

**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION  
BUREAU OF INSURANCE**

IN RE:

Cigna Health and Life Insurance Company  
NAIC Co. Code: 67369  
ME License No. LHF860  
  
Docket No. INS-26-230

**CONSENT AGREEMENT  
AND ORDER**

Cigna Health and Life Insurance Company (“Cigna” or “the Company”), the Superintendent of the Maine Bureau of Insurance (“the Superintendent”), and the Office of the Maine Attorney General (“the Attorney General”) hereby enter into this Consent Agreement pursuant to 10 M.R.S. § 8003(5)(B) to resolve, without resort to an adjudicatory proceeding, violations of the Maine Insurance Code. As set forth in more detail below, a market conduct examination identified violations of provisions of the Maine Insurance Code and Bureau of Insurance Rule Chapter 850 (“Bureau Rule Ch. 850” or “Rule 850”) relating to appeals of adverse initial decisions and requests for prior authorization of medical services and prescriptions.

**APPLICABLE LAW**

1. Under 24-A M.R.S. § 12-A, the Superintendent may assess civil penalties, issue a cease and desist order, or take any combination of these and other actions listed within this section against any person who violates any law enforced by the Superintendent; any rule lawfully adopted by the Superintendent; or any lawful order of the Superintendent.
2. Pursuant to 10 M.R.S. § 8003(5)(B), the Superintendent may resolve an investigation without further proceedings by entering into a consent agreement with a licensee and with the consent of the Attorney General.
3. 24-A M.R.S. § 4304(2) sets forth the requirements for health plans regarding prior authorization of nonemergency services.
4. 24-A M.R.S. § 4320-A(3-B) requires group health plans, other than small group health plans and high deductible health plans for use with HSAs, “to provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year. After the first behavioral health office visit, a health plan may not apply a

copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit.”

5. Bureau Rule Ch. 850, generally, sets forth standards for health plan accountability.
6. Bureau Rule Ch. 850 § 5 includes definitions for terms utilized throughout the Rule.
7. Bureau Rule Ch. 850 § 8 includes requirements for adverse health care treatment decisions, prior authorizations, and appeals of those adverse health care treatment decisions.
8. Bureau Rule Ch. 850 § 9 includes requirements for adverse benefit determinations that do not involve medical issues and appeals of those adverse determinations.

### **STATEMENT OF FACTS**

9. The Superintendent has jurisdiction over this matter pursuant to the powers set forth in the Insurance Code generally, as well as the specific provisions of 24-A M.R.S. §§ 12-A and 211 and 10 M.R.S. § 8003.
10. Cigna has been licensed in Maine as a foreign life and health insurance company since 1990, holding Maine Certificate of Authority number LHF860. Its NAIC Code is 67369, and it is domiciled in Connecticut.
11. 24-A M.R.S. § 221(5) requires the Superintendent to examine, no less frequently than once every five years, each domestic health carrier and each foreign health carrier with at least 1,000 covered lives in Maine that offer health plans. A targeted market conduct exam of Cigna, the results of which serve as the basis for this Consent Agreement, was accordingly called and conducted pursuant to 24-A M.R.S. §§ 211 and 221.
12. The examiners reviewed prior authorization requests, appeal requests and notices of adverse benefit determinations during a review period of July 1, 2023, through September 30, 2023.
13. The examiners tested the Company’s compliance with timing and notice requirements and reviewed their utilization review and appeals procedures and the utilization review and appeals sections of the plan documents associated with sample files.
14. The examiners found several instances of noncompliance with Rule 850 and the Maine Insurance Code which are set forth in more detail below and in the examiners’ Market Conduct Examination Report (“Examination Report”), which is herein incorporated by reference.

15. Where Rule 850, in part, is testing the presence of certain items in a form letter, a failure to include one item within a form letter may lead to a failure for other files being tested as all files use the same form.
16. Cigna cooperated with the examiners throughout this exam and proactively addressed several areas of noncompliance in advance of receiving the Examination Report.
17. Cigna agreed with most of the examiners' findings of noncompliance set forth in the Examination Report.

*Prior Authorizations - Bureau Rule Ch. 850 §§ 8(E), 9(A), and 24-A M.R.S. § 4304(2)*

18. The examiners reviewed a total of 478 sample files for prior authorization requests submitted during the review period. 299 sample files were standard prior authorization requests and 179 sample files were prior authorization requests in exigent circumstances. The sample files included requests for prior authorization of medical services and of prescription drugs.
19. As detailed in the Examination Report, in 152 sample files representing both standard prior authorization requests (117) and prior authorization requests in exigent circumstances (35), Cigna failed to include all required notices in its adverse decision letters and templates. This was in violation of 850 § 8(E)(6) for 150 health care treatment appeal decisions and 850 § 9(A) for two (2) appeal decisions that did not involve health care treatment decisions.
20. In sixty-one (61) sample files representing standard prior authorization requests, Cigna failed to complete the prior authorization process within the timeframes required by Rule 850 § 8(E)(2)(a).
21. Within the sixty-one (61) sample files identified in paragraph 20, there were thirty-four (34) sample files where the requests for prior authorization were denied even though Cigna had failed to meet the timing requirements. These requests should have been granted as required by 24-A M.R.S. § 4304(2) and Bureau Rule Ch. 850 § 8(E)(2).
22. In seventy-one (71) sample files representing prior authorization requests in exigent circumstances, Cigna failed to complete the prior authorization process within twenty-four (24) hours of receipt of the request as required by Rule 850 § 8(E)(3). These requests were all granted.

*Utilization Review Program - Rule 850 § 8(C)*

23. In a review of Cigna's utilization review guidelines, the examiners found that three (3) procedure documents included outdated or incorrect information regarding the decision timeframes for prior authorization requests set forth in Rule 850 § 8(E) and § 4304(2).

24. This constitutes a violation of Rule 850 § 8(C)'s requirement that a carrier's "utilization review program must be consistent with the requirements of this section."

*Copayments for Office Visits – 24-A M.R.S. § 4320-A(3-B)*

25. In reviewing plan forms associated with prior authorization sample files, the Examiners identified thirty-two (32) group plans that identified copayments for office visits that violate 24-A M.R.S. § 4320-A(3-B).
26. Ten (10) plans listed copayments for behavioral health office visits that were greater than the copayments for primary care office visits, and thirty-one (31) plans failed to provide coverage without cost sharing for the first behavioral health office visit or primary care office visit in a plan year.
27. Cigna began taking steps to update these plan documents once it was notified of this issue during the exam.

*Appeals – Rule 850 § 8(G) and (G-1), § 9(A), (B) and (C) and 24-A M.R.S. § 4303(4)(A)(2)*

28. Rule 850 includes Maine's requirements for appeals of adverse benefit determinations.
29. If the adverse benefit determination is an adverse health care treatment decision, it is subject to the appeals procedures set forth in Rule 850 § 8(G) and (G-1). The specific requirements for expedited appeals are in Rule 850 § 8(G)(2).
30. If the adverse benefit determination does not involve a health care treatment decision, it is subject to the grievance procedures set forth in Rule 850 § 9(A), (B) and (C).
31. The examiners reviewed eighty-four (84) sample files for first level appeal requests during the review period. This included sixty-seven (67) appeals of adverse health care treatment decisions and seventeen (17) appeals of adverse benefit determinations that did not involve medical issues.
  - A. Cigna sent late acknowledgment letters in twenty-two (22) samples and failed to send an acknowledgment letter in two (2) files. This violated Rule 850 § 8(G)(1)(a)(v) for twenty (20) files and Rule 850 § 9(B)(2) for four (4) files. Acknowledgment letters must be sent within three (3) business days of receiving an appeal request.
  - B. In seven (7) sample files, Cigna issued decision letters at the same time, or soon after, sending the acknowledgment letter. This limited or, in some cases, eliminated the covered persons' opportunity to request additional information or exercise other rights listed in the acknowledgement letter.
  - C. Cigna sent late decision letters in fifty-nine (59) samples. This violated Rule 850 § 8(G)(1)(c) for fifty (50) files and Rule 850 § 9(B)(2)(a) for nine (9) files.

Decision letters must be sent within thirty (30) days of receipt of the appeal or the receipt of all necessary information.

- D. In two (2) samples, Cigna sent the decision letter to the provider but failed to send the decision letter to the covered person in violation of Rule 850 § 8(G)(1)(c).
  - E. As detailed in the Examination Report, Cigna failed to include all required notices in its adverse decision letters and templates in thirty-six (36) samples. This violated Rule 850 § 8(G)(1)(c) for twenty-six (26) files and Rule 850 § 9(B)(2) for ten (10) files.
  - F. In seventeen (17) samples, the licensed health care practitioners who reviewed appeals of adverse health care treatment decisions were not clinical peers as that term is defined in Rule 850 § 5(H). This violated Rule 850 § 8(G)(1)(b).
32. The examiners reviewed the total population of eight (8) second level appeal requests during the review period. This included six (6) appeals of adverse health care treatment decisions and two (2) appeals of adverse benefit determinations that did not involve medical issues. The examiners also reviewed a ninth sample that the company had identified as an expedited second level appeal request.
- A. Cigna failed to issue a decision within 30 days of receipt of the appeal in six (6) of the seven (7) appeals where the covered person did not attend the review meeting. This violated Rule 850 § 4303(4)(A)(2).
  - B. Cigna failed to issue a decision within 45 days of the review meeting in the one (1) appeal where the covered person chose to attend the review meeting. This violated Rule 850 § 8(G-1)(3)(a).
  - C. As detailed in the Examination Report, Cigna failed to include all required notices in its adverse decision letters and templates in seven (7) samples. This violated Rule 850 § 8(G-1)(3)(f) for six (6) files and Rule 850 § 9(C)(3)(f) for one (1) file.
  - D. In one (1) of the two (2) second level appeals of adverse benefit determinations that did not involve medical issues, Cigna failed to convene a panel to review the appeal in violation of Rule 850 § 9(C)(2).
  - E. In one (1) of the six (6) second level appeals of adverse health care treatment decisions, the licensed health practitioner who reviewed the appeal was not a clinical peer as that term is defined in Rule 850 § 5(H). This violated Rule 850 § 8(G-1)(2).
  - F. The examiners reviewed one (1) additional sample file identified as an “expedited” second level appeal. This appeal file failed to include three (3) requirements applicable to 2<sup>nd</sup> level appeals in violation of Rule 850 § 8(G-1).

33. When identifying samples to review, the examiners also reviewed and analyzed a list of all second level appeals initiated during the exam period (the “universe”). The universe identified twenty-six (26) files that were incorrectly handled as single level appeals. seventeen (17) of these single level appeals resulted in adverse decisions. The adverse decision notices did not inform the covered person of their right to seek a second level of review. This violated Rule 850 § 8(G-1)(1) for seven (7) files and Rule 850 § 9(C)(1) for ten (10) files.
34. The examiners reviewed the total population of sixteen (16) expedited appeal requests during the review period.
  - A. In sixteen (16) samples, Cigna provided, or attempted to provide, verbal notification of the decision to the provider, but failed to also provide verbal notification of the decision to the covered person in violation of Rule 850 § (G)(2)(d).
  - B. In two (2) samples, Cigna failed to provide written notification of the decision within two (2) working days of the verbal notification in violation of Rule 850(G)(2)(e).
  - C. In five (5) samples, the licensed health practitioners who reviewed the appeals were not clinical peers as that term is defined in Rule 850 § 5(H). This violated Rule 850 § 8(G)(2)(a).
  - D. As detailed in the Examination Report, Cigna failed to include all required notices in its adverse decision letters and templates in three (3) samples in violation of Rule 850 § 8(G)(2)(e).

#### **VIOLATIONS OF LAW**

35. As set forth in paragraphs 18 through 24, Cigna failed to comply with all requirements set forth in Bureau Rule Ch. 850 §§ 8 and 9 and 24-A M.R.S. § 4304(2) regarding prior authorization decision timing, decision notice requirements and maintaining up-to-date written procedures.
36. As set forth in paragraphs 25 through 27, Cigna violated 24-A M.R.S. § 4320-A(3-B) by utilizing plan designs for ten (10) groups that included copayments for behavioral health office visits that were higher than copayments for primary care office visits and for thirty-one (31) groups that required copayments for the first behavioral health office visit or primary care office visit in a plan year.
37. As set forth in paragraphs 28 through 34, Cigna violated provisions in Rule 850 §§ 8 and 9 related to appeal decisions and the appeals processes carriers must have in place.

## COVENANTS

38. Cigna agrees to the Statement of Facts and Violations of Law and agrees that it is subject to disciplinary action.
39. Cigna accepts as disciplinary action the imposition of a civil penalty in the amount of one hundred and ten thousand dollars (\$110,000). No later than thirty (30) days after executing this Consent Agreement, Cigna will remit to the Maine Bureau of Insurance a company check in the amount of one hundred and ten thousand dollars (\$110,000) payable to the Treasurer of the State of Maine.
40. No later than thirty (30) days after the date of its signature, Cigna shall submit its responses to a Corrective Action Plan (CAP) provided by the examiners. The CAP shall specify steps Cigna intends to implement to correct the procedural deficiencies found during the Examination and set forth in Examination Report. The CAP should also include, as attachments, all form letters and notices that have been revised by Cigna based on the examiners' findings.
41. This Consent Agreement is not subject to appeal. Cigna waives any right it might have to appeal any matter that is a subject of this Consent Agreement.
42. This Consent Agreement constitutes an Order of the Superintendent. A violation of its terms is enforceable by the Superintendent pursuant to 24-A M.R.S. §§ 12-A and 211.
43. This Consent Agreement is also enforceable by an action in Maine Superior Court pursuant to 24-A M.R.S. § 214, 10 M.R.S. § 8003(5)(B), and 14 M.R.S. § 3138.
44. The effective date of this Consent Agreement is the date of the Superintendent's signature hereto.
45. This Consent Agreement may be modified only by a written agreement executed by all the parties hereto. Any decision to modify, continue or terminate any provision of this Consent Agreement rests in the discretion of the Superintendent and the Attorney General.
46. This Consent Agreement is a public record as that term is defined by 1 M.R.S. § 402(3). It is subject to the provisions of the Maine Freedom of Access Act, 1 M.R.S. §§ 401 through 410, and it will be available for public inspection and copying as provided for by 1 M.R.S. § 408-A.
47. This Consent Agreement is also an adverse action and will be reported to the Regulatory Information Retrieval System ("RIRS") database at the National Association of Insurance Commissioners ("NAIC").
48. Nothing in this Consent Agreement shall be construed to affect any right or interest of any person not a party hereto.

49. Terms of this Consent Agreement constitute the entire agreement between and among the parties.
50. If any provision of this Consent Agreement is for any reason determined to be invalid, the effectiveness and enforceability of all other provisions of the Consent Agreement shall not be affected by such determination.
51. By the duly-authorized signature of its representative on this Consent Agreement, Cigna warrants that it has consulted with counsel before signing the Consent Agreement or has knowingly and voluntarily decided to proceed in this matter without consulting counsel, that it understands this Consent Agreement, and that it enters into the Consent Agreement voluntarily and without coercion of any kind from any person.
52. As consideration for Cigna's execution of and compliance with the terms of this Consent Agreement, the Superintendent and the Attorney General agree to forego pursuing further disciplinary measures or other civil or administrative sanctions for the specific conduct described above in this Consent Agreement. However, should Cigna fail to comply with any term or condition of this Consent Agreement, it may be subject to any available remedy under the law for such a failure or violation.

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**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

Dated: April 17th, 2026

*Scott Morrison*

Name: Scott Morrison  
Title: General Manager

**FOR THE OFFICE OF THE ATTORNEY GENERAL**

Dated: 4/21/2026

*/s/ Thomas C. Sturtevant, Jr.*

Thomas C. Sturtevant  
Assistant Attorney General

**THE SUPERINTENDENT OF THE MAINE BUREAU OF INSURANCE**

Dated: April 27, 2026

*Robert L. Carey*

Robert L. Carey  
Superintendent