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

In re: CIGNA Healthcare of Maine, Inc.	)	
and CIGNA Behavioral Health, Inc.,	)	CONSENT AGREEMENT
Docket No. INS 03-451	)	

- INTRODUCTION -

This document is a Consent Agreement concerning the ability of CIGNA Healthcare of Maine, Inc. and CIGNA Behavioral Health, Inc. to continue to operate in the State of Maine. The parties to this Consent Agreement are CIGNA Healthcare of Maine, Inc. ("CHC"); CIGNA Behavioral Health, Inc. ("CBH"); the Superintendent of the Maine Bureau of Insurance ("the Superintendent"); and the Maine Department of the Attorney General ("the Attorney General"). The parties enter into this Consent Agreement, pursuant to 10 M.R.S.A. § 8003(5)(B) and 24-A M.R.S.A. § 12-A.

- FACTS -

1. The Superintendent is appointed pursuant to 24 A M.R.S.A. § 201 by the Governor of Maine and confirmed by the Maine Legislature to direct operations of the Maine Bureau of Insurance ("the Bureau"). The Bureau is an agency of the State of Maine authorized to license and regulate insurance companies doing business in the State.

2. The Attorney General is the chief law enforcement officer of the State of Maine.

3. CHC is a Maine corporation. It holds a certificate of authority, issued by the Superintendent pursuant to 24-A M.R.S.A. § 4204(2-A), authorizing it to operate as a health maintenance organization ("HMO"). CHC's NAIC code is 95447.

4. CHC is a direct wholly-owned subsidiary of Healthsource, Inc. and an indirect, wholly-owned subsidiary of CIGNA Health Corporation. CIGNA Health Corporation is a wholly owned subsidiary of CIGNA Corporation.

5. CBH is a Minnesota corporation. It holds a license, issued by the Superintendent pursuant to 24-A M.R.S.A. § 2771, as a medical utilization review service; it holds a license, issued by the Superintendent pursuant to 24-A M.R.S.A. § 1902, as a third-party administrator.

6. CBH is a wholly owned subsidiary of Connecticut General Corporation. Connecticut General Corporation is a wholly owned subsidiary of CIGNA Corporation.

7. CHC has a written agreement with CBH dealing with CBH's role as third party administrator for CHC. Pursuant to that agreement, CHC pays CBH a capitation fee for the provision of mental health and substance abuse services for CHC's members.

8. CHC uses Argus Health Systems, Inc. (“Argus”) as a third-party pharmacy vendor.

9. Pursuant to 24-A M.R.S.A. §§ 220(1), 1911, 2774(1) and 4215 and Bureau of Insurance Rules, Chapter 191, § 10, the Superintendent engaged American Express Tax and Business Services, Inc. (“American Express”) to conduct a market conduct examination of CHC and CBH. American Express conducted the examination in accordance with standards and guidelines set forth in the Market Conduct Examiners Handbook of the National Association of Insurance Commissioners (“the NAIC”) and rules, regulations and procedures of the Bureau. The examination by American Express (“the AmEx Examination”) covers the period from January 1, 2001 through December 31, 2001.

10. The purpose of the AmEx Examination was to determine compliance with NAIC standards and the law. The examination designates a significant instance of noncompliance with an NAIC standard, the law or company policy as an “error.” It includes a calculation of the percentage of files examined within which error was found. That percentage can be measured against tolerance rates established by the NAIC.

Specific Facts: Claims Handling

11. Title 24-A M.R.S.A. § 2436(1) makes insurance claims generally payable within 30 days after the insurer’s receipt of proof of loss. If an insurer fails to pay a claim when due, the claim bears interest at the rate of 1.5% per month. 24-A M.R.S.A. § 2436(3). NAIC guidelines mandate settlement of claims in a timely fashion as required by law.

12. Title 24-A M.R.S.A. § 2164-D(3)(C) makes the frequent failure to adopt and implement reasonable standards for prompt settlement of claims an unfair claims practice.

13. Title 24-A M.R.S.A. § 2164-D(3)(D) makes failure to develop and maintain claim files supporting decisions made regarding liability an unfair claims practice.

14. Title 24-A M.R.S.A. § 2164-D(3)(F) makes the frequent failure to affirm or deny coverage within a reasonable time an unfair claims practice.

15. The AmEx Examination selected a random sample of 100 of CHC’s paid claims from 2001.

16. With respect to paid claims samples, errors of CHC found by the AmEx Examination include instances of failure to pay claims on time, failure to pay interest due, failure to keep supporting documentation and failure to have adequate procedures for identifying and correcting errors in a timely fashion.

17. Among the sample of CHC’s paid claims, two of the most egregious cases were one in which payment was 330 days late and made without interest and one in which payment was 147 days late and made without interest.

18. The AmEx Examination found errors in 20% of the CHC sample of 100 paid claims. The NAIC published error tolerance for claims practice is 7%.

19. CHC's conduct regarding paid claims is sanctionable, pursuant to 24 A M.R.S.A. §§ 2164-D(3)(C), 2164-D(3)(F), 2436(1) and 2436(3).

20. The AmEx Examination selected a random sample of 100 of CBH's paid claims from 2001.

21. With respect to paid claims samples, errors of CBH found by the AmEx Examination include instances of overpayment, failure to pay claims on time, failure to pay interest due, failure to keep supporting documentation and failure to have adequate procedures for identifying and correcting errors in a timely fashion.

22. Among the sample of CBH's paid claims, the most egregious cases included an instance in which payment was 111 days late and made without interest. In a second instance, there was retroactive authorization of payment almost 7 months after original denial, but there was no documentation in the file explaining why the claim was paid or why it took so long to do so. In a third instance, it was impossible to identify the provider in the service provider contract.

23. The AmEx Examination found errors in 21% of the CBH sample of 100 paid claims. The NAIC published error tolerance for claims practice is 7%.

24. CBH's conduct regarding paid claims is sanctionable, pursuant to 24 A M.R.S.A. §§ 2164-D(3)(C), 2164-D(3)(F), 2436(1) and 2436(3).

25. Title 24-A M.R.S.A. § 2164-D(3)(E) makes the frequent refusal to pay claims without reasonable investigation an unfair claims practice.

26. Title 24-A M.R.S.A. § 2164-D(3)(I) makes failure to provide an accurate written explanation of denials an unfair claims practice.

27. The AmEx Examination selected a random sample of 100 of CHC's denied claims from 2001.

28. With respect to denied claims samples, errors of CHC found by the AmEx Examination include instances of incorrect payment of interest, unnecessary delay of payment created by internal company procedures, failure to act correctly upon written file materials, failure to record claims data correctly, failure to keep supporting documentation, and failure to have adequate procedures for identifying and correcting errors in a timely fashion.

29. Among the sample of CHC denied claims one of the most egregious cases was an instance in which denial was based on untimeliness, though the provider had submitted proof of timeliness. When CHC paid that claim, after being alerted to the error by an examiner, it failed to include interest. In a second instance, CHC denied a claim more than 2 months after receipt and had no explanation for the delay.

30. The AmEx Examination found errors in 16% of the CHC sample of 100 denied claims. The NAIC published error tolerance for claims practice is 7%.

31. CHC's conduct regarding denied claims is sanctionable, pursuant to 24 A M.R.S.A. §§ 2164-D(3)(C), 2164-D(3)(E), 2164-D(3)(F), 2164-D(3)(I), 2436(1) and 2436(3).

32. The AmEx Examination selected a random sample of 100 of CBH's denied claims for 2001.

33. With respect to denied claims samples, errors of CBH found by the AmEx Examination include denial without accurate explanation, failure to investigate or process reconsideration of claims in a timely fashion, failure to include interest with payment after reconsideration, failure to keep supporting documentation, failure to provide appeal information, and failure to have adequate procedures for identifying and correcting errors in a timely fashion.

34. Among the sample of CBH denied claims, the most egregious cases included an instance in which a denied claim was reconsidered and paid, without interest, 157 days after receipt of information requested for reconsideration. In another instance, it took CBH 12 days to enter a resubmitted
claim and 51 days to pay it. Payment was without interest.

35. The AmEx Examination found errors in 10% of the CBH sample of 100 denied claims. The NAIC published tolerance for claims practice is 7%.

36. CHC has no documentation for any of the Argus claims, since Argus fails to maintain records of denied claims.

37. CBH's conduct regarding denied claims is sanctionable, pursuant to 24 A M.R.S.A. §§ 2164-D(3)(C), 2164-D(3)(D), 2164-D(3)(E), 2164-D(3)(F), 2164-D(3)(I), 2436(1) and 2436(3).

38. The AmEx Examination randomly selected a total of 400 paid or denied CHC and CBH claims for 2001. It found 69 errors, which make the error rate for the combined samples 17%. The NAIC published error tolerance for claims practice is 7%.

39. At the Superintendent's direction, in November 2003, the Companies computed the amount of due but unpaid interest of Five Dollars ($5.00) or more for documented claims in calendar years 2001 and 2002. The Companies determined, and the Superintendent has verified, that the total amount of such interest due is Nine Hundred Fourteen Thousand Nine Hundred Ninety-Two Dollars and Thirty-Six Cents ($914,992.36).

Specific Facts: Grievance Procedures

40. Title 24-A M.R.S.A. § 2164-D(3)(E) makes the frequent refusal to pay claims without reasonable investigation an unfair claims practice.

41. Bureau of Insurance Rule 850, § 5(S) adopts the NAIC definition of "grievance" as any

written complaint submitted by or on behalf of a covered person regarding the:
1) 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 a health carrier.

42. Rule 850, § 9 sets forth standards for grievance procedures. Section 9(A)(1) requires insurers to maintain a written record of all grievances received during a calendar year and establishes minimum requirements for the kind of data to be included in that record.

43. The AmEx Examination discusses 6 categories of grievances:

a. CHC 1st Level Administrative Grievances.
b. CHC 1st Level Grievances.
c. CHC 2nd Level Grievances.
d. CHC Provider Appeals.
e. CBH 1st Level Grievances (including categories designated in the Examination narrative as "1st Level Administrative Grievances" and "1st Level Medical Appeals.")
f. CHC behavioral care 2nd Level Grievances.

44. With respect to CHC's 1st Level Administrative Grievances, the AmEx Examination selected 6 files from 2001 and found errors, the most of egregious of which include:

a. Failure of CHC's record to include a general description of the reasons for each grievance, in violation of Rule 850, § 9(A)(1)(a);
b. Failure of CHC's standard acknowledgement letter to inform an insured that s/he does have the right to attend the grievance review, in violation of Rule 850, § 9(C)(1).
c. Failure to retain a copy of the acknowledgement letter sent to the insured, in violation of Rule 191, § 10(B) and Rule 850, § 9(A).

The AmEx Examination also found instances of CHC's noncompliance with its own policies and procedures for handling 1st Level Administrative Grievances.

45. The AmEx Examination found errors in 50% of the sample of six of CHC's 1st Level Administrative Grievances. The NAIC published error tolerance is 10%.

46. With respect to all CHC's 1st Level Grievances, the AmEx Examination selected a random sample of 42 files and found errors, the most egregious of which include:

a. In ten instances, failure to issue a written decision within 20 days, in violation of Rule 850, § 9(C)(1)(a).
b. In two instances, failure to maintain documentation of the issuance of a written decision, in violation of Rule 850, § 9(C)(1)(a).
c. With respect to standard appeals, in 10 instances, failure to provide written notification to both the covered person and provider within 20 working days, in violation of Rule 850(G)(1)(C).
d. Failure to include in the grievance log date of review, a description of resolution at that level, or date of resolution, all in violation of Rule 850, § 9(A)(1).

The AmEx Examination also found instances of noncompliance with the Companies' own policies and procedures for handling grievances. Seventy-one percent of the Company's initial decisions had been overturned on first level review.

47. The AmEx Examination found errors in 26% of the random sample of 42 of CHC's 1st Level Grievances. The NAIC published error tolerance is 10%.

48. With respect to CHC's 2nd Level Grievances, the AmEx Examination selected a random sample of 25 files and found errors, the most egregious of which include:

a. In 12 instances, failure to provide the covered person written notice of the place, date and time of the review meeting, in violation of Rule 850, § 9(D)(3)(a).
b. In 2 instances, failure to issue a written decision within 5 working days of completing the review meeting, in violation of Rule 850, § 9(D)(3)(f).

49. The AmEx Examination found errors in 21% of the random sample of 25 of CHC's 2nd Level Grievances. The NAIC published error tolerance is 10%.

50. The AmEx Examination reviewed a total of 67 CHC 1st and 2nd Level Grievances. It found 26 errors, which make the error rate 39%. The NAIC published error tolerance is 10%.

51. With respect to CBH's 1st Level Grievances - including 1st Level Administrative Grievances and 1st Level Medical Necessity Appeals - the AmEx Examination selected a random sampling of 50 files and found errors, the most egregious of which include:

a. In 4 instances, failure to keep a letter of appeal or decision letter in the file, in violation of Rule 850, § 9(A)(2) and Rule 850, § 9(C)(1)((a).
b. In 4 instances, failure to include in an adverse decision all information required by Rule 850, § 8(G)(1)(c).
c. In one instance, failure in an expedited appeal to make a decision and notify the covered person no more than 72 hours after review is initiated, in violation of Rule 850, § 8(G)(2)(d).
d. For standard appeals, failure to provide written notification to both the covered person and provider within 20 working days after the request for appeal, in violation of Rule 850, § 8(G)(1)(c).

52. The AmEx Examination found errors in 52% of the random sample of 50 of CBH's 1st Level Grievances. The NAIC published error tolerance is 10%.

53. With respect to CHC's behavioral care 2nd Level Grievances, the AmEx Examination selected a random sample of 25 files and found errors, the most egregious of which include:

a. In 12 instances, failure to provide the covered person written notice of the place, date and time of the review meeting, in violation of Rule 850, § 9(D)(3)(a).
b. Generally, failure to include on the grievance register all required information, in violation of Rule 850, § 9(A)(1).

54. The AmEx Examination found errors in 84% of the random sample of 25 of CHC's behavioral care 2nd Level Grievances. The NAIC published error tolerance is 10%.

55. With respect to CHC's Provider Appeals, the AmEx Examination selected a random sample of 50 files and found that 60% of the Company's initial decisions had been overturned on first level review.

Specific Facts: Complaint Handling

56. Title 24-A M.R.S.A. § 4211(1) requires that every HMO establish and maintain a complaint handling system"to provide reasonable procedures for the resolution of written complaints initiated by enrollees."

57. Title 24-A M.R.S.§ 4211(2) requires that every HMO annually submit to the Superintendent a report regarding its complaint handling.

58. Title 24-A M.R.S.A. § 4211(3) requires that every HMO maintain "records of written complaints filed with it concerning other than health care services." Title 24-A M.R.S.A. § 4215(3) requires that every HMO submit all it books and records relating to health care service to, and "in every way facilitate," examinations by the Superintendent.

59. Title 24-A M.R.S.A. § 220 (2) requires that every insurer respond to inquiries of the Superintendent relating to consumer complaints within 14 days and that every insurer respond to other lawful inquiries within 30 days.

60. Title 24-A M.R.S.A. § 4211 and Bureau Rule 850(9)(A) require that HMOs record all complaints in a company register.

61. Title 24-A M.R.S.A. § 4211 requires that HMOs establish and use reasonable procedures for the resolution of complaints.

62. Title 24-A M.R.S.A. § 220(2) requires that HMOs respond to complaints from the Bureau within 14 days from receipt of the inquiry.

63. The AmEx Examination found that CHC did not file an annual report regarding its handling of complaints in 2001, in violation of 24-A M.R.S.A. § 4211(2).

64. The AmEx Examination selected a random sample of 53 CHC complaint files for review. Within that sample, the AmEx Examination found errors, the most egregious of which include:

a. In 6 instances, failure to make a timely response to an inquiry from the Bureau, in violation of 24-A M.R.S.A. § 220 (2).
b. In 6 instances, failure to create a record from which it could be determined whether CHC had fully addressed the complaint or what corrective action had been taken, in violation of 24-A M.R.S.A. § 4211(3).

c. In 6 instances, failure to maintain adequate information for easy retrieval of a file, in violation of 24-A M.R.S.A. § 4211(1) and 24-A M.R.S.A. § 4215(3).
d. In 3 instances, failure to maintain complaint files for the required duration of time, in violation of 24-A M.R.S.A. § 4211(1), § 4211(3), 24-A M.R.S.A. § 4215(3) and Rule 850, § 191(10)(B).
e. In 3 instances, failure to respond within 30 days to an inquiry from a person other than the Bureau, in violation of 24-A M.R.S.A. § 220 (2).

65. CHC was unable to produce one of the files comprising the AmEx Examination sample, in violation of 24-A M.R.S.A. §§ 4211(3) and 4215(3).

66. The AmEx Examination was unable to reconcile complaint information known to the Bureau with information available at the examination site, because of CHC's practices in handling complaints among offices at various geographic locations. Those CHC practices violate 24-A M.R.S.A. §§ 4211(1) and 4215(3).

67. CBH was unable to produce a complete complaint register for the AmEx Examination, in violation of 24-A M.R.S.A. §§ 4211(3) and 4215(3).

68. The AmEx Examination found errors in 15% of the random sample of 53 complaint files. The NAIC published error tolerance is 10%.

Specific Facts: SAS 70

69. The agreement between CHC and CBH requires that a Statement of Auditing Standards No. 70 ("SAS 70") or other appropriate evidence of internal controls be produced annually.

70. In the Superintendent's December 31, 1999 report of examination, it was noted that no SAS 70 had been produced theretofore.

71. The AmEx Examination revealed that there still has been no SAS 70 report produced.

Specific Facts: Records Retention

72. Title 24-A M.R.S.A. § 3408 requires that every domestic insurer "have and maintain at its principal place of business and home office…accurate and complete accounts and records of its transactions and affairs."

73. Rule 191, § 10(B) requires that HMO's

shall retain records of their affairs and transactions for a period of at least 6 years and shall require any person…under contract …to retain records…relating to the HMO for a period of at least 6 years.

74. Rule 140, § 11(A) requires that every insurer maintain for 3 years a file containing

every printed, published or prepared advertisement of individual policies and typical printed, published or prepared advertisements of blanket, franchise and group policies…disseminated in this state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised.

75. CBH does not have a written record retention policy.

76. The AmEx Examination revealed the following violations of 24-A M.R.S.A. § 3408, Rule 140 and/or Rule 191:

a. Nonexistence of a complete CBH complaint register.
b. Multiple instances in which the CHC complaint register has inadequate information for the easy retrieval of an entire file or fails to include all required information.
c. Absence of an acknowledgement letter in a grievance file.
d. CHC's inability to locate a requested complaint file.
e. Absence of supporting documentation for two policy cancellations.
f. Absence of documentation of producer training.
g. Absence of documentation for two Argus paid claims.
h. Absence of documentation for any Argus denied claim.

Specific Facts: Member Notification

77. Title 24-A M.R.S.A. § 4209(6) requires that an HMO must give each individual enrollee at least 10 days' prior written notification of cancellation for nonpayment of enrollment charges by mailing notification either to the last known address of the enrollee or to the enrollee at the group policyholder's office.

78. In 4 instances, CHC's cancellation procedure failed to provide notification directly to individual enrollees, in violation of 24-A M.R.S.A. § 4209(6).

Specific Facts: Marketing

79. Title 24-A M.R.S.A. § 2736-C(6)(A) requires that every health insurer "actively market individual health plan coverage…to individuals in this State."

80. CHC does not actively market individual health plan coverage to individuals in this State, in violation of 24-A M.R.S.A. § 2736-C(6)(A).

81. Rule 140, § 5(C) requires that an application form contain a statement advising the applicant of a policy's provisions relating to pre-existing conditions and that the statement immediately precede the place for the applicant's signature, when it is to be completed by the applicant and mailed to a health insurer.

82. In 2001, CHC used application forms violating the requirements of Rule 140, § 5(C), in that the forms did not have the pre-existing condition statement immediately preceding the place for the applicant's signature but rather on a separate form.

Specific Facts: Producer Licensing

83. Title 24-A M.R.S.A. § 1411(1) prohibits any person from acting or purporting to act as an insurance producer without first being duly licensed.

84. NAIC Standard F-2 requires that producers be licensed in the jurisdiction where an application is taken.

85. In 2001, CHC used two unlicensed individuals as its agents, in violation of 24-A M.R.S.A. § 1411(1).

Specific Facts: Provider Network

86. NAIC Standard E-8 requires that an insurer issue to each enrollee a provider directory and that there be timely and reasonable updates to the directory. Further, 24-A M.R.S.A. § 4209(2) requires that an updated provider directory be provided each enrollee upon reenrollment or original enrollment.

87. The AmEx Examination revealed inconsistencies between the CHC Provider Directory and the CBH provider files. Further, since CHC did not maintain copies of older directories in paper form, the examiners were unable to determine whether accurate and updated paper directories were made available to enrollees.

- COVENANTS –

88. No later than December 31, 2003, pursuant to 10 M.R.S.A. § 80003 (5), 24-A M.R.S.A. § 12-A, and as a penalty for violations of law enumerated in paragraphs 11 through 87 above, the Companies will pay the Bureau Nine Hundred Thousand Dollars ($900,000.00).

89. No later than December 31, 2003 and pursuant to 10 M.R.S.A. § 80003(5) and 24-A M.R.S.A. § 12-A, the Companies will provide the Superintendent verifiable evidence that they have paid Nine Hundred Fourteen Thousand Nine Hundred Ninety-Two Dollars and Thirty-Six Cents ($914,992.36) due as interest on claims paid late for the calendar years 2001 and 2002.

90. No later than January 30, 2004, and pursuant to 10 M.R.S.A. § 80003(5) and 24-A M.R.S.A. § 12-A, the Companies will provide the Superintendent a verifiable computation of interest due for claims paid late during the period of September 18, 1999 to January 1, 2001. The computation will be for cumulative amounts of Five Dollars ($5.00) or more.

91. Upon notice that, pursuant to paragraph 90 above, the Bureau has verified amounts determined due for claims made during the period of September 18, 1999 to January 1, 2001, the Companies will forthwith pay persons owed those amounts. No later than 45 days after receiving notice from the Bureau, the Companies will provide the Superintendent verifiable evidence that payments are complete.

92. No later than December 31, 2003, the Companies will file for the Superintendent's review and approval a plan of corrective action addressing every violation of law discussed in paragraphs 11 through 87 of this Consent Agreement. That plan of corrective action will include, at a minimum:

a. A schedule of quarterly meetings to be held with the Superintendent and attended by senior executives of CIGNA Healthcare of Maine, Inc. and CIGNA Behavioral Health, Inc.
b. Identification of the cause(s) of each violation.
c. How the Companies intend to identify what corrective measures are necessary.
d. What measures the Companies have already identified as necessary.
e. How the Companies intend to implement strategies identified as necessary.
f. A summary of the responsibilities of corporate officers and management employees who will be instituting measures taken to prevent reoccurrence of each violation, including specifically
the titles and identities of those individuals.
g. Exactly what individuals identified as responsible for creating change will do to accomplish their mandates.
h. An estimate of the time required to complete corrective measures, with respect to each violation or type of violation.
i. A schedule of periodic reporting designed to keep the Superintendent apprised of progress in instituting corrective measures.

Terms of the plan of corrective action will be specific and concrete.

93. Immediately upon signing this Consent Agreement, the Companies will appoint an individual to serve as liaison with a designees of the Superintendent, for purposes of explaining, shaping and implementing the plan of corrective action required by paragraph 92 above. The appointed individual will have authority sufficient to make all reasonable accommodations necessary.

94. No later than January 30, 2004, the Companies will take the following actions:

a. File with the Superintendent an SAS 70 report of the internal controls of CBH completed by an external auditor. An SAS 70 report of the internal controls of CBH will be filed with the Superintendent on an annual basis thereafter.
b. Provide the Superintendent a certification verifying that its current medical director:
    i. Is licensed by the State of Maine Board of Licensure in Medicine or the State of Maine Osteopathic Board, or
    ii. Has applied for licensure by the State of Maine Board of Licensure in Medicine or the State of Maine Osteopathic Board.
    The certification will inform the Superintendent of the expected completion time of any pending application for licensure and commit the Companies to use at all times of medical directors licensed by the State of Maine Board of Licensure in Medicine or the State of Maine Board of Osteopathic Licensure.
c. Develop and implement a specific action plan that identifies the necessary activities to be carried out in Maine to address consumer and provider needs in the area of behavioral

care. Such a plan will be developed in consultation with the Director of the Bureau's Consumer Healthcare Division and shall include, at a minimum, consumer and provider outreach activities and complaint review sessions with Bureau staff.

d. Designate specific staff assigned to address complaints and grievances for Maine enrollees and providers for both medical and behavioral health issues. Additionally, the Companies will develop, for review and approval by the Bureau, a training plan to include specific training on Bureau Rule 850 requirements. The plan will include a schedule for the training of dedicated staff.
e. Develop an action plan for providing ongoing education to consumers, policyholders and providers on changes in business operations that affect consumers, policyholders or providers. The Companies will use all reasonable efforts to improve provider networks and to improve communications with the Superintendent, the Bureau, consumers, policyholders and providers, prior to the implementation of changes affecting any of the aforementioned.

95. Immediately upon signing this Consent Agreement, the Companies will appoint an individual to serve as liaison with a designee of the Superintendent, for purposes of explaining, shaping and implementing the action plan required by paragraph 94 above. The appointed individual will have authority sufficient to make all reasonable accommodations necessary.

96. This Consent Agreement is not subject to review or appeal. It is enforceable by an action in the Superior Court.

97. The Companies understand and acknowledge that this Consent Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, will be available for public inspection and copying pursuant to 1 M.R.S.A. § 408, and will be reported to the NAIC "RIRS" database.

98. Nothing herein shall be construed so as to prohibit the Superintendent or Attorney General from seeking an order to enforce this Consent Agreement.

99. Nothing herein shall be construed so as to prohibit the Superintendent or Attorney General from instituting further enforcement action against the Companies, administratively or in any court of competent jurisdiction, in the event that the Companies do not comply with any term or condition set forth herein.

100. Nothing herein shall be construed so as to affect in any way the authority of the Superintendent or Attorney General to institute further legal action, administratively or in any court of competent jurisdiction, against the Companies, in the event Superintendent or Attorney General receives evidence that further legal action is necessary for the protection of Maine consumers.

101. Nothing in this Consent Agreement shall be construed so as to affect the rights or interests of any person who is not an undersigned signatory to this Consent Agreement.

102. This Consent Agreement may be modified only by the written consent of all of the undersigned parties.

103. By their signatures hereto, the Companies acknowledge that they have consulted with counsel prior to executing this Consent Agreement and that, by their signatures, they voluntarily agree to be bound without exception by all of the terms and conditions set forth herein.

CIGNA Healthcare of Maine, Inc.

Dated:_____, _____

By: _____
DONALD M. CURRY
Its President

State of New Hampshire
Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

CIGNA Behavioral Health, Inc.

Dated:_____, _____

By: _____
KEITH DIXON
Its President

State of Minnesota
Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Maine Bureau of Insurance

Dated: _____, _____

_____
ALESSANDRO A. IUPPA,
Superintendent

Maine Department of Attorney General

_____
G. STEVEN ROWE,
Attorney General

Dated: _____, _____

_____
JAMES M. BOWIE, Bar No. 2496
Assistant Attorney General