STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

CIGNA HEALTH AND LIFE INSURANCE COMPANY

AS OF

DECEMBER 31, 2020

NAIC COMPANY CODE: 67369

TABLE OF CONTENTS

FOREWORD

January 23, 2023

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
Division of Financial Regulation
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director Stolfi:

This market conduct examination report of CIGNA HEALTH AND LIFE INSURANCE COMPANY (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers licensed to conduct business in the state of Oregon. The examiners conducted the examination of the insurer in accordance with the Oregon Revised Statutes (ORS) 731.300. All work papers and data developed in the production of this report are the sole property of the division. The examiner in charge was Heather Harley, AMCM, FLMI, HIA.

Certain unacceptable or noncomplying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

Respectfully Submitted,
Tashia Sizemore
Tashia Sizemore
Life and Health Program Manager

Signed and acknowledged before me on January 24, 2023 by Janet Vitus as Notary in Marion County, State of Oregon.

Janet Vitus

OFFICIAL STAMP
JANET VITUS
NOTARY PUBLIC - OREGON
COMMISSION NO. 1030442
MY COMMISSION EXPIRES NOVEMBER 21, 2026

EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill (HB) 3391, known as the Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as Oregon Revised Statutes (ORS) 743A.067. RHEA requires, among other things, that a health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost sharing requirements on the specific reproductive health services.

The focus of this targeted market conduct examination includes, but was not limited to, both insurer policyholder services and complaints and claims as related to cost sharing provisions of state and federal law.

This report is generally written in a "report by error" format. The report does not present a comprehensive overview of the insurer's practices. The report provides details of the non-compliant or problematic practices that were discovered during the course of the examination. All unacceptable or noncompliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices does not constitute acceptance of such practices.

The examiners concluded that claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. Specific findings related to the examination are summarized below:

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share such as copays, coinsurance, and deductible in the adjustment and payment of some claims. This occurred in multiple instances for paid and denied medical and pharmacy claims.

- **Failure to resolve complaints and maintain records in violation of ORS 733.170 and OAR 836-053-1080** – The insurer failed to demonstrate it adequately resolved complaints in some instances. The insurer did not provide the examiners with evidence that the various controls over the complaint, appeal, or grievance processes such as reports are used to monitor and ensure compliance with RHEA. The insurer provided responses to the complaint interrogatories and data call after the due date. The insurer failed to demonstrate that personnel involved with complaints, appeals, and grievances are aware the requirements related to RHEA.

This examination report, relating to RHEA claims for the period of January 1, 2019, to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

SCOPE OF EXAMINATION

A targeted market conduct examination of Cigna Health and Life Insurance Company was completed pursuant to Oregon Revised Statutes (ORS) 731.300 and in accordance with the procedures and guidelines as established by the Oregon Division of Financial Regulation (DFR). The examination protocols generally follow the market regulation handbook as adopted by the NAIC to the extent that it is consistent with Oregon laws. The focus of the examination was to determine if the insurer was in compliance with both federal and state law requiring proper cost sharing in health claims. The time period for review purposes covered dates of service between January 1, 2019 and December 31, 2020. Representatives from the firm of INS Regulatory Insurance Services, Inc. (INS) were engaged to administer the examination.

The insurer was originally incorporated as Orange State Life Insurance Company in 1963 and domesticated in Florida. Through various corporate purchases, restructurings, and mergers, it is now known as Cigna Health and Life Insurance Company and domesticated in Connecticut. The insurer's national principal products include group health benefit plans and professional services, the majority of which are offered through employers and other groups. The insurer provides only large group health insurance in Oregon. The insurer is licensed in all states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

This targeted market conduct examination evaluated the insurer's compliance with the Oregon Insurance Code within the statutes and Oregon Administrative Rules (OAR) in fulfilling its contractual obligations to policyholders relating to both policyholder services and complaints and claims. In the review of policyholder services and complaints, the examination focused on the procedures for complaints to be recorded in compliance with state and federal law, specifically OAR 836-053-1080, in facilitating proper compliance with cost sharing. The scope of the claims examination specifically reviewed compliance by the insurer for proper cost sharing for all claims including not imposing cost-sharing on preventive services, as defined by the U.S. Department of Health and Human Services (HHS) and the U.S. Health Resources and Services Administration (HRSA) and for the reproductive health and related preventive services required under ORS 743A.067.

The examination was conducted onsite and remotely in two phases. Phase I of the examination focused on review of the insurer's administrative functions and operations and provided the examination team a chance to become familiar with its operation. In Phase II, the examination team focused on the insurer's procedures and practices as it relates to administration of benefits required under RHEA. The insurer provided onsite access for claims and complaints systems review. During these phases, the following procedures were performed:

1. The insurer responded to initial and subsequent interrogatories, inquiries, and possible findings.
2. The insurer provided documents.
3. The insurer provided defined universes of files as requested.
4. The examiners selected random samples of files from those universes and reviewed those files for compliance.

FINDINGS AND OBSERVATIONS: CLAIMS

a. Lack of Examination Cooperation

On multiple occasions during the examination the insurer failed to properly facilitate the examination and make available requested and accurate information. The insurer failed to promptly, timely, and conveniently make available information to readily ascertain treatment of policyholders by not providing data and files responsive to the examiners' requests. Examples of failure to facilitate the exam include, but aren't limited to, correctly identifying RHEA claims, failing to provide claims information, failing to make prescription drug claim information available, and providing incorrect claims payment dates.

b. Interrogatory analysis and observations

The insurer was asked various questions about its claim functions. Examples of inquiry included description of the claims department, workflow charts, description of computer systems used, sample documents such as the explanation of benefits (EOB), walk through of the claims submission process, and other information and documents. The examiners and the insurer clarified the scope of the interrogatories via telephone and email correspondence between August 25 and September 10, 2021.

Responses were due September 17, 2021. The insurer provided responses to the claim interrogatories between September 18 and September 21, 2021.

This examination revealed a deficiency in the proper implementation of RHEA cost share provisions by the insurer for medical claims (involving provider services). The same deficiencies were not observed in the pharmacy claims.

The insurer informed the examiners during the onsite review in March 2022 that there had been an implementation failure for RHEA. The insurer further advised that review efforts had begun with remediation expected to begin in April 2022.

The insurer provided information that it first applied RHEA cost share provisions in November 2019, being 11 months after the effective date of the law. Due to the RHEA-related call letter issued by the state in August 2021, internal re-evaluation of implementation of RHEA by the insurer was instituted and the business units began review and updating in November 2021. The insurer also identified 21 diagnosis codes where cost share was not correctly applied.

Finding 1: Noncompliance with ORS 743A.067 relating to the processing of claims

The claim file reviews substantiated the deficiencies in the implementation of RHEA in the medical files (not including pharmacy claims). The failure rates relating to RHEA cost share

provisions are as follows, all above the NAIC tolerance level of 7 percent for the medical files:

- Paid RHEA-related claims review – The overall error percentage rate for the entire sample inclusive of medical and pharmacy claims is 11 percent. When considering medical files only, the error rate is 46.2 percent. Furthermore, a review of randomly chosen additional medical claims resulted in an error rate of 50 percent.

- Denied RHEA-related claims review – The overall error percentage rate for the entire sample inclusive of medical and pharmacy claims is 0.9 percent. When considering medical files only, the error rate is 50 percent. Furthermore, a review of randomly chosen additional medical claims resulted in an error rate of 25 percent.

c. Data analysis and observations

The examiners requested claims that had been paid or denied (both RHEA-related claims and all claims) during the examination period to include claims from individual health benefit plans, small group health benefit plans, large group health benefit plans, associations, trusts, MEWAs, and others. The insurer provided claims from large group plans as its business line in Oregon. The scope of the claims examination specifically reviewed compliance by the insurer for proper cost sharing for all claims including the insurer not imposing cost sharing on preventive services, as defined by HHS and HRSA and for reproductive health and related services required under Section 2 of RHEA.

Paid RHEA-related claims

The insurer provided a listing of 5,040 paid RHEA-related claims for the examination period. A random sample of 109 claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook, sampling guidelines.

In 15 instances out of 109 paid RHEA-related claim files reviewed, for an error percentage of 13.8 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claims. This is in violation of ORS 743A.067.

Sample size	# Errors	% Errors
109	15	13.8%

This review revealed that 14 of the 15 claim files with cost share inappropriately applied were medical claims not including pharmacy claims. However, the sample was comprised of substantially more pharmacy claims with 26 medical claims as compared to 83 pharmacy claims. The sample size was properly proportioned but given that the error percentage was 53.8 percent within the smaller population of medical files, a random selection of 10 additional paid RHEA-related medical claim files were chosen to review.

In five instances out of 10 additionally selected paid RHEA-related medical claim files that were chosen for review, for an error percentage of 50 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claims. This is in violation of ORS 743A.067.

Sample size	# Errors	% Errors
10	5	50.0%

Denied RHEA-related claims

The insurer provided a listing of 3,175 denied RHEA-related claims for the examination period. A random sample of 109 claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook, sampling guidelines.

In one instance out of 109 denied RHEA-related claim files reviewed, for an error percentage of 0.9 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claim. This is in violation of ORS 743A.067.

Sample size	# Errors	% Errors
109	1	0.9%

This review revealed that there were two medical files in the sample (the other files in the sample were pharmacy claims) with one of those having cost share inappropriately applied. The small sample size was properly proportioned but given that the error percentage was 50 percent within the small population of medical claims, a random selection of 20 additional denied RHEA-related medical claim files were chosen to review.

In five instances out of 20 additional denied RHEA-related medical claim files that were chosen for review, for an error percentage of 25 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claims. This is in violation of ORS 743A.067.

Sample size	# Errors	% Errors
20	5	25.0%

All paid claims

The insurer provided a listing of 230,231 all paid claims, which included both RHEA-related claims and non-RHEA-related claims, for the examination period. A random sample of 109 all paid claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook, sampling guidelines.

All denied claims

The insurer provided a listing of 103,322 all denied claims, which included both RHEA related

claims and non-RHEA-related claims, for the examination period. A random sample of 109 all denied claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook, sampling guidelines.

d. Onsite observations

The examiners provide the following observations regarding the review of claim processes of the insurer:

1. The insurer stated that there were deficiencies in the implementation of RHEA that are currently under review as supported by the file review of the examiners. The insurer states that it plans remediation beginning in April 2022. The examination file reviews reveal the following:
    - Paid RHEA-related claims review – The overall error percentage rate for the entire sample inclusive of medical and pharmacy claims is 13.8 percent. When considering medical files only, the error rate is 53.8 percent. Furthermore, with a review of randomly chosen additional medical claims resulting in an error rate of 50 percent.

    - Denied RHEA-related claims review – The overall error percentage rate for the entire sample inclusive of medical and pharmacy claims is 0.9 percent. When considering medical files only, the error rate is 50 percent. Furthermore, with a review of randomly chosen additional medical claims resulting in an error rate of 25 percent.

    The insurer failed to provide an appropriate universe of claims upon request for the paid RHEA-related claims.[1] The sample drawn from the universe of claims provided by the insurer revealed 4.6 percent of the files were not RHEA related. In review of randomly chosen additional medical claims, this additional sample of the paid RHEA-related claims revealed 20 percent of the files not to be RHEA related to the main diagnostic code for these medical treatments were not RHEA related while a procedure within the visit was RHEA listed procedure.

2. The insurer failed to provide initial data requested information by not providing cost share information. The insurer failed to provide this information in 17.4 percent of the paid RHEA-related files, 0.9 percent of the denied RHEA-related files and 35.8 percent of the paid all claims. The insurer provided responses to the claim interrogatories and data call after the due date.

FINDINGS AND OBSERVATIONS: POLICYHOLDER SERVICES AND COMPLAINTS

Finding 2: Failure to resolve complaints and maintain records in violation of ORS 733.170 and

[1] More information on the insurer's failure to properly facilitate the examination and make available requested and accurate information is found in the Appendix.

OAR 836-053-1080

a. Interrogatory analysis and observations

Two different procedure documents were provided to examiners. These were the complaint handling and Oregon appeals policy for customers; both were updated during the examination period. Various reports of complaints were provided to examiners. In materials provided to examiners, the insurer indicated they do not produce Oregon-specific complaint or appeal reports. The insurer is a national carrier, and its complaints, appeals, and grievances reporting is done at a national level as opposed to a regional or state-specific level. The insurer produces a national monthly report of regulatory complaints and a national quarterly report in which states are identified as necessary with national acknowledgment and resolution rates and top root causes.

b. Data analysis and observations

The examiners requested complaints that had been closed or received during the examination period. The review evaluated the insurer's policies and procedures for compliance with Oregon statutes and rules, specifically RHEA and OAR 836-053-1080.

The insurer identified a universe of 188 complaints that had been closed or received during the examination period. A random sample of 79 complaints was selected. This sample was requested, received, and reviewed by the examiners. Thirty-nine of the 79 complaints involve a claim-related complaint with two of those claim complaints related to RHEA. In 10.3 percent of the complaints, the insurer failed to demonstrate that consumer complaints were adequately resolved

Responses to the interrogatories and data lists were due September 17, 2021. The insurer provided responses to the claim data call on September 27, 2021, after the due date.

c. Onsite observations

The examiners provide the following observations regarding the review of policyholder services and complaints processes of the insurer:

1. The insurer did not provide the examiners with evidence that the various controls over the complaint, appeal, or grievance processes such as reports are used to monitor and ensure compliance with RHEA. The insurer provided reference material referring to federal law on preventive services without clearly explaining Oregon specific requirements related to reproductive health and reports related to complaint volume.

2. The insurer would not be able to separate, in its systems, the complaints, appeals, or grievances relating to RHEA without manual intervention.

   In 49.3 percent of the complaints, the insurer did not initially provide associated claim file numbers in response to the initial data request, failed to provide the resolution

letter date in one sample, and failed to provide accurate information in two other samples. The insurer provided responses to the complaint interrogatories and data call after the due date.

3. The insurer failed to demonstrate that personnel involved with complaints, appeals, and grievances were adequately trained on the requirements related to RHEA.

RECOMMENDATIONS

Claims

As a result of the examiners' observations, it is recommended that the insurer ensure that the following claim processes and procedures are implemented:

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.

2. The insurer review its claims adjudication system and make all necessary adjustments to assure that claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.

3. The insurer submit accurate, timely, and complete information to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.

4. Insurer personnel be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA-related services without other restrictions or delays.

5. The insurer provide a report to DFR of claims that are readjusted and remediated due to systemic RHEA deficiency findings that were discovered in this examination.

6. The insurer make a specific review of actions and contracts by third party administrators to ensure that these administrators are properly integrated and trained for adjustment of RHEA-related claims.

Policyholder service and complaints

As a result of the examiners' observations, it is recommended that the insurer ensure that the following processes and procedures are implemented:

1. The insurer provides proper monitoring of the complaint and grievance systems for trend analysis and compliance with state and federal law. This includes proper controls over the complaint and grievance process to track complaints based on subject.

2. Insurer personnel are properly trained and knowledgeable in RHEA requirements given the noted systemic claims deficiencies.

3. The insurer submit accurate, timely, and complete information is provided to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.

4. The insurer adheres to the established complaint and grievance process so that complaints are acknowledged and resolved in a timely manner.

APPENDIX

Appendix A: Overview of examination sampling

Universe	Sample	Examiner comments
Complaints		
188	79	None
Paid RHEA-related claims		
5040	109	(5) of the requested files were not RHEA related. Given the smaller size of medical claims not involving pharmacy claims, the examiners reviewed (10) additional medical claims to confirm the findings in the initial sample. Two of these (10) files were not related to RHEA.
Denied RHEA-related claims		
3, 175	109	Given the smaller size of medical claims not involving pharmacy claims, the examiners reviewed (20) additional medical claims to confirm the findings in the initial sample.
All paid claims		
230, 231	109	None
All denied claims		
103, 322	109	None

Summary of the claim sample errors with the diagnosis and CPT codes

Population: Paid or denied	Examination review item (sample)	Diagnosis code	CPT code	Finding
Paid	58	unav.	unav.	Improper cost share
Paid	84	Z3202	84702	Improper cost share
Paid	87	Z01419	99395	Improper cost share
Paid	89	Z202	87491	Improper cost share
Paid	90	Z30017	11981	Improper cost share
Paid	93	R112	99214	Improper cost share
Paid	94	R300	99213	Improper cost share
Paid	95	Z3009	81025	Improper cost share
Paid	97	O9989	84702	Improper cost share
Paid	98	Z23	86317	Improper cost share
Paid	104	Z3202	99212	Improper cost share
Paid	106	R102	99214	Improper cost share
Paid	R-12	Z202	87800	Improper cost share
Paid	R-14	R109	81003	Improper cost share
Paid	R-15	O021	unav.	Improper cost share
Paid	R-17	E782	82105	Improper cost share
Paid	R-18	N926	99213	Improper cost share
Paid	R-19	K5900	84703	Improper cost share
Paid	R-20	Z01419	99386	Improper cost share
Paid	R-24	N898	87210	Improper cost share
Denied	109	Z01411	99395	Improper cost

				share
Denied	R-6	Z332	59841	Improper cost share
Denied	R-7	Z202	86803	Improper cost share
Denied	R-12	I10	84443	Improper cost share
Denied	R-16	B20	82306	Improper cost share
Denied	R-20	Z3041	99211	Improper cost share