and instructions to its producers. The tests are intended to expose indicators of such a practice and may not be conclusive.

Based on our testing, the Company's policy of producer appointments and terminations does not appear to result in unfair discrimination against policyholders.

Standard F-5
Records of terminated producers adequately document reasons for terminations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section F, Standard 5

As noted in Standard F-3 above, the Company advised that they did not terminate any producers during 2001, accordingly, examiners were unable to review this standard.

H. Policyholder Service

The policyholder service portion of the examination is designed to test a Company's compliance with statutes regarding notice/billing, delays/no response, premium refund, coverage questions, and nonforfeiture options.

The policyholder service review included standards relating to the adequacy and level of policyholder service provided by the Companies.

In response to our request for renewal information, CHC provided a listing of 92 large group renewals (fully insured, 50+) and 1021 small group renewals applicable to Maine business for the period January 1, 2001 through December 31, 2001. A random sample of 50 items was selected for review across the populations in accordance with the Handbook.

The examiners reviewed a random sample of renewal notices from the above sample to determine if the notices were mailed in accordance with Maine statutes and regulations. The examiners also reviewed a random sample of premium notices to determine if they were mailed in accordance with Maine statutes and regulations.

Review Summary:

Source	Population Size	Sample Size	Sample Type	Errors Discovered	Error Rate
Large Group Renewals	92	4	Random	0	0%
Small Group Renewals	1021	46	Random	0	0%
Total	1113	50			

Standards
Policyholder Service

Standard H-1
Premium notices and billing notices are sent out with an adequate amount of advance notice.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 1

In order for the statutory limitations on cancellations to operate appropriately, it is important for premium and billing notices to be provided on a timely basis.

The examiners reviewed the system used by the Company to send premium and billing notices to its policyholders. The premium and billing notices appear to be sent out with an adequate amount of advance notice.

Standard H-2
Policy issuance and insured requested cancellations are timely.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 2

During review of the above sample, examiners reviewed the policy issuance procedures and noted they were performed timely. Also, any of the above sample policies that had subsequently cancelled, were reviewed with no indication of lack of timely cancellation noted.

Standard H-3
All correspondence directed to the Company is answered in a timely and responsive manner by the appropriate department.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 3

Throughout the examination, examiners reviewed correspondence files in conjunction with each area of testing. No unusual or unreasonable delays were identified.

Standard H-5
Policy transactions are processed accurately and completely.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 5

Throughout the examination, examiners reviewed policy transactions and noted they were accurately and completely processed, unless otherwise noted in the comments.

Standard H-7
Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 7

Examiners reviewed the Company's process for providing evidence of creditable coverage and noted the Company appears to be in compliance.

Standard H-8
Whenever the Company transfers the obligations of its contracts to another company pursuant to an assumption reinsurance agreement, the company has gained the prior approval of the insurance department and the company has sent the required notices to its affected policyholders.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section H, Standard 8

Based upon discussions with the Company, it was noted that the Company did not enter into any reinsurance assumption agreements during the period covered by this examination.

J. Underwriting and Rating

The underwriting portion of the examination is designed to provide a view of how the Companies treat the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It was determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of a review include:

1. Rating practices;
2. Underwriting practices;

3. Use of correct and properly filed and approved forms and endorsements;
4. Termination practices;
5. Unfair discrimination;
6. Use of proper disclosures, buyers guides and delivery receipts;
7. Reinsurance; and
8. Associations.

The Company provided two listings of Maine policies that cancelled, terminated or non-renewed during the examination period of January 1, 2001 to December 31, 2001. The first file included enrollees covered under legacy Healthsource Maine, Inc. benefit plans, which are coded in the MHC claim system as follows: HSME (large group HMO), FIPS (Point of Service Plans), SHMO (Small Group HMO) and LNHP (Direct Enrollment/Non-Group Coverage). The second file consisted of groups covered under CHC's Transformation benefit plans, which are structured in the PMHS claim system. The following is a summary of the populations and the sample selected:

System	Type of Product	Record Count	Sample Size
MHC	ME HSME Groups	100	5
MHC	ME FIPS Groups	60	3
MHC	ME SHMO Groups	859	40
MHC	ME LNHP Groups	14	1
PMHS	Groups	2	1
	1035	50	

The examiners assessed whether the declinations and rejections appeared to be unfairly discriminatory and whether reasons were provided to applicants. The policies were reviewed to assess whether reasons for adverse underwriting decisions appeared appropriate and were in compliance with applicable Maine statutes and regulations.

Standards
Underwriting and Rating

Standard J-5
The company underwriting practices are not to be unfairly discriminatory. The company adheres to applicable statutes, rules and regulations, and company guidelines in the selection of risks.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section J, Standard 5

Examiners reviewed the Company's underwriting practices in connection with the above sample and noted no instances where the Company appeared to be unfairly discriminatory.

Standard J-8
Policies, riders and endorsements are issued or renewed accurately, timely and completely.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section J, Standard 8

During review of the Company's policy files, examiners noted no instances where policies, riders and endorsements were not timely issued.

Standard J-10
Cancellation/non-renewal/discontinuance notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section J, Standard 10

Examiners reviewed the Company's policies for cancellation and non-renewal. These policies appear to be in accordance with policy provisions and state laws, except as follows:

During our sample testing, we noted 4 items where the Company had notified the groups of cancellation for nonpayment of premium. Per discussion with the Company, the current cancellation procedure only requires that the Company notify the group and the Bureau of Insurance that a cancellation notice was sent for nonpayment of premium. Maine Statute 24-A, Section 4209 (6)b, and Company policy and procedures Section 8.10.1, both require that the individual members within a group be notified at the time the group cancellation notice is sent to the group and the Bureau of Insurance. **(Finding #22)**

Also, during testing of Cancellations/Terminations, examiners noted that one of the fifty items in the sample had an incorrect termination date. The group selected had actually been terminated eight years ago and was included in error in the population. No supporting documentation could be provided by the Company.

Two additional cancellations were also lacking supporting documentation. Per the Company, the sales department was notified verbally by the group to terminate its coverage, but no supporting documentation could be provided.
(Finding #21)

Standard J-11
Cancellation practices comply with policy provisions, HIPAA and state laws.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section J, Standard 11

Except as noted in Standard J-10 above, examiners noted no other discrepancies in the Company's cancellation practices.

Standard J-12
Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section J, Standard 12

Based upon the above testing, examiners noted no instances were the Company was not correctly accounting for unearned premiums and returning when appropriate.

L. Claims

Paid Claims

The claims portion of the examination is designed to provide an overview of how the Company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. Compliance is determined by testing a random sample of files and applying various tests to open and closed claims. For purposes of testing, "claim file" means the file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation of benefit statements, copies of checks or check numbers and amounts, releases, complaint correspondence, all applicable notices and correspondence used for determining and concluding claim payments or denials, and any other documentation necessary to support claim handling activity.

The review is concerned with the Company's claim practices by line of business for compliance with statutes, rules and regulations and policy provisions. Some of the areas considered in this review include:

1. Time studies to measure acknowledgement, investigation and settlement times;
2. General handling study;
3. Claims without payment survey;
4. Litigation survey;
5. Claims form review;
6. Time study on cancelled checks;
7. Unfair claim practices review; and
8. Review of other procedures, as deemed necessary.

Examiners tested paid claims by randomly selecting three paid claim samples from the population of paid claims related to the period January 1, 2001 through December 31, 2001. The samples were pulled from the following major system groups written in Maine: CHC MHC and PMHS paid claims, CBH paid claims, and Argus Pharmacy paid claims. (Population and sample sizes are noted below.)

Examiners randomly selected paid claims from the above populations and requested the claim files to compare the data per the Companies' system to the original claim support submission

(electronic or hard copy) from the claim files to determine whether the Companies correctly processed the paid claim in accordance with the policy provisions and state regulations. The examiners classified the number and types of errors with respect to the specific fields tested, and identified the source of the errors found.

For the paid claim samples, an error is defined as any one or more elements of the paid claim that was not properly handled by the Companies in relation to the Companies' policy or a state law or regulation. Errors are determined on a statute by statute basis.

Denied Claims

We tested denied claims by selecting a random sample of denied claims relating to the period January 1, 2001 to December 31, 2001 from the following systems for business written in Maine: CHC MHC and PMHS denied claims, CBH denied claim and Argus Pharmacy denied claims. Examiners randomly selected a sample of denied claims from each of the three claim populations. (Population and sample sizes are noted below.)

Examiners requested the appropriate claim files to review and determine whether the Companies correctly denied the claim in accordance with policy provisions and state laws and regulations. The examiners classified the number and types of errors with respect to the specific fields tested, and identified the source of the errors noted.

For the denied claim sample, an error is defined as any one or more elements of the denied claim, which was not properly handled by the Companies in relation to the Company's policy or state laws and regulations. We looked for potential violations of statutes relating to fair claim handling practices.

Standards
Claims

Standard L-1
The initial contact by the Company with the claimant is within the required time frame.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 1

Maine Statute Title 24-A, Section 2164-D requires acknowledgement with reasonable promptness to pertinent written communication with respect to claims arising under its policies. This section also requires the Company to provide forms, accompanied by reasonable explanation for their use, necessary to present claims within 15 calendar days of such a request.

The examiners used three samples to examine the Companies' claims (as noted above). See Standard L-3 for a summary of the results of the claim review. The examination disclosed that in general the Companies appear to be making a good faith effort to contact its claimants within the required time frames.

Standard L-2
Investigations are conducted in a timely manner.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 2

Maine Statutes Title 24-A, Section 2164-D, requires the Company to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

The examiners used three samples to examine the Companies' claims (as noted above). See Standard L-3 for a summary of the results of the claims review. The examination disclosed that in general the Companies appear to make a good faith effort to investigate the claim related events reported by claimants in a timely manner.

Standard L-3
Claims are settled in a timely manner as required by statute, rules or regulation.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 3

Review Summary

Line of Business	Population Size	Sample Size	Sample Type	Errors Identified	Sample Error Rate
CHC MHC and PMHS System	1,109,598 MHC 17,673 PMHS	100	Random	20	20%
CBH System	36,559	100	Random	21	21%
Argus Pharmacy	515,367	50	Random	2	4%

Maine Statutes Title 24-A, Section 2164-D require the Companies to affirm coverage or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim. Section 2436 states that a claim for payment of benefits under a policy or certificate delivered or issued for delivery in Maine is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy.

The examiners used three samples to examine the Companies' paid claims (as noted above). See exceptions noted below:

During review of the CHC paid claims testing, examiners noted that in several claims reviewed that were not paid within 30 days of receipt, the Company had not included interest calculated on the payment amount in accordance with M.R.S.A., Section 2436. Discussions with the Company have indicated that it was noted during 2001 that the MHC claims system was not capable of paying interest on overdue claims. An IT project was conducted during 2001 to make changes to the MHC system to allow for this payment of interest when appropriate. Per the Company, this

change was completed during 2001, but for most of 2001, no interest was paid on overdue claims.

During testing of paid and denied claims from the MHC system (as noted below), examiners noted several errors where claims were incorrectly paid or denied. The Company reviewed these issues and subsequently adjusted these claims to pay the correct amount where appropriate. Examiners subsequently reviewed the adjusted claims in the MHC system and noted that these claims subsequently adjusted in 2002 still did not include any payment of interest. It appears that the MHC system still is not properly calculating and paying interest on overdue claims. **(Finding #23)**

CHC MHC and PMHS Paid Claims

Examiners selected a sample of 100 paid claims from the CHC listing of 2001 paid claims from the MHC and PMHS system. The MHC system was the original claims processing system for CHC and was used primarily during 2001. The PMHS system is a new system that was used primarily during the last quarter of 2001. The two populations were combined for testing purposes and the sample was selected from the combined files.

During our review, the following exceptions were noted:

1. One claim was noted as having been received on April 3, 2000 and denied for no authorization on May 2, 2000. It appears that a claims processor changed the members PCP in error without the request of the member due to the receipt of another claim - which caused the authorization not to match. The member subsequently called to complain about the PCP being changed without her request. The claim was subsequently corrected and paid on 2/26/01 - 330 days later and no interest was included in the payment amount. This claim appears to have been denied in error and should have paid additional interest.
2. For nine claims, examiners were unable to verify that the amount paid agreed to the correct fee schedule. The amount paid did not agree to the default fee schedule provided and no additional fee information was included in the provider file.
3. One claim contained a line item for ambulance mileage reimbursement. Per the provider contract, the charge should have been compensated at the lesser of billed charges or the rates set in the fee exhibit - which called for mileage to be paid at $6 per mile. Per the claim form, the charge was for 33 miles, which should have paid $198 per the contract, however the billed amount of $363 was paid. The Company advised that this was a system set-up issue that was not realized and corrected until after the claim was paid which caused the claim to pay as a non-contracted provider.
4. One claim was noted as having been paid 42 days after receipt with no additional interest included in the payment amount. Review of the claim history seems to indicate that the claim was for a large transplant case and was paid later than 30 days due to internal reviews and the required approvals, not due to member or provider issues. As the claim was paid later than 30 days, additional interest should have been considered in the payment amount.

5. One claim was noted as having been paid 36 days after receipt with no additional interest included in the payment amount. Review of the claim history did not indicate any reason for the payment time to exceed 30 days. As the claim was paid later than 30 days, additional interest should have been considered in the payment amount.
6. The Company was unable to provide a copy of a cancelled check as proof of payment for 1 item in the sample.
7. Review of the claim payment history for 1 claim indicated that no copay was applied in error. According to the benefit summary, a $15 copay would have applied for this benefit.
8. One claim was received on 5/9/01 and paid on 6/21/01. During review of this claim with examiners, it was noted that the claim was paid incorrectly and should have paid an additional $16. The claim was corrected on 11/15/02 after review with the Company and reprocessed. Subsequent review of the revised claim amount does not indicate that any interest was considered with the revised payment amount.
9. One claim was received on 9/11/00 and was paid on 2/5/01 - 147 days later. Review of the file indicates that the claim had been denied due to lack of timely filing, but was later reversed upon appeal. Notes in the appeal file seem to indicate the provider submitted evidence of prior filing attempts. As the claim was paid later than 30 days and the provider submitted proof of prior filing attempts as approved by the appeals committee, additional interest should have been considered in the payment amount.
10. Review of one claim indicates that the claim had been paid and reversed three times and currently was incorrectly paid. The Company explained that they have had some problems with payment to the particular vendor. **(Finding #19)**
11. During review of the only PMHS paid claim selected, examiners noted that the Company was unable to provide a remittance advice for the claim selected. Also, the service was performed by providers Johnson and Aronson but the cancelled check provided was for Maine Center for Cancer. **(Finding #31)**

CBH Paid Claims

During review of the CBH paid claims, Examiners selected a random sample of 100 paid claims from the Company's listing of 2001 paid claims. Based upon our review, the following exceptions were noted:

1. During review of one claim, it was noted that authorization related questions by the Company resulted in a delay in the claim payment beyond the 30 day period. It did not appear that the Company considered additional interest payment for this overdue claim.
2. One claim was noted as having an incorrect provider number entered by the claims processor which caused the claim to overpay.
3. One claim was originally denied for no authorization on 7/25/00. A retro authorization was loaded on 2/12/01 and the claim was paid. There was no documentation in the file to indicate why the retro authorization was loaded or why the claim was paid. Examiners were unable to determine if the delay was due to the Company and if interest was considered for this overdue claim.
4. One claim was previously denied on 12/4/00 for no authorization, but the authorization was on file. Subsequently, the claim was corrected based upon a call from the member, but no additional interest was considered on the overdue payment. Also, the benefit

summary indicated that a $20 copay would apply, but no copayment was taken on the claim.

5. One claim was originally denied on 12/22/00 for "not within effective date". However, a new authorization was loaded on 1/18/01, but not paid until 5/9/01. No explanation was provided for the delay in payment and no interest was included in the payment amount. Examiners were also unable to verify the amount paid to the provider contract or a fee schedule - the authorization said to pay prevailing rate charge, but the provider screen shows contract provide status and the amount paid does not agree to either amount.
6. Examiners were unable to verify the amount paid on five claims as the amount paid did not agree to the rate listed in the provider agreement for the specific procedure code reviewed.
7. One claim was noted as having been paid 46 days after receipt. The Company indicated that the claim was being researched in eligibility and was not cleared for payment until 2/12/02, but no interest was included in the payment amount.
8. Examiners noted four claims where the benefit information indicated that a $15 copay would apply for the service provided, but the claim was processed with only a $10 copay applied.
9. Review of the benefit information for one claim indicated that the first five office visits would have a $20 copay and then 50% coinsurance would apply. Information provided by the Company indicated that the first five office visits were applied with only a $15 copay.
10. One additional claim also had a $10 copay applied when the benefits schedule showed a $15 copay for this service. Also, the copy of the cancelled check provided was not legible and examiners were unable to verify the payment amount.
11. Examiners were unable to verify the payee for one claim - the contract provided was for Community Counseling Center, but the provider was listed as Michael Garett at a different address and payment was made to Michael Garett not to Community Counseling Center.
12. One original claim was denied on 10/12/01 as the charge was incurred after termination of coverage. Eligibility was updated on 12/19/01 and the claim was later paid on 12/27/01 but no interest was included in the payment amount.
13. The Company denied payment for portions of 1 claim under the explanation that they were not "medically necessary", however, there was no documentation in the file to support this denial reason.
14. For one claim, examiners were unable to identify the provider in the service provider contract provided by the Company. **(Finding #33)**

ARGUS Pharmacy Paid Claims

In conjunction with the paid claims testing of CHC and CBH, examiners also selected a random sample of 50 paid claims from the Companies' Third Party Pharmacy Vendor - ARGUS. Of the 50 items in the sample, ARGUS was unable to provide documentation for 2 claims. **(Finding #37)**

Standard L-4
The Company responds to claim correspondence in a timely manner.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 4

Maine Statutes Title 24-A, Section 2164-D require acknowledgement with reasonable promptness to pertinent written communication with respect to claims arising under its policies.

The examiners used three samples to examine the Companies' claims (as noted above). See Standard L-3 for a summary of the results of the claim review.

Standard L-5
Claim files are adequately documented.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 5

Without adequate documentation, the various time frames required by statutes and/or regulation cannot be demonstrated.

See Standard L-3 for a summary of the results of the claim review. The examination disclosed exceptions noted above and in the denied claims review.

Standard L-6
Claim files are handled in accordance with policy provisions, HIPAA and state law.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 6

The examiners used three samples to examine the Companies' claims (as noted above). See Standard L-3 for a summary of the results of the claim review. The examination disclosed that in general the Companies handle their claims in accordance with policy provisions, HIPAA requirements and in compliance with applicable Maine statutes, rules and regulations.

Standard L-7
Company claim forms are appropriate for the type of product.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 7

Examiners found that the Companies use the appropriate claim forms for the type of products they market.

Standard L-9
Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPAA and state law.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 9

Review Summary

Line of Business	Population Size	Sample Size	Sample Type	Errors Discovered	Error Rate
CHC MHC and PMHS System	105,264 MHC 6,724 PMHS	100	Random	16	16%
CBH System	5,265	100	Random	10	10%
Argus Pharmacy	67,243	50	Random	See Below	See Below

Examiners reviewed a separate sample of denied and closed-without-payment claims.

Based upon the review, it was noted that document retention standards should be reviewed and enhanced. Also, the sample error rates were higher than expected. The following exceptions were noted during this review:

CHC MHC and PMHS Denied Claims

During review of the CHC denied claims populations, examiners noted that two claims systems were in use during 2001 - MHC and the new PMHS system. Examiners obtained downloads from both systems and combined them for review purposes. A sample of 100 items was selected from the combined file. Based upon this review, the following exceptions were noted:

1. One claim reviewed was for a large transplant case received on May 1, 2001 and paid on June 27, 2001 - 57 days later. Review of the file indicated that the claim was delayed due to the different levels of CIGNA review required for large claims - over $80,000 payments require additional levels or review and approval. This claim was included in the denied sample because the sample line selected was denied due to payment of a per diem on the total claim. The payment amount appears to be correct per the contract, however, the delay in payment seems to be due to internal review and not due to provider or member issues. Accordingly, it appears that additional interest should have been considered on this claim as it was over 30 days.
2. One claim was denied due to lack of timely filing, however, during review with the examiners, it was noted that the provider had attached proof of timely filing to subsequent correspondence. Review with claims personnel indicated that this was in fact a denial error and the claim was subsequently reprocessed to pay on 11/7/02. Subsequent review of the reprocessed claim by examiners indicated that the payment did not include any interest consideration in the payment amount.
3. One claim reviewed indicated that the claim was denied as a duplicate. Review of the file indicated that the claim paid under Medicare as primary and CHC as secondary. The statement from Medicare showed a remaining balance which was CHC's responsibility. The claim was incorrectly denied. Review with CHC claims personnel with the examiners indicated that this was in fact a denial error and the claim was subsequently reprocessed to pay on 11/7/02. Subsequent review of the reprocessed claim by examiners indicated that the revised payment amount did not include any overdue interest calculation.

4. One claim reviewed was denied due to being part of a global fee. Further review indicated that the claim was a pregnancy related claim that normally would have been paid under the delivery package, however, the member miscarried and there was not a delivery package charge. Examiners reviewed this claim with CHC Claims Personnel who agreed that this was in fact an error and the claim was subsequently reprocessed to pay on 10/31/02. Subsequent review by the examiners indicated that the claim was paid but no additional interest was included for the overdue payment.
5. An additional claim was denied due to no authorization. Further review of the claim indicated that there was an authorization on file that should have covered the service provided. Examiners review of this claim with CHC Claims Personnel indicated that this was in fact an error and the claim was subsequently reprocessed to pay on 11/7/02. Subsequent review by the examiners indicated that the claim was paid but no additional interest was included for the overdue payment.
6. One claim reviewed was noted as having been overpaid. The claim was for a large hospital claim. Review of charges indicated that the claim had been submitted twice and the 2nd copy included many of the charges from the 1st submission (that had previously been paid). Examiners reviewed the payments made on the first claim and the additional payments made on the 2nd submission and noted that one line charge seemed to have been paid again in error. All other charges seem to have been paid correctly.
7. One claim was noted as having been denied for no PCP on file. The claim was for self-referred OBGYN and current claims guidelines say no authorization or PCP would be needed for this type of service. Discussions with the Company indicated that previous guidelines said to deny the claim if no PCP was on file, but no evidence of this previous guideline could be provided. As current guidelines stated to pay the claim - this was considered to be denied in error.
8. Two claims were denied as past filing limit. The claims were appealed and reversed based upon evidence of timely filing by the provider. The claims were subsequently paid, however, no interest was included in the payment amounts for over 30 days.
9. One claim indicated that Medicare paid most of the claim as primary. An error was made on the data entry of the claim (1 line was omitted) which caused the claim to not process as total charges did not match the EOB provided. This was an error and the Company should have paid their portion of the claim with interest.
10. One claim reviewed indicated that a line charge was properly denied for duplicate while the other line charge was paid less the copay. Review of the previously paid claim indicated that the copay was also applied on that charge. Review with CHC Claims Personnel indicated that this was in fact an error - because the claim was split and paid separately, the copay was incorrectly applied twice in error. **(Finding #20)**
11. One PMHS claim was received on 9/25/01 and paid on 12/31/01. Included in the payment was interest on the 67 days overdue. However, examiners were unable to agree the provider to the remittance and cancelled check provided.
12. During review of one claim, it was noted that the claim was received on 9/4/01 but not denied until 11/15/01. No explanation for the long period before denial was provided.
13. One claim did not contain a provider name in the source population file. Per review, the claim was originally denied for no authorization due to a system error and then reprocessed and paid on 6/6/02 - 175 days later. Authorization evidence was not provided

for review and examiners were unable to verify the payment amount. Also, it appears that no interest was included in the payment.

14. One claim reviewed was provided under provider Intermed, but the remittance and cancelled check provided were for Generations DBA Yarmouth Family Practice. Per the Company, an error was made when the system pulled the incorrect vendor number for this claim causing the payment to go to Generations instead of Intermed.
15. One claim was denied for no authorization, but no authorization information was provided to Examiners for review. The claim was later corrected and paid on 11/5/02 with a small interest amount. Examiners were unable to verify what the correction related to and how the interest was calculated. **(Finding #31)**

CBH Denied Claims

During review of the CBH denied claim sample, the following exceptions were noted:

1. During review of one claim, it was noted that the psychiatry charge was denied as included in the per diem rate paid under another procedure code. However, a note on the authorization indicated that "per diem rates are not inclusive of psychiatry charges - please pay negotiated rates as follows... Procedure Code 99213 $23.50" (the charge under review). The authorization seems to contradict the Company's explanation of payment.
2. Two sample items were included in a claim with a date of service 10/3/01 received on 10/15/01 and denied for COB information on 10/31/01. Dates of service 10/10, 10/17 and 10/24 were also submitted on 11/5/01 and denied 11/19/01 for COB info. COB info. was received on 4/30/02 and the claim was reconsidered on 5/1/02 and paid on 5/7/02. A copy of the letter requesting COB information provided by the Company was dated 3/22/02 - 4.5 months after the original claim was denied. Also, the authorization used to pay the claim appears to have been effective 10/17/01 but one line paid had a date of service of 10/10/01, prior to the authorization effective date.
3. During review of one claim, it was noted that a 157 day period between the receipt of additional insurance information and when the claim was processed. Per the Company, it appeared that the COB information was called in but the claims area was not made aware of it in order to reconsider the claim. No interest was included in the overdue payment amount.
4. One claim was denied for an itemization of a charge billed. The provider sent the itemized bill but the file was still on hold awaiting COB information requested from the member. No documentation of a COB information request was noted in the file.
5. One file was denied for COB and student status information. Per the Company, they have never received the student status and have not reconsidered the claim. Based upon review of the claim file notes, Examiners noted under Patient Comment #3 - "student status received via fax - sent for filing". This seems to indicate that the student status was received, but the claim has still not been reprocessed.
6. One claim was noted as having been denied and later paid. Per the Company, the claim was denied in error, however, no interest was included in the revised payment amount.
7. One claim was denied and then paid due to Health Plan Grievance Committee appeal. Appeal information was not provided. Examiners were unable to verify if additional interest should have been included with payment.

8. One claim was denied in error. Per the Company, the original claim was reprocessed under a terminated registration. The claim was reconsidered and paid under the active member number, but interest should have been included in the payment amount and was not.
9. One claim was denied as not a covered service because it was submitted with the wrong diagnosis code. The claim was later resubmitted and paid, although it took 12 days to enter the system and 51 days to pay. The delay appears to be a Company delay and interest should have been included in payment amount. **(Finding #34)**

Argus Pharmacy Denied Claims

During review of the denied claim populations, examiners had selected a sample of 50 claims denied in 2001 from the Argus Pharmacy population. Discussions with the Company have indicated that they would not be able to provide any documentation of this sample, as they have been advised by Argus (their pharmacy TPA) that they do not maintain documentation for denied claims. Accordingly, Examiners are unable to complete the review in this area.

This appears to be a violation of M.R.S.A., Section 2164-D (3) (D) Unfair Claims Practices Law which requires an insurer to develop and maintain documented claims files supporting decision made regarding liability. **(Finding #25)**

Standard L-10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 10

Examiners reviewed cancelled checks for each item in the above samples to determine whether claim proceeds are being promptly mailed or delivered and whether the checks and drafts are payable to the correct payee and for the correct amount and are properly endorsed.

Examiners verified the check information including the payee, check date, amount, and endorsement to the cancelled check. In the case of Electronic Fund Transfers (EFT), the payment information was traced to supporting EFT documentation provided by the bank. No reportable exceptions were noted during this review, however, some exceptions were noted above in paid claims testing.

Standard L-11
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 11

Throughout the claims review, examiners reviewed for instances where the Companies' claims handling practices appeared to compel claimants to institute litigation. Although the Companies

had a high level of appeals, we did not note any instances where the Companies appeared to compel claimants to institute litigation.

Standard L-13
The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA).

NAIC Market Conduct Examiners Handbook - Chapter XVII, Section L, Standard 13

Examiners noted no instances where insureds with differing qualifying events covered under the policy or insureds with similar qualifying events covered under the policy were discriminated against.

SUMMARY OF FINDINGS AND CONCLUSIONS

Comment #	Subject	Examination Cycle	Report Section/ Page #	Comment Description
2	IAD Audit	Company Operations and Management	A-1 Page 11-12	Lack of IAD Coverage
3	Record Retention	Company Operations and Management	A-6 Page 15	CBH Lack of Record Retention Policy
4	CBH SAS 70	Company Operations and Management	A-5 Page 14	Lack of CBH SAS 70
6	Record Retention and lack of marketing individual products	Marketing and Sales	D-1 Page 46-47	Lack of documentation and marketing
7	Record Retention	Complaint Handling	B-1 Page 20	CHC missing complaint files
8	Lack of complaint tracking	Complaint Handling	B-1 Page 20	CBH - Lack of complaint tracking
9	Advertising Findings	Marketing and Sales	D-1 Page 47	Advertising findings
10	OOC review findings	Marketing and Sales	D-5 Page 50-52	Outline of Coverage issues
11	Producer Training	Producer Licensing	D-2 Page 48-49	Lack of documented training program
13	Producer Licensing	Producer Licensing	F-1 Page 60	Two unlicensed agents
14	Missing complaints	Complaint Handling	B-1 Page 20-21	CHC missing complaint files

15	Administrative Grievance Testing	Grievance Process	C-2 Page 29	CHC first level admin. grievance exceptions
16	Complaint Testing	Complaint Handling	B-3/B-4 Page 23-25	CHC complaint exceptions
17	Grievance Testing	Grievance Process	C-2 Page 30 – 33	CHC 1st and 2nd level Grievances
18	2411 Violation	Complaint Handling	B-2 Page 22-23	CHC lack of filing with MBOI
19	MHC Paid Claim Exceptions	Claims	L-3 Page 77-79	MHC Paid Claim exceptions
20	MHC Denied Claim Exceptions	Claims	L-9 Page 85-88	MHC Denied Claim exceptions
21	Cancellations - Missing docs and incorrect dates	Underwriting and Rating	J-10 Page 69	Lack of documentation
22	Notification of Member	Underwriting and Rating	J-10 Page 69	Lack of member notification upon cancellation
23	MHC Claims System - failure to pay interest on overdue claims	Claims	L-3 Page 75-76	Lack of interest payment on overdue claims
24	Grievance Testing % of overturned	Grievance Handling	C-4 Page 42 -43	CHC 1st and 2nd level grievances overturned
25	Argus Denied Claims - record retention	Claims	L-9 Page 91	Lack of Support - Argus denied claims
26	Administrative Grievance Testing - CBH	Grievance Handling	C-2 Page 33-34	CBH 1st level administrative grievances
28	Network Adequacy - Provider Exceptions	Network Adequacy	E-8 Page 57-58	Network Adequacy provider exceptions
29	Medical Necessity Grievance Testing	Grievance Handling	C-2 Page 35-37	CBH 1st level medical necessity grievances
30	2nd Level Grievance Testing	Grievance Handling	C-2 Page 38-39	CBH 2nd level grievances
31	PMHS Paid and Denied Claims	Claims	L-3 Page 79 L-9 Page 88	PMHS Paid Claim exception and PMHS Denied Claims exceptions
32	Expedited Appeals	Grievance Handling	C-7 Page 43-44	Lack of expedited indication
33	CBH Paid Claims Exceptions	Claims	L-3 Page 79-82	CBH Paid Claim Exceptions

34	CBH Denied Claims Exceptions	Claims	L-9 Page 89-91	CBH Denied Claims exceptions
35	Provider Appeals - Policy and Procedures	Grievance Handling	C-2 Page 39	Lack of Provider Appeals policy
36	Provider Appeals Testing	Grievance Testing	C-2 Page 39-41	Provider Appeals testing exceptions
37	Argus Paid Claims	Claims	L-3 Page 82	Company unable to provide documentation for 2 Argus paid claim files

Note: Above listing of findings relates to original listing of examination findings. The lack of numeric sequence of the above listing relates to findings that have subsequently been cleared with the Company.

ACKNOWLEDGMENT

The courtesy and cooperation extended by the officers and employees of the Company during the course of the Examination is hereby acknowledged.

The Examination was conducted and respectfully submitted by the undersigned.

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Richard J. Nelson
Examiner In-Charge

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Eric A. Cioppa, being duly sworn according to law, deposes and says that in accordance with the authority vested in him by Alessandro A. Iuppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, he has made an examination on the condition and affairs of the

of Freeport, Maine as of December 31, 2001, and that the foregoing report of examination, subscribed to by him, is true to the best of his knowledge and belief.

_____
Eric A. Cioppa
Deputy Superintendent

Subscribed and sworn to before me
This ____ day of _____, 2004

_____
Debra L. Tozier
Notary Public

My commission expires: