# Market Conduct Examination
# CIGNA HealthCare of Maine, Inc.

**And**

# CIGNA Behavioral Health, Inc.

**NAIC Company Code #95447**
**NAIC Exam Tracking System #ME008-M5**

**2 Stonewood Drive**
**Freeport, ME 04033**

**Examination Period:**
**4/01/02 thru 6/30/02**

# Contents

August 1, 2003

## SALUTATION

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 24-A M.R.S.A. § 221 and in conformity with your instructions, a targeted market conduct examination has been made of:

**CIGNA HealthCare of Maine, Inc. (CHC)**

**and its affiliate**

**CIGNA Behavioral Health, Inc. (CBH)**

CHC is organized and incorporated under the laws of the State of Maine. The examination reviewed only the operations of CHC and CBH as they impact residents and policyholders residing in the State of Maine or claimants involved in losses in, or related to, Maine claims. The on-site phase of the examination was conducted at the offices of CHC servicing Maine business located at:

**2 Stonewood Drive**
**Freeport, ME 04033**

The following report is respectfully submitted.

## SCOPE OF EXAMINATION

Prompt payment of claims has become a national issue. Many states are conducting or have conducted market conduct examinations regarding the issue of prompt payment of claims. On the state level, the Maine Bureau of Insurance (hereinafter the "Bureau") has received inquiries from the provider and legislative communities of the payment practices of the insurance industry. Based on the national spotlight coupled with concern at the state level, the Superintendent has decided that targeted market conduct examinations regarding the prompt payment of claims will be performed on all managed-care organizations operating in the State of Maine over the course of 2002 and 2003.

This examination includes claims paid during the 2nd quarter 2002 including April 1, 2002 through June 30, 2002. This examination period will be utilized consistently for all managed-

care organizations being examined in this cycle. This was a targeted examination limited in scope to the examination of prompt payment issues as outlined in 24-A M.R.S.A. § 2436 (1) (2) and (3) and the documentation standards outlined in 24-A M.R.S.A. § 3408.

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 (hereinafter the "Handbook") and the rules and regulations prescribed by the State of Maine through tests developed by the Bureau. Sampling was used in accordance with Handbook standards.

Readers of this report must recognize that due to the targeted focus of the examination, only matters pertaining to prompt payment of claims have been reviewed in the course of this examination. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Maine Bureau of Insurance. Statutory cites and regulation references are as of the period under examination unless otherwise noted.

## HISTORY AND PROFILE

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 Corp (CIGNA Corp.). 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, after reporting losses for the three previous years, CHC did report a profit in 2001 and 2000, due to declining loss ratios.

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

## METHODOLOGY

This examination is based on the Standards and Tests for a Market Conduct Examination of a health insurance company as found in Chapter XVII of the Handbook, specifically as it relates to claims payment practices. The standards were tested through detailed review of a random sample of 100 claim files paid during the 2nd quarter 2002 using sampling methodology described in the Handbook.

Standards were evaluated using tests designed to adequately measure how the examinee met the standard and legal requirements of 24-A M.R.S.A. § 2436. Each test applied is described and the result of testing is provided in the "STANDARDS" section of this report. The standard, its statutory authority under Maine law, and its source in the Handbook are stated and contained within a **bold border**.

## STANDARDS

The specific Handbook standards and tests developed by the examiners are outlined in this section.

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| **Standard L-3**<br>Claims are settled in a timely manner as required by statues, rules and regulations.<br><br>*NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 3; and 24-A M.R.S.A. § 2436* |
| **Standard L-4**<br>The company responds to claim correspondence in a timely manner.<br><br>*NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 4; and 24-A M.R.S.A. § 2436* |
| **Standard L-5**<br>Claim files are adequately documented. |

*NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 5; and 24-A M.R.S.A. § 2436 & 3408 (1)*

This examination was designed to determine the compliance of the Company with 24-A M.R.S.A. § 2436 (1), (2) and (3) by applying specific tests to the sampled items based on Standards L-3, L-4 and L-5 of the Handbook. The results of the testing reflect compliance or noncompliance with the standards and statute.

**TEST 1:** Standard L-3 establishes a general framework for the timely settlement of claims. The corresponding Maine statute, 24-A M.R.S.A. § 2436 (1), states in part:

*"A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State 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 the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured" or "beneficiary"; includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue."*

TEST 1: Based on 24-A M.R.S.A. § 2436 subsection (1), a claim must be paid within 30 days after proof of loss is received and ascertainment of the loss is made by the insurer, otherwise it is considered overdue.

**TEST 2:** In addition to the standards outlined in Test 1, Title 24-A M.R.S.A. § 2436 (1) outlines the standards to apply when additional information is needed by the Company in order to process an undisputed claim as contemplated in Standard L-4. The subsection continues as follows:

*"If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information;"*

The standards of documentation outlined in Standard L-5 are further solidified by 24-A M.R.S.A. § 2436 (2) which states:

*"An insurer may dispute a claim by furnishing to the insured or beneficiary, or a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position."*

TEST 2: Based on 24-A M.R.S.A. § 2436 (1) and (2), a claim file must contain adequate documentation of the claims process including written notification to the claimant of reasonable additional or disputed information is required by law.

**TEST 3:** If the Company fails to pay an undisputed claim within the 30 day timeframe required by law, there is a late payment interest penalty assessed. This is a further testing requirement of

Standard L-3. The application of the interest penalty is addressed in 24-A M.R.S.A. § 2436 (3) which states:

*"If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date."*

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| TEST 3: Title 24-A M.R.S.A § 2436 (3) requires an insurer to pay an interest penalty to the claimant if the insurer fails to pay undisputed claims within 30 days of proof of loss. |

## APPLICATION OF TESTS

This section outlines the application of the tests to the random sample of 100 items selected from the population of paid claims items during the 2nd quarter 2002. The results of applying the criteria outlined in the tests are as follows:

| **TABLE 1:** | | | | | | |
|---|---|---|---|---|---|---|
| ***Test #*** | ***Type*** | ***Sampled*** | ***N/A*** | ***Pass*** | ***Fail*** | ***% Pass*** |
| **TEST 1** ***Paid < 30 days*** | Paid Items | 100 | 0 | 92 | 8 | 92 |
| **TEST 2** ***Adequate Documentation*** | Paid Items | 100 | 0 | 100 | 0 | 100 |
| **TEST 3** ***Interest on Claims > 30 days*** | Paid Items | 100 | 92 | 2 | 6 | 25 |

The 8 paid items that were not paid within 30 days and therefore failed Test 1 were then subjected to Test 3 to determine Company compliance with the interest penalty portion of 24-A M.R.S.A § 2436 (3). Of the 8 items that were not paid within 30 days:

- 2 items had penalty interest calculated and paid correctly
- 3 items had penalty interest paid but calculated incorrectly (2 underpaid,1 overpaid)
- 3 items had no penalty interest paid

Based on the inconsistent application of late payment interest coupled with the relatively small number of claims where payment was not made within 30 days after proof of loss, it was determined to select an additional random sample of 100 items selected from the CHC population where payment was not made within 30 days after proof of loss. Results as shown in Table 2.

| TABLE 2: | | | | | | |
|---|---|---|---|---|---|---|
| ***Test #*** | ***Type*** | ***Sampled*** | ***N/A*** | ***Pass*** | ***Fail*** | ***% Pass*** |
| **TEST 2** ***Adequate Documentation*** | Paid Items | 100 | 0 | 92 | 8 | 92 |
| **TEST 3** ***Interest on Claims > 30 days*** | Paid Items | 100 | 37 | 21 | 42 | 33 |

Of the 37 items removed from the sample as N/A:

- 14 items were for reversal/reprocessing
- 19 items were for overpayment recovery
- 4 items were for reversal of denials

Of the 42 failing items:

- 35 items had no interest paid
- 7 items had interest paid but calculated incorrectly

Because the CBH portion of claims processed during the examination period was only 2% of the population, a random sample of 50 items was selected from the CBH population where payment was not made within 30 days after proof of loss. Results as shown in Table 3.

| TABLE 3: | | | | | | |
|---|---|---|---|---|---|---|
| ***Test #*** | ***Type*** | ***Sampled*** | ***N/A*** | ***Pass*** | ***Fail*** | ***% Pass*** |
| **TEST 2** ***Adequate Documentation*** | Paid Items | 50 | 0 | 22 | 28 | 44 |
| **TEST 3** ***Interest on Claims > 30 days*** | Paid Items | 50 | 9 | 0 | 41 | 0 |

Of the 9 items removed from Test 3 as N/A:

- 3 items dealt with duplicate coverage issues
- 6 items exceeded the 30 day process time but no penalty interest was due

Of the 41 items that failed Test 3:

- 12 items had no interest paid
- 29 items had interest paid but calculated incorrectly and/or not paid in a timely manner

## COMMENTS & RECOMMENDATIONS

### COMMENT #1:

CHC appears to pay 92% of claims within the required 30 days. The NAIC Market Conduct Examiners Handbook provides for a tolerance level of 7%, when dealing with claim related tests. The examination did reveal substantial failure to pay penalty interest when due and serious inconsistencies in calculating penalty interest due by both CHC and CBH.

### RECOMMENDATION:

CHC and CBH should implement automated system changes and manual processing procedures to properly recognize when penalty interest is due and properly calculate the penalty interest amount.

### COMMENT #2:

Title 24-A M.S.R.A. § 2436 (1) states in part "A claim that is neither disputed nor paid within 30 days is overdue." and (3) states "If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date." The Bureau defines the paid date as the date a claim check is issued or an electronic transfer is executed. The Bureau does not consider the day of receipt of a claim in the 30 day calculation. It was noted by examiners that CHC and CBH did not define the paid date nor calculate the 30 day process time in the same manner as the Bureau.

### RECOMMENDATION:

It is recommended that both CHC and CBH bring their systems and procedures into compliance with the Bureau's definition.

### COMMENT #3:

It was noted that CHC did not pay late payment interest when there was an account balance issue with a provider.

### RECOMMENDATION:

Recent legislation has established provisions for dealing with this issue. CHC should ensure their practices and procedures comply with 24-A MRSA § 4303 (10).

STATE OF MAINE
COUNTY OF KENNEBEC, SS

Van E. Sullivan, being duly sworn according to law, deposes and says that in accordance with the authority vested in him by Alessandro Iuppa, Superintendent of Insurance, pursuant to the

Insurance Laws of the State of Maine, he has made an examination of the condition and affairs of the

**CIGNA HealthCare of Maine, Inc. (CHC)**

**and its affiliate**

**CIGNA Behavioral Health, Inc. (CBH)**

of Freeport, Maine as of 2nd quarter 2002, and that the foregoing report of examination subscribed to by him is true to the best of his knowledge and belief.

The following examiners from the Bureau of Insurance assisted:

Carolee B. Nichols
Paul C. Greenier

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Van E. Sullivan
Market Conduct Division Supervisor

Subscribed and sworn to before me this _____ day of _____, 2004

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Notary Public
My Commission Expires:

I hereby certify that the attached report of examination dated August 1, 2003 shows the condition and affairs of CIGNA HealthCare of Maine, Inc. (CHC) and its affiliate CIGNA Behavioral Health, Inc. (CBH), Freeport, Maine as of 2nd quarter 2002 and has been filed in the Bureau of Insurance as a public document.

This report has been reviewed.

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Eric A. Cioppa
Deputy Superintendent

This ____ day of _____, 2004