

**STATE OF MAINE**  
**Department of Professional and Financial Regulation**  
*Bureau of Insurance*



**EXAMINATION REPORT OF:**

**Cigna Health & Life Insurance Company**

**(NAIC 67369, ME Lic. LHF 860)**

Examination Period:

January 1 – September 30, 2023

April 9, 2026

Honorable Robert L. Carey  
Superintendent  
Maine Bureau of Insurance

Dear Superintendent Carey:

Pursuant to 24-A M.R.S. §§ 211 and 221, in accordance with the instructions of your predecessor, a targeted market conduct examination has been made of:

**Cigna Health and Life Insurance Company**

The examination reviewed Cigna Health and Life Insurance Company's utilization review and appeals procedures and its handling practices of prior authorization requests and appeal requests for their Maine major medical line of business. The exam was called December 6, 2023, and covered the period from January 1, 2023, through September 30, 2023 (appeals review segment) and April 1, 2023, through September 30, 2023 (prior authorization review segment).


Maine Bureau of Insurance staff conducted the exam entirely off-site at the Bureau. The following examiners participated in the examination and in the preparation of this examination report:

Connie Mayette, CPCU, AIE, MCM, AU, AIC, AINS  
Market Conduct Managing Examiner

Miranda Rampulla, MCM, PIR  
Senior Market Conduct Examiner

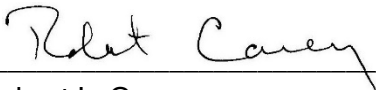
Justin Whalen, MCM  
Senior Market Conduct Examiner

The following report is respectfully submitted.

  
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Connie Mayette  
Examiner-in-Charge

Pursuant to 24-A, M.R.S. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of Cigna Health and Life Insurance Company. I hereby accept this Report of examination and make it an official record of the Bureau of Insurance.

  
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Robert L. Carey  
Superintendent

April 9, 2026  
\_\_\_\_\_  
Date

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## Company Profile

Cigna Health and Life Insurance Company (“Cigna” or the “Company”) is a health insurer domiciled in Connecticut. It is a wholly-owned subsidiary of Connecticut General Life Insurance Company, which is an indirect subsidiary of The Cigna Group. The Company has been licensed as a health insurer in Maine since June 29, 1981.

Cigna provides health care and related benefits, the majority of which are offered through employers and other groups. Its principal product offerings in 2023 are group health insurance, individual Medicare and Life insurance<sup>1</sup>.

According to the Company’s 2023 Rule 945<sup>2</sup> filing, the company reported 18,070 covered lives in its large group health insurance programs sold in Maine, and total revenues of \$156,540, 291 for this line of business.

## Executive Summary

The State of Maine Department of Professional and Financial Regulation, Bureau of Insurance (“Bureau” or “BOI”) conducted an examination of Cigna Health and Life Insurance Company. This examination was conducted pursuant to 24-A., M.R.S. § 221(5) which states in relevant part “[t]he Superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this section may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination.”

The examination was a targeted statutory examination of Cigna’s fully insured major medical plans to determine their compliance with certain provisions of the Maine Insurance Code, located within Title 24-A of the Maine Revised Statutes (M.R.S.) and Maine Bureau of Insurance Rule 850 (Health Plan Accountability).

Maine statutes and provisions of Rule 850 place certain requirements upon insurers and provide rights and protections to those individuals insured by health plans in Maine.

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<sup>1</sup> Company and product details were taken from Cigna’s 2023 Management Discussion & Analysis Statement.

<sup>2</sup> Rule 945 is a Maine Annual Report Supplement for specific data from health insurers and HMOs selling major medical insurance.

Some covered services, treatments or prescriptions required advance approval from the health plan before coverage applies. The examiners specifically tested compliance with requirements in Rule 850 §§8(E) and § 9(A) and related statutes in Title 24-A for the handling of these prior authorization or precertification requests. The examiners also tested the company's compliance with requirements in Rule §§ 8(G) and (G-1) and §§ 9(B) and (C) and related statutes in Title 24-A regarding the handling of appeals of adverse determinations. These provisions relate to the timing of decisions, the way decisions must be conveyed, and the specific information that must be provided when a request is denied or adverse determination is upheld on appeal. These requirements ensure that Maine consumers are notified promptly of their rights when coverage is denied.

The examiners tested 478 prior authorization requests and 109 appeal requests for compliance. Written policies and procedures in Cigna's utilization review program and the appeals process were also reviewed for compliance and consistency.

Subsequent to the initial data request, 37 additional requests for information were issued for explanation or additional documentation regarding the company's procedures, quality management and oversight, sample files, and delegation of review, plus related follow-ups to several of those requests.

Cigna was responsive to the examiners' requests for information and provided prompt and meaningful responses to the criticisms issued. Written criticisms, commonly known as "crits," are notifications to the company of potential compliance violations flagged by the examiners. Forty crits were issued encompassing both areas of the examination. Cigna agreed with many of the violations and indicated corrective action would be initiated.

## **Scope of Examination**

The focus of the examination was to determine Cigna's compliance with prior authorization requirements by reviewing prior authorization samples from the review period of April 1 to September 30, 2023, and with appeal requirements by reviewing appeal samples from the review period of January 1 to September 30, 2023. The written procedures governing the company's handling of prior authorization requests and requests for appeal were also reviewed. The examination covered the company's fully insured, ACA-compliant major medical plans situated in Maine and those self-funded governmental or church plans that are subject to state jurisdiction pursuant to ERISA. Other self-funded employer plans are not subject to state jurisdiction and were not included.

The scope of the examination was expanded to include compliance with 24-A, M.R.S. § 4320-A(3-B). This mental health parity requirement prohibits a health plan from applying a copayment for a behavioral health office visit that is greater than the copayment applied for a primary care office visit. This provision also requires first dollar coverage for the first office visits for behavioral health and primary care in a plan year.

The examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223, and consistent with the standards set forth in the National Association of Insurance Commissioners' Market Regulation Handbook (MRH) as required by Section 223(2). The MRH was used for purposes of sample determination and overall guidance.

Some unacceptable or noncompliant practices may not have been discovered in the course of the examination; failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by exception rather than by test.

## Methodology

The examiners reviewed the company's written utilization review policies and procedures and reviewed its handling of prior authorization requests that originated during the review period. Listings of universe files of all prior authorization (PA) requests received during the exam period were also obtained, in five specific subsets of requests:

- Pharmacy – All Behavioral Health PA requests
- Pharmacy – Standard (non-urgent) PA requests (other than Behavioral Health)
- Pharmacy – Exigent<sup>3</sup> PA requests (other than Behavioral Health)
- Non-Pharmacy - Standard (non-urgent) PA requests
- Non-Pharmacy - Exigent PA requests

Random samples were selected using the Excel RAND function following the sample sizes recommended by the MRH for all segments. The total population of non-pharmacy exigent requests was reviewed, as it was only a few files larger than the recommended minimum sample size. When it was noted that none of the few non-pharmacy behavioral health

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<sup>3</sup> "Exigent circumstances" is defined in Rule 850 § 8(5)(Q-1) as circumstances that "exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a nonformulary drug." Carriers often use the term "urgent" to describe "exigent circumstances."

requests processed by Evernorth Behavioral Health<sup>4</sup> were included in the samples, the total population of those six files was reviewed separately, with Cigna’s agreement.

**PA Universe File Numbers and Sample Sizes**

PA Level	Service Type	Total Requests	Sample Size
All	Pharmacy Behavioral Health	133	79
Standard	Pharmacy non-Behavioral Health	759	113
Exigent	Pharmacy non-Behavioral Health	224	84
Standard	Non-Pharmacy non-Behavioral Health	2337	115
Standard	Non-Pharmacy Behavioral Health	6	6
Exigent	Non-Pharmacy non-Behavioral Health	81	81

For the appeals portion of the examination, the examiners reviewed Cigna’s written appeal procedures and guidelines and the company’s handling of appeal requests. Listings of universe files of all appeal requests received during the review period were obtained, in three specific subsets of appeals:

- First Level Appeals
- Second Level Appeals
- Expedited Appeals

The first and second level appeal segments included both appeals of adverse health care treatment decisions (medical necessity) and appeals of adverse benefit determinations not involving healthcare treatment decisions (administrative and benefits). A random sample of the first level appeals was selected using the Excel RAND function for the sample size recommended by the MRH. The examiners reviewed the total populations of the second level and expedited appeals.

**Appeal Universe Numbers and Sample Sizes**

Appeal Level	Total Requests	Sample Size
First Level Appeals	214	84
Second Level Appeals	8	8
Expedited Appeals	17	17

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<sup>4</sup> Evernorth Behavioral Health is a Cigna affiliate that is licensed in Maine as a utilization review entity (URF34247). It reviewed the behavioral health prior authorization requests during the examination review period.

Medical necessity appeals are subject to the requirements in Rule 850 § 8, while administrative/ benefit appeals are subject to § 9; the applicable tests were applied based on the type of appeal. The first level appeals included 67 samples that were medical necessity appeals and 17 samples that were administrative/benefit appeals. Second level appeals included six medical necessity samples and two administrative/benefit samples. All expedited appeals were for medical necessity.

## **Examination Results**

The regulatory requirements tested in the sample review of PAs involved three main areas of consideration: timely notification of determinations, wrongful denial of determinations that were not timely, and whether the required information was provided when the request for authorization of a service or prescription was denied.

The examiners also compared the company's handling of behavioral health prescription requests to its handling of non-behavioral health prescription requests to assess whether more stringent requirements were placed on the behavioral health requests. It was determined that the higher prevalence of denials in this segment was attributed to the availability of generic and bio-equivalent drugs, and that similar requirements were applied when non-formulary drugs with generic and bioequivalent substitutes were requested that were not behavioral health drugs.

The regulatory requirements tested in the review of appeals also involved timely notification of decisions and whether the required information was provided when the appeal determination upholds the original denial. Maine regulations applying to appeals also require that health care treatment decisions be made by an appropriate clinical peer of the referring or servicing practitioner. For second level appeals, a review panel must be appointed, and a majority of its participants must not have been involved in prior decisions relating to the request. The aggrieved consumer also has the right to participate in person in the second level review, and different timing deadlines apply when a review is attended. These requirements were also tested.

## **FINDING 1. Standard Prior Authorizations – Timeliness of Notification**

Determinations not involving exigent circumstances were not timely, and/or were not timely conveyed to both the provider and the covered person.

### **24-A, M.R.S. § 4304(2)**

2. *Prior authorization of nonemergency services. Except for a request in exigent circumstances...a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection...*
  - A. *Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination.*
  - B. *If the carrier responds to a request by a provider for prior authorization with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information.*

**AND**

### **Rule 850 § 8(E)(2)**

2. *For initial determinations not involving exigent circumstances, a health carrier or the carrier's designated URE shall make the determination (whether adverse or not) and so notify the covered person and his or her provider within 72 hours or 2 business days, whichever is less...*

*If the carrier or the carrier's designated URE responds with a request for additional information, the carrier shall make a determination and so notify the covered person and his or her provider within 72 hours or 2 business days, whichever is less, after receiving the requested information.*

The examiners reviewed 299 non-exigent PA requests and found that 61 of the samples in the segments indicated below were not completed within the time frame required by 24-A M.R.S. § 4304(2) and 850 § 8(E)(2). Completion includes notification to the covered person and his or her provider. In some cases, the determination was made and the provider was notified within the required time, but mailing of the notification to the covered person occurred later.

Cigna agreed with all but three of the violations in this determination and stated that the exam review period occurred during a time when they were short-staffed, but that steps

had been taken in early 2023 to hire additional staff. Training was completed later in 2023 and productivity increased, but it did not impact the review period.

**Standard (Non-Exigent) Prior Authorizations - Timeliness**

PA Segment	Sample Size	Violations
BH Pharmacy	65	18
All Other Pharmacy	113	16
BH Non-Pharmacy	6	1
All Other Non-Pharmacy	115	26
<b>Total</b>	<b>299</b>	<b>61</b>

**FINDING 2. Standard Prior Authorizations – Denial Not Within Timeframe**

Requests not involving exigent circumstances which were not completed within the required time were wrongfully denied.

**24-A, M.R.S. § 4304(2)**

*2. Prior authorization of nonemergency services. Except for a request in exigent circumstances...a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection...*

*If a carrier does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted.*

**AND**

**Rule 850 § 8(E)(2)**

*For initial determinations not involving exigent circumstances, a health carrier or the carrier’s designated URE shall make the determination (whether adverse or not) and so notify the covered person and his or her provider within 72 hours or 2 business days, whichever is less...*

*c. If the carrier or the carrier’s designated URE does not grant or deny a request for within the time frames, the request is granted.*

The decisions in 61 non-exigent sample files in the segments indicated below were found to be untimely as indicated in Finding 1 above. Of the 61 requests, 27 were approved, but 34 were denied. As 24-A M.R.S. § 4304(2) and 850 § 8(E)(2)(c) require the request to be granted if it is not granted or denied within the required time frames, the 34 requests were wrongfully denied. Cigna agreed with this determination and initiated corrective action to include Maine in its Deemed Approved reporting process to comply with these requirements.

**Standard (Non-Exigent) Prior Authorizations – Untimely Denial**

PA Segment	Untimely Samples	Number Denied
BH Pharmacy	18	14
All Other Pharmacy	16	10
BH Non-Pharmacy	1	1
All Other Non-Pharmacy	26	9
<b>Total</b>	<b>61</b>	<b>34</b>

**FINDING 3. Exigent Prior Authorizations – Timeliness of Notification**

Determinations involving exigent circumstances were not timely, and/or were not timely conveyed to both the provider and the covered person.

**Rule 850 § 8(E)(3)**

3. *When exigent circumstances exist, a health carrier or the carrier’s designated URE shall make the determination (whether adverse or not) and so notify the covered person and his or her provider within 24 hours after receiving the request.*

The examiners reviewed 179 exigent PA requests and found that 71 of the samples were not completed within the time frame required by 850 § 8(E)(3). Completion includes notification to the covered person and his or her provider. In some cases, the determination was made and the provider was notified within the required 24 hours, but mailing of the notification to the covered person occurred later.

## Exigent Prior Authorizations - Timeliness

PA Segment	Sample Size	Violations
BH Pharmacy	14	6
All Other Pharmacy	84	18
Non-Pharmacy	81	47
<b>Total</b>	<b>179</b>	<b>71</b>

## FINDING 4. Required Information in PA Adverse Determination Notifications

The adverse determination letters did not include all the information required.

### Rule 850 § 8(E)(6)

6. *A health carrier shall provide written notification of any adverse health care treatment decision, which shall include:*

*b) reference to the specific plan provisions on which the decision is based;*

*i) a description of the expedited review process applicable to claims involving exigent circumstances...*

*k) notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process...*

**OR**

### Rule 850 § 9(A)

*"...For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required below:*

*2) "reference to the specific plan provisions on which the determination was based;"*

*9) "a description of the expedited review process applicable to claims involving exigent circumstances..."*

The examiners reviewed a total of 476 prior authorization requests in the segments indicated below, which included 152 adverse determinations. None of the denied requests provided all the required information, with each missing one or more of the elements identified above.

Under the definition set forth in Rule 850 § 5(Q-1), exigent circumstances include “when a covered person is undergoing a current course of treatment using a nonformulary drug.” The language in all letters failed to include this in the cited eligibility requirements for an expedited review.

**All Prior Authorization Requests – Required Information in Adverse Determinations**

PA Segment	Section	Sample Size	Adverse Decisions	Violations
BH Pharmacy	§ 8(E)(6)	79	52	52
Standard Pharmacy	§ 8(E)(6)	111	41	41
	§ 9(A)	2	2	2
Exigent Pharmacy	§ 8(E)(6)	84	19	19
Standard Non-Pharmacy	§ 8(E)(6)	115	21	21
Standard Non-Pharmacy BH	§ 8(E)(6)	6	1	1
Exigent Non-Pharmacy	§ 8(E)(6)	81	16	16
		<b>Total</b>	<b>152</b>	<b>152</b>

**FINDING 5. Parity in Cost Sharing – Primary Care and Behavioral Health Office Visits.**

Employer plans effective on or after January 1, 2023, did not reflect the required parity in cost sharing between primary care and behavioral health office visits, or the requirement to cover the first office visit without cost sharing.

**24-A, M.R.S., § 4320-A(3-B)**

*“A group health plan, other than a small group health plan subject to subsection 3-A, with an effective date on or after January 1, 2023 must 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. For the purposes of this subsection, “behavioral health office visit” means an office visit to address mental health and substance use conditions...”*

The examiners reviewed the plan documents submitted with the prior authorization samples. Of the employer plans represented in the samples, 32 employer plans effective on or after January 1, 2023, failed to comply with the requirements of § 4320-A(3-B). These plans were designed with a higher copayment amount for behavioral health office visits than the copayment amount applicable for primary care office visits and/or with the first office visits subject to cost sharing.

Cigna agreed with this finding and stated that actions were in progress to ensure that all plans going forward would be compliant. Some, but not all, of the cited plans had been corrected for the 2024 plan year.

## **FINDING 6. Level 1 Appeals – Timeliness of Acknowledgement Letter**

Acknowledgement letters conveying the covered person’s rights in the Level 1 appeal were not sent timely.

### **Rule 850 §8(G)(1)(a)(v)**

- i. *The carrier must allow the covered person to review the claim file and to present evidence and testimony as part of the internal appeals process.*
- ii. *The carrier must provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.*
- iii. *Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.*
- iv. *The health carrier must provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier.*
- v. *The health carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal. (emphasis added)*

OR

**Rule 850 §9(B)(2)(a)**

- a) *“A covered person does not have the right to attend, or to have a representative in attendance at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days after receiving a grievance.” (emphasis added)*

The examiners reviewed 84 Level 1 appeal requests as indicated in the chart below. In 24 of those files, the company failed to comply with §§ 8(G)(1)(a)(v) or 9(B)(2) as it did not provide the required acknowledgement within three (3) working days after receiving the appeal request.

**Level 1 Appeals – Acknowledgement Letter**

Appeal Segment	Section	Sample Size	Violations
Level 1 – Administrative/Benefit	§ 9(B)(2)	17	4
Level 1 – Medical Necessity	§ 8(G)(1)	67	20
	<b>Total</b>	<b>84</b>	<b>24</b>

**FINDING 7. Level 1 Appeals – Timeliness of Notification**

Level 1 Appeal decisions were not timely, and/or were not timely conveyed to both the provider and the covered person.

**Rule 850 §8(G)(1)(c)**

- c) *“For standard appeals, the health carrier or the carriers’ designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 30 following the request for an appeal...”*

OR

**Rule 850 §9(B)(2)(a)**

- a) *“A health carrier shall issue a written decision to the covered person within 30 days after receiving a grievance...”*

The examiners reviewed 84 Level 1 appeal requests as indicated in the chart below. In 59 of those files, the company failed to provide a written decision to the covered person and the provider within 30 days after receiving the appeal request, as required by §§ 8(G)(1)(c)(v) or 9(B)(2)(a).

### Level 1 Appeals – Timeliness of Notification

Appeal Segment	Section	Sample Size	Violations
Level 1 – Administrative/Benefit	§ 9(B)(2)	17	9
Level 1 – Medical Necessity	§ 8(G)(1)(c)	67	50
	<b>Total</b>	<b>84</b>	<b>59</b>

## FINDING 8. Level 1 Appeals – Decision Letter to Covered Person

Appeal decisions were not provided to the covered person.

### Rule 850 §8(G)(1)(c)

- c) *“For standard appeals, the health carrier or the carriers’ designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 30 following the request for an appeal...”*

The examiners reviewed 67 Level 1 medical necessity appeal requests as indicated in the chart below. The company failed to provide the covered person with the appeal decision in two (2) of those files.

### Level 1 Appeals – Decision Letter to Covered Person

Appeal Type	Sample Size	Violations
Level 1 Appeals – Medical Necessity	67	2

## **FINDING 9. Level 2 Appeals – Timeliness of Decision (Unattended Review)**

### **Title 24-A, M.R.S. § 4303(4)(A)**

This statute states, in relevant part:

- 2) *...Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier...*

The examiners reviewed the total population of eight (8) Level 2 appeals requested during the examination period. In seven (7) cases, the insured did not request the opportunity to appear in person for the review, and the decision was not issued within 30 calendar days in six (6) of those as required by § 4303(4)(A)(2).

### **Level 2 Appeals – Untimely Decisions/Unattended Reviews**

<b>Appeal Type</b>	<b>Sample Size</b>	<b>Unattended Reviews</b>	<b>Violations</b>
Level 2 Appeals	8	7	6

## **FINDING 10. Level 2 Appeals – Timeliness of Review Meeting (Attended Review)**

The review meeting was not held timely when the covered person requested to attend the review.

### **Rule 850 § 8(G-1)**

This provision states, in relevant part:

- d) *Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedure for conducting a second level panel review shall include the following:*
- a. *The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review...*

The examiners reviewed the total population of eight (8) Level 2 Appeals requested during the examination period. In one (1) file, the covered person requested to appear in person for the review. The review meeting was not held within 45 days after receiving the request as required by § 8(G-1)(3)(a).

### Level 2 Appeals – Untimely Review Meeting/Attended Reviews

Appeal Type	Sample Size	Attended Reviews	Violations
Level 2 Appeals	8	1	1

### FINDING 11. Level 2 Appeals – Review Panel

The second level grievance was not reviewed by a panel.

#### Rule 850 § 9(C)(2)

- 2) *The carrier shall appoint a panel for each second level grievance review panel for each grievance subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the health carrier who were not previously involved in the grievance.*

The examiners reviewed the total population of eight (8) Level 2 Appeals requested during the examination. Two cases reviewed adverse benefit determinations not involving health care treatment decisions. In one (1) file, the review was conducted by one person, an appeal processor, and no panel was convened as required by § 9(C)(2).

### Level 2 Appeals – No Review Panel

Appeal Type	Sample Size	Reviews under § 9	Violations
Level 2 Appeals	8	2	1

### FINDING 12. Expedited Appeals – Verbal Notification

The covered person was not notified verbally of the expedited appeal decision as required.

#### Rule 850 § 8(G)(2)(d)

This provision states, in relevant part:

- d) *In an expedited review, a health carrier or the carrier’s designated URE shall make a decision and notify the covered person and the provider acting on behalf of the covered person via telephone as expeditiously as the covered person’s medical condition requires, but in no event more than 72 hours after the review is initiated...*

The examiners reviewed the total population of expedited first level appeal requests received during the examination period. In all 16 files, the company provided or attempted

to provide verbal notification to the provider but failed to also provide verbal notification to the covered person as required by § 8(G)(2)(d). Additionally, the verbal notification to the provider was not made within the required 72 hours in two (2) of the files.

**Expedited Appeals – No Verbal Notification to Covered Person**

Appeal Type	Sample Size	Violations
Expedited Appeals	16	16

**FINDING 13. Expedited Appeals – Written Notification**

The written notice of the expedited appeal decision was not provided within two working days of the verbal notification as required.

**Rule 850 § 8(G)(2)(e)**

*e) If the initial notification was not in writing, a health carrier or the carrier’s designated URE shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision...*

The examiners reviewed the total population of expedited first level appeal requests received during the examination period. In two (2) files, the company failed to provide the written confirmation of the decision within two (2) working days of the verbal notification, as required by § 8(G)(2)(e).

**Expedited Appeals – Untimely Written Notification**

Appeal Type	Sample Size	Violations
Expedited Appeals	16	2

**FINDING 14. Appeals - Required Information in Adverse Determinations**

The adverse appeal determination letters did not include all the information required.

**Rule 850 §§ 8(G)(1)(c) (standard); 8(G)(2)(e) (expedited); (G-1)(3)(f) (second level)**

All adverse decisions of healthcare treatment decisions, including those issued in expedited and second level appeals, must contain the information set forth in Rule 850 § 8(G)(1)(c).

Rule 850 § 8(G)(1)(c) states, in relevant part:

c) *...An adverse health care treatment decision shall contain:*

- i. *The names, titles and qualifying credentials of the person or persons evaluating the appeal.*
- ii. *A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*
- iii. *Reference to the specific plan provision on which the benefit determination is based.*
- iv. *The reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination.*
- vii. *Notice 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. §4312(3). A description of the process for submitting a written request for second level appeal must include the rights specified in subsection G-1.*

**OR**

**Rule 850 §§ 9(B)(2) (first level review) and 9(C)(3)(f) (second level review)**

All adverse determinations not involving health care treatment decisions, including those issued in second level reviews, must contain the information set forth in Rule 850 § 9(B)(2).

Rule 850 § 9(B)(2) states, in relevant part:

b) *If the decision is adverse to the covered person, the written decision shall contain:*

- ii. *A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*
- iii. *Reference to the specific plan provision on which the benefit determination is based.*
- iv. *The reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination.*
- vii. *A description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review and the rights specified in subparagraph C(3)(c)...*

The examiners reviewed 109 appeal requests in the segments indicated below with 55 of the files resulting in an adverse determination. The decision letter in 47 of those 55 files did

not include all the information required by § 8(G)(1)(c) or § 9(B)(2) with each missing one or more of the elements listed above.

### Appeals – Required Information

Appeal Type	Section	Sample Size	Adverse Decisions	Violations
Level 1 Appeals – Administrative/Benefit	§ 9(B)(2)(b)	17	15	10
Level 2 Appeals – Administrative/Benefit	§ 9(C)(3)(f)	2	2	1
Level 1 Appeals – Medical Necessity	§ 8(G)(1)(c)	67	28	26
Level 2 Appeals – Medical Necessity <sup>5</sup>	§ 8(G-1)(3)(f)	7	7	7
Expedited Appeals	§ 8(G)(2)(e)	16	3	3
	<b>Total</b>	<b>109</b>	<b>55</b>	<b>47</b>

## FINDING 15. Appeals – Clinical Peer

Appeals of adverse health care determinations were not evaluated by an appropriate clinical peer of the treating provider.

### Rule 850 § 8(G)(1)(b)

This provision states, in relevant part:

*b) An appeal of an adverse health care treatment decision...shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse determination, unless additional information not previously considered during the initial review is provided on appeal...*

**OR**

### Rule 850 § 8(G-1)(2)

This provision states, in relevant part:

<sup>5</sup> In the population submitted for expedited appeals, one file was identified as an expedited second level appeal. Since Rule 850 does not contemplate an expedited review at this level, this file was counted with the second level medical necessity appeals in this finding for failing to include information required.

- 2) *The carrier shall appoint a panel for each second level appeal, which shall include one or more panelists who are disinterested clinical peers of the treating provider...*

**OR**

**Rule 850 § 8(G)(2)(a)**

This provision states, in relevant part:

- a) *An expedited appeal of an adverse health care treatment decision...shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse determination, unless additional information not previously considered during the initial review is provided on appeal...*

As defined in Rule 850 § 5(H): *“Clinical peer” means a physician or other licensed health care practitioner who holds a non-restricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of a carrier.*

The examiners reviewed the 89 health care treatment decisions that were included in the segments indicated in the chart below. In 23 of those files, the reviewer for the company was not a clinical peer as required by the governing section of Rule 850.

**Appeals – Clinical Peer**

<b>Appeal Type</b>	<b>Section</b>	<b>Sample Size</b>	<b>Violations</b>
Level 1 Appeals – Medical Necessity	§ 8(G)(1)(b)	67	17
Level 2 Appeals	§ 8(G-1)(2)	6	1
Expedited Appeals	§ 8(G)(2)(a)	16	5
	<b>Total</b>	<b>89</b>	<b>23</b>

## **FINDING 16. Level 1 Appeals – Procedural Violation of Rights**

Rapid processing of some Level 1 appeals did not afford consumers the rights required by Rule 850.

### **Rule 850 § 8(G)(1)(a)**

- i. *The carrier must allow the covered person to review the claim file and to present evidence and testimony as part of the internal appeals process.*
- ii. *The carrier must provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.*
- iii. *Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.*
- iv. *The health carrier must provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier.*
- v. *The health carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal.*

**OR**

### **Rule 850 § 9(B)(2)**

2. *“A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days after receiving a grievance.”*

The examiners reviewed 84 first level appeal requests from the universe of such requests during the examination review period. In seven (7) of the cases, a procedural violation occurred when a decision upholding the prior adverse decision was issued in conjunction

with the acknowledgement letter or before the time allotted by the company to submit additional information had elapsed. As a result, the consumer was denied the opportunity to exercise the rights identified in § 8(G)(1)(a) or § 9(B)(2).

### Level 1 Appeal Rights

Appeal Type	Section	Sample Size	Violations
Level 1 Appeals – Medical Necessity	§ 8(G)(1)(a)	67	3
Level 1 Appeals – Administrative/Benefit	§ 9(B)(2)	17	4
	<b>Total</b>	<b>84</b>	<b>7</b>

## FINDING 17. Single Level Appeals

Some Level 1 appeals were processed as Single Level Appeals and did not provide the opportunity for a second level appeal.

### Rule 850 § 8(G-1)(1)

- 1) *“A health carrier that subjects benefit decisions to utilization review or offers managed care plans shall provide the opportunity for a second level appeal to covered persons who are dissatisfied with a first level appeal decision...”*

**OR**

### Rule 850 § 9(C)(1)

- 1) *“A health carrier shall provide a second level grievance review process to covered persons who are dissatisfied with a first level grievance review determination under subsection B...”*

The examiners reviewed the initial universe file lists of appeals requested during the examination period, and questioned cases that were identified as “Single Level Appeals.” These cases had been incorrectly processed as Single Level appeals under ERISA requirements. Of these 26 files, 17 resulted in adverse determinations, and the covered person was not provided the opportunity for a second level appeal at the time the adverse decision was issued as required by Rule 850.

### Level 1 Appeals – Process Rights

Appeal Segment	Section	Universe Size	Violations
Level 1 – Medical Necessity	§ 8	181	7
Level 1 – Administrative/Benefit	§ 9	33	10
	<b>Total</b>	<b>214</b>	<b>17</b>

### FINDING 18. Level 2 Appeal – Procedural Violation

A second level appeal was not handled in accordance with second level appeal requirements.

#### Rule 850 § 8(G-1) Second Level Appeals of Adverse Health Care Treatment Decisions

The following subsections state, in relevant part:

- 1) *A health carrier that subjects benefit decisions to utilization review or offers managed care plans shall provide the opportunity for a second level appeal to covered persons who are dissatisfied with a first level appeal decision. The covered person requesting a second level appeal has the right to appear in person, and shall be provided adequate notice of that option by the carrier...*
- 2) *The carrier shall appoint a panel for each second level appeal...*

One of the appeals submitted for review in the population of expedited appeals was identified as an expedited second level appeal. Rule 850 § 8 does not include a provision for expediting a second level appeal. Section 8(G) governs first level appeals – standard appeals in §8(G)(1) and expedited appeals in §8(G)(2). The requirements for second level appeals are found in §8(G-1), stated above. This case in the expedited appeals samples was a second level appeal and therefore subject to the requirements in § 8(G-1). As it was processed the same as an expedited first level appeal, its handling was not in compliance with the requirements of § 8(G-1). The covered person was not given the right to appear in person, and the carrier did not appoint a panel for the second level appeal.

### Level 2 Appeals – Procedural Violation

Appeal Segment	Section	Sample Size	Violations
Level 2 Appeals – Medical Necessity	§ 8(G-1)	1	1

## **FINDING 19. Utilization Review Program – Noncompliant Procedures**

The company's written Utilization Review Program included procedures that were not compliant with the requirements of Rule 850 § 8.

### **Rule 850 § 8(C) Written Utilization Program**

*A health carrier that provides or performs utilization review shall implement a written utilization review program that, consistent with the requirements of Title 24-A, M.R.S.A. §2771(3) and this rule, shall comprehensively describe all utilization review activities and procedures, both delegated and non-delegated, applicable to any of its health plans. The utilization review program must be consistent with the requirements of this section.*

The examiners reviewed Cigna's written utilization review program to verify that the policies and procedures it contained were compliant with the requirements of Rule 850 § 8. Some procedural guidelines were found not to be compliant in the following areas:

- 1) The referenced turnaround time for non-urgent preservice requests was "within 2 business days." Section 8(E)(2) requires determination and notification of such request to the covered person and the provider "within 72 hours or 2 business days, whichever is less" of receiving the necessary information.
- 2) The guidelines failed to include Maine's specific requirement for urgent preservice requests as stated in § 8(E)(3), which requires notification to the covered person and the provider within 24 hours of receiving the request.
- 3) The guidelines failed to include the requirement that the request must be deemed approved if a carrier does not grant or deny a request for prior authorization within the time frames required under § 8(E)(2).
- 4) The company's definition of "urgent" did not include all elements of Maine's "exigent circumstances," specifically "*when a person is undergoing a current course of treatment using a non-formulary drug.*"

## Recommendations

The following are the recommended corrective actions for Cigna to address the compliance concerns identified in this examination.

1. Initiate training and/or staffing adjustments to ensure that all prior authorizations are determined and conveyed within the appropriate time frame.
2. Implement training and system protocols to ensure that non-exigent prior authorization requests that are not determined and conveyed within the required time frame are deemed approved as required.
3. Review and amend adverse determination letter templates and instructions to include all the information and notifications required.
4. Complete the steps already initiated to ensure all plans cover the first behavioral health and primary care office visit without cost-sharing and do not impose greater copayments on behavioral health office visits than on primary care office visits.
5. Implement training and system protocols to provide first level appeal acknowledgement letters timely and ensure time is allowed for the covered person to exercise their rights to review their files and to submit information before decision is rendered.
6. Revise procedures to ensure that provider appeals on behalf of Maine customers are processed in accordance with Rule 850 requirements regardless of rendering provider's location.
7. Implement training and system protocols to ensure all covered persons with non-ERISA ASO first level standard adverse appeals are notified of and provided the opportunity to request a second level review.
8. Implement training and system protocols to ensure second level appeals are reviewed by an appropriate panel.
9. Implement training and/or staffing adjustments to ensure second level appeal determinations are made and conveyed timely.
10. Implement training and system protocols to ensure expedited appeal decisions are conveyed verbally to both the covered person and the provider within 72 hours of receipt of the appeal request, and the written confirmation is sent to both within two working days of the verbal notification.

11. Ensure that health care treatment appeal decisions are made by or include the appropriate clinical peer.
12. Revise appeals procedures and implement training so that all second level appeals of adverse health care treatment decisions are processed in compliance with 850 § 8(G-1).
13. Ensure that written utilization review procedures are compliant with the requirements of 850.

## **Acknowledgement**

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