MARKET CONDUCT REPORT ON EXAMINATION

OF

CIGNA HEALTHCARE OF NEW YORK

AS OF

DECEMBER 31, 2000

DATE OF REPORT: **JANUARY 31, 2003**
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EXAMINER: **FROILAN L. ESTEBAL**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

June 2, 2003

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21643 and 21980 dated October 26, 2000, and annexed hereto, I have made an examination into the affairs of Cigna HealthCare of New York, Inc. ("CHCNY"), a for-profit health maintenance organization (HMO) Certified pursuant to Article 44 of the Public Health Law, and Connecticut General Life Insurance Company (CGLIC), a licensed stock life insurance company incorporated under the Law of Connecticut. The CGLIC appointment was limited to the out-of-network coverage, which is issued by CGLIC as part of a point of service (POS) product offered to CHCNY members.. The following report, as respectfully submitted, deals with the findings concerning the manner in which CHCNY and CGLIC conduct their business practices and fulfills their contractual obligations to policyholders and claimants.

The examination was conducted at the offices of CHCNY located at 499 Washington Blvd., Jersey City, New Jersey, 900 Cottage Grove Road, Bloomfield, Connecticut, and 32 Valley Street, Bristol Connecticut. Whenever the term "CHCNY", or "HMO" appear herein, without qualification, they should be understood to refer to CIGNA HealthCare of New York, Inc. Whenever the term CGLIC or Company appear herein, without qualification they should be understood to refer to Connecticut General Life Insurance company.

1. SCOPE OF EXAMINATION

A previous examination into the financial condition and affairs of CHCNY was conducted as of December 31, 1997. This market conduct review covers the period from January 1, 2000 through December 31, 2000.

The primary purpose of this report is to determine the manner in which CHCNY conducts its business practices and fulfills its contractual obligations to policyholders and claimants and assist Cigna HealthCare's management in addressing problems that are of such a critical nature that immediate and corrective action is required. Additionally, the scope of this examination included claims processed by (CGLIC) on behalf of Cigna Healthcare of New York as outlined under the holding company service agreement. This is not to be construed as a full market conduct examination of CGLIC, but rather is limited to a review of the out-of-network portion of the Cigna Health Access (CHA) Point of Service product that is available to CHCNY members. This report on examination is confined to comments on those issues that involve matters that deviate from laws, regulations and rules, or which are deemed to require an explanation or description.

2. EXECUTIVE SUMMARY

The findings and recommendations noted herein indicate a need for the Company to take immediate action to improve its management control structure as it pertains to claims processing. Also evident from the review of claims processing is the need to implement or improve monitoring and quality control measures in place, which findings are further corroborated by claims system and processing inefficiencies. The statistical model utilized for testing both attribute (processing operations) and financial accuracy for this examination, revealed a number of diverse errors that together indicate underlying problems in a number of areas of the claims adjudication function. Examples of this are reflected in:

- substantial error rates on processed claims resulting from various processing and systems faults as detailed herein under item 3C;
- improper processing and often unnecessary forwarding of certain claims to contracted vendors;
- failure to remit required New York Health Care Reform Act ("HCRA") surcharges;
- insufficient explanation of benefits language ("EOB") in violation of Section 3234 of the Insurance Law;
- providing utilization review and external review rights based on state of residency and not based on the state where a contract is issued for delivery, in violation of Article 49 of the Insurance Law;
- Violations of Sections 3224a(a) and (c) "Prompt Pay Law"

The findings detailed in this report support the Department's recommendations that management examine the current structure upon which performance statistics are compiled and analyzed.

It is recommended that Cigna HealthCare perform an in-depth review of its information systems structure including operational controls and report to its findings to the Department.

3. CLAIMS PROCESSING

A review of Cigna HealthCare's claims processing activities was performed. This review was carried out by using a statistical sampling methodology covering the period January 1, 2000 through December 31, 2000 in order to evaluate the overall accuracy and compliance environment of Cigna HealthCare's claims processing. In order to achieve the goals of this review, claims were segregated into two primary populations:

a) In-network Claims (HMO); and

b) Out-of-network Claims (from Point-of-Service "POS" Product named Cigna Health Access ("CHA") where the in-network portion of the product is underwritten by CHCNY and Out-of Network portion is underwritten by Connecticut General Life Insurance Company, an affiliate).

These primary populations were then further segregated between facility "hospital" and non-facility "medical" claims segments and separated by Cigna HealthCare's two primary claims processing systems, Medicom and Amisys. The Medicom System is Cigna's national system. The processing of CHCNY Medicom claims takes place in Bristol, Connecticut. Amisys is a proprietary claim processing system, with claim processing done in Rockaway, New Jersey. Amisys is used to process claims for smaller accounts and are located exclusively in New York and New Jersey. The Amisys operation is currently being relocated to Concord, New Hampshire. Medicom processing accounts for approximately 70% of New York claims compared to 30% from Amisys.

For purposes of testing the claim processing systems, eight sub-groups were established by the examiner as follows:

1. Amisys In-Network Medical claims - HMO
2. Amisys In-Network Hospital claims - HMO
3. Medicom In-Network Medical claims - HMO
4. Medicom In-Network Hospital claims - HMO
5. Amisys Out-of-Network Medical claims - POS
6. Amisys Out-of-Network Hospital claims - POS
7. Medicom Out-of-Network Medical claims - POS
8. Medicom Out-of-Network Hospital claims – POS

A random statistical sample was drawn from each of the eight groups. For purposes of this review, those claims characterized as Pharmacy, Medicare, Injectables, Capitated Payments, Diabetic, NY Demographic and SMC Pools, HCRA bulk payments, and TPA vendor claims were excluded.

This statistical random sampling process was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if 10 attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample.

The following parameters were established to determine the sample size for the statistical sampling model:

a) **Confidence Level –**

The rate was set at 95%, which infers that there is a 95% chance that the sample will yield an accurate result.

b) Tolerance Error -

The rate was set at 5%. It was determined that a 5% error rate would be acceptable for this sample.

c) Expected Error –

It was anticipated that a 2% error rate exists in the entire population subject to sampling, which was deemed acceptable for the model design.

d) Sample Size –

The sample size for each of the eight populations described herein was comprised of 167 randomly selected unique claims. An exception was made for two of the sampled groups (Amisys out-of-Network and Medicom out-of-Network) since the population was less than 167. A second random sample of 100 claims from the other six groups was also generated as "replacement items" in the event it was determined that a particular claim selected in the sample should not be tested. Accordingly, various replacement items were appropriately utilized. Overall, 1,040 claims for the scope period were selected for review. This total is divided into 668 claims for in-network (HMO) and 372 claims for out-of-network (POS).

To ensure the completeness of the HMO claims population being tested, the total dollars paid were accumulated and reconciled to the year-end 2000 financial statements filed by Cigna HealthCare. A different approach was formulated to arrive at the population and control reconciliation for the POS out-of-network ("OON") claims. Such claims are recorded in the paid claims of CGLIC. There is no system in place that segregates and reports transactions and dollar amount totals attributable specifically to the out-of-network portion of the New York CHA OON claims from other CGLIC business. The HMO uses an extrapolation to determine the percentage of NY OON business from its "National Earnings System" total. Overall, there was a 2% variance between the extrapolated amount and the control total for the extracted data provided to the examiners.

To assure that all claims processed for both in-network and out-of network (payment or a non-payment) were accounted for, a reconciliation of transaction counts was performed by the examiners.

A. Summary of Claims Review Findings:

Examination findings indicated substantial internal control and claims processing deficiencies within Cigna HealthCare's claims processing systems. These deficiencies appear to have an adverse impact on Cigna HealthCare's ability to process claims with minimal errors. For the purpose of this review, financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with Cigna HealthCare's claim processing guidelines and any applicable statutory requirement. For the purposes of this report, all financial errors are also considered processing errors. An error in processing accuracy may or may not affect the financial accuracy.

In summary, of the 1040 claims reviewed, 346 or 33% of claims reviewed contained one or more claims processing procedural errors. Of these 346 claims, 241 or 23% of claims reviewed contained one or more financial errors. It should be noted that only one error is assigned per claim regardless of how many individual errors were found in a single claim processed. It is noted that there were many claims reviewed which contained more than one error, and several contained three or more errors.

The following charts illustrate the financial and procedural accuracy findings separated between in-network and out-of-network claims, as summarized above:

Summary of Financial Accuracy - HMO In-Network (INN)

	Amisys INN Medical	Amisys INN Hospital	Medicom INN Medical	Medicom INN Hospital
Claim Population	83,978	1,775	188,209	18,129
Sample Size	167	167	167	167
Claims with Financial Errors	27	38	38	35
Calculated Error Rate	**16.17%**	**22.75%**	**22.75%**	**20.96%**
Calculated Accuracy Rate	**83.83%**	**77.25%**	**77.25%**	**79.04%**
Upper Error limit	21.75%	29.11%	29.11%	27.13%
Lower Error limit	10.58%	16.40%	16.40%	14.78%
Upper limit Claims in error	18,266	517	54,794	4,919
Lower limit Claims in error	8,888	291	30,858	2,680

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Summary of Procedural Accuracy – HMO In-Network

	Amisys INN Medical	Amisys INN Hospital	Medicom INN Medical	Medicom INN Hospital
Claim Population	83,978	1,775	188,209	18,129
Sample Size	167	167	167	167
Claims with Errors	45	60	48	56
Calculated Error Rate	**26.95%**	**35.93%**	**28.74%**	**33.53%**
Calculated Accuracy Rate	**73.05%**	**64.07%**	**71.26%**	**66.47%**
Upper Error limit	33.68%	43.21%	35.61%	40.69%
Lower Error limit	20.22%	28.65%	21.88%	26.37%
Upper limit Claims in error	28,280	767	67,015	7,377
Lower limit Claims in error	16,978	509	41,177	4,781

Note: The Upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Summary of Financial Accuracy – POS Out-of-Network (OON)

	Amisys OON Medical	Amisys OON Hospital	Medicom OON Medical	Medicom OON Hospital
Claim Population	54,486	176	12,397	307
Sample Size	167	20	167	18
Claims with financial errors	52	7	39	5
Calculated Error Rate	**31.14%**	**35.00%**	**23.35%**	**27.78%**
Calculated Accuracy Rate	**68.86%**	**65.00%**	**76.65%**	**72.22%**
Upper Error limit	38.16%	55.90%	29.77%	48.47%
Lower Error limit	24.11%	14.10%	16.94%	7.09%
Upper limit Claims in error	20,792	98	3,691	149
Lower limit Claims in error	13,139	25	2,100	22

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

Summary of Procedural Accuracy – POS Out-of-Network

	Amisys OON Medical	Amisys OON Hospital	Medicom OON Medical	Medicom OON Hospital
Claim Population	54,486	176	12,397	307
Sample Size	167	20	167	18
Number of claims with errors	58	8	60	11
Calculated Error Rate	**34.73%**	**40.00%**	**35.93%**	**61.11%**
Calculated Accuracy Rate	**65.27%**	**60.00%**	**64.07%**	**38.89%**
Upper Error limit	41.95%	61.47%	43.21%	83.63%
Lower Error limit	27.51%	18.53%	28.65%	38.59%
Upper limit Claims in error	22,858	108	5,356	257
Lower limit Claims in error	14,989	33	3,552	118

Note: The Upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

B. Internal Controls

The concept of internal control incorporates a number of key elements in the successful operation of any entity. These controls are embodied in such areas as manpower, compliance, operational, monitoring (usually the audit and/or quality assurance areas), accounting (books and records and management reporting, including information systems), and overall management policies and procedures set by the Board of Directors through to the line supervisor. The statistical sample findings not only show individual errors – symptoms (which can be projected to the whole), but also management issues that relate to the cause of the errors. It is important that management recognizes and develops programs to address the control weaknesses noted herein.

It is recommended that Cigna HealthCare's management review internal control procedures and make the necessary modifications to ensure that accurate data is provided to senior management so that appropriate business decision can be made.

Circular Letter No. 9(1999) dated May 25, 1999 "Adoption of Procedure Manuals" was issued to Article 43 Corporations, public Health Law Article 44 Health Maintenance Organizations and Insurers Licensed to Write Health Insurance in New York State. The Circular Letter states in pertinent parts as follows:

> "In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules and regulations. One way for the board to ensure itself that such procedures are in place is to direct the officers responsible for claims adjudication to (i) issue, and up-date as necessary, a claims manual which sets forth the company's claims adjudication procedures; (ii) distribute the claims manual and necessary up-dates to all persons responsible for the supervision, processing and settlement of claims and obtain an

> acknowledgement of receipt; and (iii) provide the training necessary to ensure the claim manual's implementation including a formal educational program and periodic re-training. It is recommended that the board obtain the following certifications annually: (i) from either the company's director or internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.
>
> The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself.

Given the findings and claims processing deficiencies as noted throughout this Market Conduct Report on Examination, it is incumbent upon the board of directors of Cigna Healthcare of NY, as well as the board of directors of its parent corporation to ensure that necessary written procedures are implemented and monitored in accordance with Circular Letter No. 9(1999).

It is noted that in the minutes from the July 20, 1999 CHCNY Board of Directors minutes, the HMO's president stated that Circular Letter No. 9 was distributed to the directors on June 15, 1999.

It is recommended that Cigna Healthcare of New York establish a process for updating and reviewing the implementation of claims processing procedures in accordance with Circular Letter No. 9(1999). This includes distribution of detailed, accurate and timely reports relative of its claims processing activities to senior management, its board of directors and the directors of the parent corporation on a regular basis so that management can be in a better position to fulfill its responsibility to oversee the claims adjudication process.

Cigna HealthCare provided the examiners with internal review performance indicators for both Medicom and Amisys operations for the year 2000. However, these performance indicators do not separate New York and non-New York Claims. The performance report shows combined results taken from internal control testing of claims processed by CHCNY and its affiliates. The combined analysis prevents the examiners, as well as the HMO's claims management, from evaluating and analyzing trends and potential sources of problems which are specific to CHCNY's claims.

It is recommended that CHCNY maintain reports pertaining to CHCNY's claims processing performance separate from those of its affiliates.

The following charts illustrate the HMO's internal control financial and procedural claims accuracy findings for Medicom and Amisys:

Bristol Office Internal Review Results 2000 (Medicom)

	Payment Accuracy	**Processing Accuracy**	**Financial Accuracy**
JANUARY	97.73%	95.79%	98.95%
FEBRUARY	97.66%	93.91%	98.52%
MARCH	97.70%	95.60%	98.84%
APRIL	98.39%	96.08%	98.99%
MAY	97.76%	95.23%	98.66%
JUNE	98.05%	95.61%	99.01%
JULY	98.25%	96.48%	99.11%
AUGUST	97.86%	95.49%	99.07%
SEPTEMBER	97.87%	95.30%	99.17%
OCTOBER	97.36%	94.31%	98.16%
NOVEMBER	97.8%	94.61%	97.47%
DECEMBER	97.00%	93.50%	98.36%
Average	**97.80%**	**95.20%**	**98.78%**

Rockaway Office Internal Review Results 2000 (Amisys)

	Payment Accuracy	**Process Accuracy**	**Financial Accuracy**
JANUARY	98.85%	99.15%	98.69%
FEBRUARY	98.59%	99.48%	98.12%
MARCH	98.93%	99.39%	98.49%
APRIL	99.49%	99.72%	98.75%
MAY	97.83%	99.43%	98.37%
JUNE	98.95%	99.42%	98.63%
JULY	98.81%	99.34%	98.63%
AUGUST	98.26%	98.15%	96.04%
SEPTEMBER	98.37%	97.39%	96.94%
OCTOBER	97.92%	97.45%	97.87%
NOVEMBER	96.89%	98.57%	97.29%
DECEMBER	97.74%	99.08%	98.23%
Average	**98.18%**	**98.88%**	**97.95%**

CHCNY's internal control review discloses procedural accuracy rates of 95% and 99% for Medicom and Amisys, respectively, and financial accuracy levels of 99% and 98% for Medicom and Amisys, respectively. This differs significantly from the examination accuracy levels shown above. CHCNY states that it does not review or measure accuracy solely on the basis of the number of times claims are processed incorrectly regardless of amount. It gauges accuracy based upon the overall dollar accuracy of claims processed during a given period. This results in a higher internal financial accuracy rate since it places greater emphasis on the financial magnitude of the errors, rather than on the number of instances of errors.

C. Detail of Claims Review Findings

The following represents examples of substantive errors and control weaknesses found during the review of claims processing:

Deductibles and Coinsurance

- Cigna HealthCare's Medicom claims processing system did not retain data relative to the subscriber's deductible and coinsurance accumulations for the period covered under this examination. Only the current year's deductible and coinsurance information is maintained on the system. All previous year's data is purged from the claim system. However, the HMO was able to utilize archived records and reconstruct the subscribers paid claims history to determine the deductible and coinsurance accumulations for most, but not all of the sampled claims. It is imperative that all such deductible and coinsurance information be retained. The subscriber's out-of-pocket expense information is a critical part of the claims review process. It also provides an audit trail that helps document the history of the claim should additional review, response to subscriber inquiry, or research in contested claims become necessary.

New York State Insurance Department Regulation No. 152 (11 NYCRR 243) sets forth standards of retention of records by insurance companies.

Section 243.2(b)(4) states that an insurer shall maintain:

> "a claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

Cigna HealthCare's failure to retain all the requisite claims information is contrary to the requirements of Department Regulation No. 152.

It is recommended that Cigna HealthCare retain all requisite claims information and comply with the requirements of New York State Insurance Department Regulation No. 152 (11 NYCRR 243).

- A review of out-of-network claims revealed numerous instances where the deductible limits were applied incorrectly. As noted previously, the prior year's deductible and coinsurance information were not available in the claim system, therefore, the HMO had to reconstruct all prior events leading up to the sampled claim. There were several instances where the HMO paid claims where deductible limits had not been reached, resulting in overpayment of claims. There were also instances where the HMO applied the charges towards the deductible even though the maximum has already been achieved. Of the 346 claims containing errors, 27 claims involved the application of incorrect deductibles and/or coinsurance.

It is recommended that Cigna HealthCare implement the necessary changes to its claims processing system to ensure that deductible and coinsurance information are properly applied.

- Subscribers' "out-of-pocket" information" was excluded from Explanation of Benefit ("EOB") statements generated from the Amisys claim system and sent to subscribers. The review of claims processed on the Medicom claim system indicated that some EOBs did include out-of-pocket accumulation information, while others did not. Additionally, the subscribers' maximum coinsurance limits, and/or whether they have been met, are not disclosed in the EOB statements, which resulted in numerous complaints regarding application of the coinsurance (see EOB comments further herein on page 20).

It is recommended that as a good business practice, the HMO include the subscribers' "out-of-pocket" information in the EOB statements for the benefit of its subscribers. The statement should include both the subscribers' coinsurance accumulations and maximum coinsurance limits for the contract year.

Systems Information Structure

- In some instances, the Medicom processing system displays inconsistent information with regards to the subscriber's benefit plan. As a result, some claims were paid incorrectly. In one example, a claim reflected a coinsurance level of 70/30 on the benefit screen (meaning payment of 70% of reasonable and customary rates, with 30% coinsurance). The system however incorrectly reflected a benefit level of 80/20, resulting in overpayment of the claim. System processors who adjudicate claims manually rely on data entered into the system. All other claims reviewed from this subscriber were consistently paid using the incorrect benefit level.

It is recommended that Cigna HealthCare evaluate its claim processing system relative to its benefit information structure and determine and eliminate causes for inconsistencies between the benefit level shown on the provider contract screen and the benefit level shown on the claim-processing screen.

- In some instances, it was noted that the in-network system was not updated with the current point-of-service ("POS") benefit information. For example, a sampled claim reviewed showed that the subscriber had POS coverage (option to go out-of-network), however, the claim was denied for "no POS coverage" since the in-network system did not show that this subscriber contract included the coverage.

It is recommended that Cigna evaluate its claim processing system with respect to information contained within the in-network and out-of-network systems, specifically with regard to Medicom, to determine and eliminate causes for inconsistencies between systems.

- Numerous instances were noted where deductible and coinsurance maximum limits were entered into the system incorrectly, resulting in incorrect accumulations. In one example, the benefit screen showed a deductible of $500. However, the HMO stopped applying payments towards the deductible at $300. Further investigation showed that the "F3" code (a system code that indicates that deductibles are met) was posted incorrectly at $300 instead of $500.

It is recommended that CHCNY make the necessary changes to its claims processing system to ensure deductible limits are properly recorded.

Third Party Vendors

- Based upon analysis of claims data provided to the examiners, about one-third of CHCNY's claims arrive in the HMO's mailroom in error. The majority of these claims are third party vendor claims that should have been sent directly to the third party administrator instead of going to Cigna HealthCare, thereby delaying the processing of the claim. The HMO provided no reason as to why so many claims wind up in the wrong location. The HMO needs to improve its communication with its providers with regard to proper mailing routes for specific claims. Cigna HealthCare's management

should evaluate the current method of directing claim routes and improve upon the system of sorting claims received in order to minimize the process of having to forward claims. The HMO appears to be aware that there is a problem, however, the lack of corrective actions result in serious processing inefficiencies including:

- unnecessary multiple processing of a claim;
- claim payment delays;
- improper and often unnecessary claim forwarding;
- improper adjudication of claims;
- unnecessary and confusing denial EOB statements sent to providers; and
- erroneous payment of capitated claims.

It is recommended that management evaluate and improve upon the current mapping of claim mailing routes, as well as the sorting and forwarding of claims received, with special attention directed to vendor related claims.

It is further recommended that the HMO improve upon communication with its providers regarding proper mailing address for specific claims.

- Claims processors routinely forward out-of-network mental health claims to its third party vendor and affiliate, Cigna Behavioral Health "CBH", when these claims are ultimately Cigna HealthCare's processing responsibility. Only CBH has access to the systems that determine whether a claim is an in or out-of-network claim since that function is performed by CBH. Therefore, Cigna HealthCare's claim processors are not able to process out-of-network claims that initially come to Cigna HealthCare without forwarding the out-of-network claims to CBH, only to have them returned by CBH, thus delaying payments. In addition, CHCNY sends out confusing EOB statements, which both deny and forward such claims.

It is recommended that CHCNY implement a process whereby out-of network claims initially received by Cigna HealthCare can be identified and processed in a timely manner.

Previous recommendations regarding mapping of claims submission and communication with providers are also included herein above.

Reasonable and Customary Rates ("R&C")

R&C reimbursement rates for out-of-network claims are updated in the Medicom claims system approximately twice every year. The examination revealed that the claims processing system only reflects the current R&C rate and that the prior rates are purged from the system. This resulted in incorrect rates being applied to claims that were incurred but unpaid prior to the time the updated R&C rates became effective. The only way claims processors can access prior R&C rates is through a cumbersome process of requesting and retrieving data from archives. Processors are not instructed or trained on how to retrieve "prior" rates. As a result, CHCNY uses incorrect (newer) rates for a significant percentage of its claims that should have been subject to the prior rate in effect. During the review of out-of-network claims, there were 17 sampled claims noted where incorrect R&C rates were applied.

It is recommended that Cigna maintain both current and prior R&C rates in its claims processing system and ensure that proper rates are applied as determined by the date of service indicated on the claim.

Explanation of Benefits Statements (EOB)

As part of the review of Cigna HealthCare's claims practices and procedures, an analysis of the Explanation of Benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and Cigna HealthCare. It should clearly communicate to the subscriber and/or provider that Cigna HealthCare has processed a claim and how that claim was adjudicated. It should correctly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

§3234(b)(7) of the New York State Insurance Law states in part:

> "(b) The explanation of benefit statement form must include at least the following:"
>
> "(7)…a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made".

Contrary to the above, Cigna HealthCare does not include the requisite information regarding the right to appeal on its EOBs. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights, in violation of §3234(b)(7).

It is recommended that Cigna HealthCare comply with §3234(b)(7) of the New York Insurance Law.

Subsequent to the examination date, during 2002, Cigna HealthCare began issuing EOBs for claims processed on its MediCom system that contained the requisite appeals language and indicated that it would begin issuing compliant EOBs for claims processed on the Amisys system beginning some time in 2003.

It was noted that Cigna HealthCare does not include any fraud warning and/or notification on how to report healthcare fraud on its EOBs.

Section 86.2 of 11NYCRR 86 (Regulation 95) was amended to include all health maintenance organizations and states as follows:

> "§86.4 Warning statements.
>
> All applications provided to applicants for [non-automobile] commercial insurance and all claim forms for insurance, except personal automobile insurance, delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:
>
> "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Notwithstanding that the above Regulation does not require the warning statement to be placed on EOBs it would be prudent for Cigna HealthCare to include such a warning as well as a toll free number to report fraud and/or abuse.

It is recommended that Cigna HealthCare include a fraud warning and disclose on the EOB a toll free number where subscribers can call in the event they suspect that fraud has been committed.

Incorrect Payment Destination

- Assignments of Benefit – There were 5 instances noted where the processor apparently failed to review the assignment provision on the claim form. This resulted in errors where payment was sent to the wrong party. Further problems occurred, causing delays in payment to the correct beneficiary.

It is recommended that Cigna HealthCare provide the necessary training to its claim processors to better enable the processor to determine if the assignment provision is applicable.

- Incorrect address – The HMO, at certain instances, runs into a conflict when the address written on the claim form submitted differs from address or addresses shown on the claims system. This at times resulted in EOB statements going to the wrong location when an incorrect systems address was selected. In one example, the claim processor sent out a request for additional information to an address that was different from the address where the claim form was sent. The provider sent the same submission several times without responding to the request for additional information. The re-submissions were all denied as duplicate. It appears that communication from the HMO never reached its intended destination.

It is recommended that the HMO implement the necessary procedures to correctly process claims where address on the submitted claim form differs from address listed on the claims system, and verify the correct address through inquiry to determine the proper mailing address.

- Incorrect Suffix – A suffix is a code assigned by Cigna HealthCare to link the provider's address and fee schedules. The suffix is used to distinguish between subsidiaries and affiliates of hospital groups, which operate under the same Tax Identification Number ("TIN"). There were several instances where the wrong suffix was used in payment of a hospital claim. For example, Mt. Sinai Hospital includes several affiliated. A different suffix will be applied to each hospital to distinguish proper payment address and payment schedules. The examination revealed that at times an incorrect suffix was used, resulting in a payment sent to the wrong hospital. Additionally, the wrong fee schedules were used since hospitals within the same group use different contracted fee schedules determined by varied geographic locations.

It is recommended that Cigna HealthCare provide the necessary training to its claim processors to ensure that proper suffix code is being used.

Multiple Reprocessing

A significant number of sampled claims were re-submissions of previously submitted claims. In some instances noted, the claims would not have needed to be re-submitted several times, had the claim been processed properly in the first instance. In one example, a claim was

re-submitted to Cigna HealthCare 11 times. A review of this claim revealed that the claim that was initially submitted included sufficient information to allow the HMO to properly adjudicate the claim. Ultimately, the provider was paid, but with the incorrect amount.

It is recommended that Cigna HealthCare evaluate the reasons for claim re-submissions and make the necessary enhancements to its training program and provider outreach efforts, so that the volume of claim re-submissions due to processing errors can be reduced.

Out-of-network claims processed as in-network

There were 19 instances where the HMO treated out-of-network claims incorrectly as in-network claims. This resulted in the use of an incorrect fee schedule to process payment of claims. In-network claims use contractual rates as opposed to out-of-network claims, which use R&C rates. This use of the lower contractual rates could cause subscribers to be balance billed for a higher amount or a higher co-insurance amount than if the correct R&C rate was paid.

In-Network claims paid as Out-of-Network

In similar fashion there were 17 instances noted where the HMO processed in-network claims as Out-of Network claims. Under this scenario "R&C" rates are used erroneously instead of the participating provider contractual rate. This error creates additional problems involving the application of deductibles and coinsurance.

It is recommended that Cigna HealthCare provide the necessary training to its claim processors so that both in-network and out-of-network claims will be adjudicated properly.

Detection of Payments between systems

A potential weakness noted involves claims that have already been paid as out-of-network which can be paid again if re-submitted and incorrectly processed as an in-network claim. The Medicom claims system does not have a feature built in that would notify a processor that a claim was already paid as out-of-network. In one example, a claim was resubmitted in-network that had already been paid as out-of-network. In this case the double payment was averted only because the subscriber called Cigna regarding another matter and during the conversation the subscriber mentioned that the claim had been paid already. Without the necessary link between the in-network and out-of-network platform, the potential for double payments remains likely.

It is recommended that Cigna make the necessary changes to its claims processing systems to ensure that both the in-network and out-of-network systems cannot pay the same claim.

Unnecessary double processing of out-of-network Claims

Most out-of-network claims received by the HMO are unnecessarily processed as in-network first before processing as out-of-network. Processors routinely and knowingly process claims fitting the description of an out-of-network claim as in-network. This results in inefficient double processing of a claim. Problems created include creation of an EOB statement to the subscriber stating that the claim is being denied because it is an out-of-network claim. The claim, at a later time, will be processed out-of-network which is how the claim should have been processed in the first place. The examiners were informed that the denial

EOB statement should have been suppressed, so as not to confuse the subscriber. However, our review showed that the EOB statement is sent to the subscriber nonetheless.

It is recommended that Cigna HealthCare implement the necessary modification to its training program to ensure that both in-network and out-of-network are processed efficiently. It is further recommended that the HMO modify its claims system so that internal messages that are supposed to be suppressed are not printed on the explanation of benefit ("EOB") statements.

POS claims without referrals

POS coverage entitles a subscriber to seek specialist services without a referral. The HMO's claims processors appear to apply conflicting referral requirements when adjudicating certain POS claims. If the specialist is a non-participating provider, the HMO will properly treat the claim as an out-of-network claim. However, if the specialist is a participating provider, the HMO stated that the proper procedure is to deny a participating specialist claim for no referral, when the service is accessed without the member going through their PCP and getting a referral. This procedure could put the member in the position of being billed by the provider for a covered out-of-network service.

It is recommended that Cigna HealthCare properly adjudicate claims for subscribers who utilize their POS coverage and choose a provider that participates in the CHCNY network.

Incorrect referrals allowed

Instances were noted where the system displayed incorrect counts of visits and referrals prescribed by a PCP, resulting in improper denial of the claim. In one example a claim was denied when the HMO stated that the subscriber exceeded the number of referrals allowed; however, a further check of the referral count on the system indicated that the subscriber had not used up all authorized referrals. The examiners were informed that processors are trained to count referrals used manually.

It is recommended that Cigna HealthCare make the necessary changes to its claims processing system to ensure that referral counts are properly accounted for.

Chiropractor visits

Instances were noted where CHCNY's claim processing system reflected incorrect counts of chiropractor visits and related limitations. In one example, the HMO paid a claim even though the subscriber had already exceeded the maximum 30 allowable visits in a contract year. In another example, Cigna denied a claim for missing the required "medical necessity note" after only 6 visits. This is in conflict with Cigna HealthCare's policy of requiring a medical necessity note only after 15 visits.

It is recommended that Cigna HealthCare make the necessary adjustments to its claims processing system to ensure that chiropractic claims are properly adjudicated and that correct service counts are reflected in the claims processing system.

Request for Coordination of Benefit ("COB") information

In certain instances, CHCNY requests information from a subscriber pertaining to COB information. However, after the initial request is sent out, the HMO takes no further action. The HMO treats these claims as if the claim is closed or the claim is denied, unlike pended claims where follow-ups are sent. The review encountered several claims outstanding for a long time where neither a payment nor follow-ups were issued.

During the time of the examination, the HMO revised its policy with regard to COB requests. Beginning in November 2001, CHCNY treated these claims as pended claims, where follow-up notices are sent. Follow-up requests for COB information are sent after 30, 60, and 90 days, respectively, before Cigna HealthCare issues a denial for no response.

HCRA Surcharges

During the review of hospital claims processed on the Amisys system, 10 instances out of 372 sampled hospital claims were noted where Cigna HealthCare did not remit the required New York Health Care Reform Act ("HCRA") surcharges to New York State Department of Health. Currently, surcharges (8.18% of the claim settlement) are applicable to claims from hospitals (all levels of care), freestanding clinical labs, ambulatory surgery centers, and diagnostic and treatment centers that have registered with the State of New York Department of Health.

It is recommended that Cigna HealthCare implement the necessary changes to its claims processing system to ensure that the required New York Health Care Reform Act ("HCRA") surcharges are paid to the State of New York Department of Health.

This matter will be referred to the Department of Health for further investigation.

Utilization Review

§4903 and §4904 of the New York State Public Health Law set forth the minimum utilization review program standards, requirements of utilization review determinations and appeals of adverse determinations by utilization review agents, respectively.

§4903(4) of the New York State Public Health Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

- During the review of hospital claims, some instances were noted where the HMO's Utilization Review, "Nurses Review", took longer than thirty days after a requested review to generate a decision. In one example, it took more than three months to complete the review. In this particular case, the claims processor requested the review twice. Ultimately, the HMO denied the claim rather than waiting for the review to be completed.

It is recommended that Cigna HealthCare comply with §4903(4) of the New York State Public Health Law and complete utilization reviews within thirty days of receipt.

- Titles I and II of Article 49 of the New York Insurance Law (see Sections 4900(d-5), 4900(i), 4903, 4904 and 4910) does not require New York residency as a condition precedent to the utilization review and external review rights and protections afforded therein. Further, Section 3201(b) of the Insurance Law requires all policy forms delivered or issued for delivery in New York conform to the requirements of the Insurance Law which would include the aforementioned rights and protections contained in Article 49. This applies to health insurance contracts issued by Connecticut General Life Insurance Company (CGLIC), including point of service coverage (POS) issued jointly with Cigna HealthCare as part of the Cigna Health Access (CHA) HMO/POS program.

In August 1999, in response to a request from a Cigna HealthCare attorney for a written Department opinion, the Department's Health Bureau advised CGLIC that New York contracts must afford external review rights set forth in Insurance Law Article 49 even where they cover residents of other States. Contracts issued outside New York covering New Yorkers would not have to provide for external review unless they were covered by Sections 59.0, 59.1, 59.2 and 59.4 of Department Regulation 123 {11 NYCRR 59} which requires that certificates of coverage delivered in New York would have to comply with New York requirements.

In March 2002, after receiving a complaint that CGLIC provided a New Jersey resident covered under a New York contract with New Jersey external appeal rights, the Department's Consumer Services Bureau again advised the Company that it must comply with New York utilization review and external review requirements for contracts issued for delivery in New

York, regardless of where the insured resides. The Department's position was reiterated at a subsequent meeting with Company representatives. CGLIC countered with a proposal that it be permitted to apply New York utilization review and external review requirements only to New York residents, regardless of where the contract is issued for delivery. CGLIC also raised a conflict of law issue indicating that some states apply their utilization review requirements to all residents, regardless of where a contract is issued for delivery.

On July 22, 2002 the Department sent CGLIC a letter again advising that the Company must comply with the utilization review and external review standards and timeframes imposed by Titles I and II of Article 49. CGLIC was also informed that our Department contacted other states identified by the Company as having a conflict of law with New York, and the position was not altered by the responses that were received. In that letter, the Department directed CGLIC to immediately begin extending New York utilization review and external review rights to every insured covered under New York contracts and, within ten days, to provide the Department with a corrective action plan for CGLIC's review of all claims, from September 1, 1999 to date, where CGLIC failed to provide the insured with the appropriate New York rights.

CGLIC did not respond to the Department's directive within the timeframe set forth in the July 22, 2002 letter. In a letter dated October 11, 2002, CGLIC responded by setting a goal to complete staff training by February 1, 2003, and that every affected insured would begin getting appropriate appeal rights once training was completed. After further contact by the Department, CGLIC sent a letter dated November 4, 2002 advising that the company would immediately begin complying with New York requirements.

Since 1999, CGLIC has continued to provide utilization review and external review rights based on state of residency and not based on the state where a contract is issued for delivery, in violation of Article 49 of the Insurance Law and in willful disregard of directives issued by this Department. CGLIC's failure to begin complying with New York requirements once the non-compliance was identified, and the Company's failure to respond to Department directives resulted in insureds who do not reside in New York being adversely affected by the Company's non-compliance with New York requirements since 1999 because other states do not have the stringent utilization review and external review standards as those in New York.

It is recommended that CGLIC come into immediate compliance with the utilization review and external review rights and protections afforded by Titles I and II of Article 49 of the New York Insurance Law as regards every insured who resides outside New York State who is covered by a policy form or certificate of coverage delivered or issued for delivery in New York.

It is further recommended that CGLIC provide adequate documentation to demonstrate to the Department that it has come into compliance with Article 49 of the Insurance Law.

This matter will be referred to the Department's Office of General Counsel for determination of further corrective action that must be taken by the Company to address the insureds that were potentially harmed by CGLIC's violative practices regarding Article 49 of the Insurance Law since 1999.

CIGNA has submitted a plan to address this matter to the Department for review. There are ongoing discussions to finalize a plan that is acceptable to the Department.

Miscellaneous Errors

Additional errors found which further supports the Department's concern regarding an inadequate control structure within the claims processing system included the following:

- incorrect CPT codes entered to process claims;
- missing microfilms of claims or part of claim submissions;
- incorrect EX (explanation) or REM (remarks) codes used in processing of claims;
- incorrect date stamp for date of claims receipt.

4. PROMPT PAY LAW

Section §3224-a of the New York Insurance Law "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" requires all insurers to pay undisputed claims or the undisputed portion of the claim within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest shall be payable.

§ 3224-a(a) of the New York Insurance Law states that:

> "Except in a case where the obligation of an insurer to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

§ 3224-a(c) of the New York Insurance Law states in part that:

> "any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care

> payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

A statistical sample was selected from all claims where the payment date was more than forty-five days from the receipt date to determine compliance with the paragraphs (a), (b) and (c) of § 3224-a of the New York Insurance Law.

The following charts illustrate the HMO's examination findings relative to New York Insurance Law §3224-a:

New York Insurance Law §3224-a(a) - HMO In-Network (INN)

	Amisys INN Medical	Amisys INN Hospital	Medicom INN Medical	Medicom INN Hospital
Total Population	83,978	1,775	188,209	18,129
Over 45 day Population	8,765	171	583	93
Sample Size	167	167	167	93
S3224-a(a) violations	157	160	163	78
Calculated Error Rate	**94.01%**	**95.81%**	**97.60%**	**83.87%**
Upper Error limit	97.61%	98.85%	99.92%	91.35%
Lower Error limit	90.41%	92.77%	95.29%	76.40%
Upper limit Claims in error	8,556	169	583	85
Lower limit Claims in error	7,925	159	556	71

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

New York Insurance Law §3224-a(a) Out-of-Network (OON)

	Amisys OON Medical & Hospital	Medicom OON Medical	Medicom OON Hospital
Total Population	54,486	12,397	307
Over 45 day Population	5,735	44	3
Sample Size	167	44	3
S3224-a(a) violations	158	31	3
Calculated Error Rate	**94.61%**	**70.45%**	**100.00%**
Upper Error limit	98.04%	83.94%	100.00%
Lower Error limit	91.19%	56.97%	100.00%
Upper limit Claims in error	5,622	37	3
Lower limit Claims in error	5,230	25	3

Note: The upper and lower error limits represent the range of potential error (e.g., if 100 samples were selected the rate of error would fall between these limits 95 times.)

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims paid over forty-five days from receipt during the period from January 1 through December 31, 2000, or just over four percent (4.3%) of the 359,457 claims processed during the period. Therefore, the error rates are expressed in terms of the over-forty-five day population only.

A particular Examination objective was to determine whether interest was appropriately paid pursuant to § 3224-a(c) of the New York Insurance Law to those claimants not receiving payment settlements within the timeframe required by § 3224-a(a) of the New York Insurance Law. Of the claims found to be in violation of Section 3224-a(a), a number were also found to be in violation to the interest provisions in Section 3224-a(c) as illustrated below:

New York Insurance Law §3224-a(c) - HMO In-Network (INN)

	Amisys INN Medical	Amisys INN Hospital	Medicom INN Medical	Medicom INN Hospital
S3224-a(a) violations	157	160	163	78
S3224-a(c) violations	25	122	34	16

New York Insurance Law §3224-a(c) - Out-of-Network (OON)

	Amisys OON Medical & Hospital	Medicom OON Medical	Medicom OON Hospital
S3224-a(a) violations	158	31	3
S3224-a(c) violations	80	3	0

The following observations noted during the examination period may explain the high error ratio are as follows:

- The design of Cigna HealthCare's claims processing system was such that it did not provide claims processing examiners with an interest warning message resulting in continued processing of the claim without paying any interest or reporting that interest is due.
- Cigna HealthCare's claims processing system utilized a complex manual process to adjudicate claims.
- Claims processors were not well trained in the application of the Prompt Pay Law (§3224-a of the New York Insurance Law).

It is recommended that Cigna HealthCare implement the necessary procedures in order to ensure compliance with §3224-a of the New York Insurance Law ("Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services").

It is recommended that Cigna HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 2000 through present and, submit a plan to the Department which addresses those claims where interest was due pursuant to §3224-a of the New York Insurance Law.

It is recommended that Cigna HealthCare automate the interest paying process within its claims processing system.

It is recommended that Cigna HealthCare implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law.

It is recommended that Cigna HealthCare's Quality Assurance Department establish procedures to periodically test New York claims for compliance with §3224-a of the New York Insurance Law.

5. AGENTS AND BROKERS

During the review of CHCNY's sales distribution system, it was noted that the HMO utilized unlicensed employees to market a number of its products and such employees were compensated in a manner that is dependent upon the volume of business produced. With respect to the HMO's employees that are utilized to solicit its products, New York Insurance Law Section 2101 defines the term "insurance agent" and denotes an exemption to the licensing of any regular salaried officer or employee of a licensed insurer under certain conditions. Specifically, New York Insurance Law Section 2101(a)(1) states in pertinent part that the term "insurance agent" shall not include any regular salaried officer or employee of a licensed insurer if:

> "...such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business obtained;"

Since the HMO's employees are compensated in a manner that is directly dependent upon the volume of business produced, they are deemed to be insurance agents and are required to obtain the requisite license.

In addition, New York Insurance Law §2102(a)(1) states:

> "No person, firm, association or corporation shall act as an insurance agent, insurance broker, reinsurance intermediary or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

Further, New York Insurance Law §2114(a)(3) states:

> "No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting or procuring in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

It is recommended that CHCNY take the necessary steps to ensure that all of the HMO's employees who receive a commission or fee based on sales, comply with New York Insurance Law Sections 2102(a)(1) and 2114(a)(3).

6. FRAUDS PREVENTION AND DETECTION

The HMO's Special Investigation Unit ("SIU"), which is based in Bloomfield, CT., is primarily responsible for the prevention and detection of fraud for Cigna Corporation and its subsidiaries including CHCNY. During the visit to the Connecticut site, the examiners were informed that the SIU has not performed any review or audit of claims processed out of the

Rockaway, New Jersey office, which encompasses all of the Amisys System. Approximately 30% of the HMO's New York claims are processed by Amisys. During the time of the site visit, the SIU informed the examiners that there was no access to the Amisys System from their location. Accordingly, there were no fraud prevention tools used with respect to analysis and detection of fraud for claims processed out of the Amisys System. In addition, the SIU has not had a visit to the Rockaway office.

It is recommended that Cigna HealthCare's SIU include claims processed by the Amisys System in its fraud prevention and detection analysis.

7. HEALTHY NY

"Healthy NY" is a program designed to encourage small employers to offer health insurance coverage to their employees, dependents and other qualified individuals. Beginning in January 2001, all HMOs were required to offer this product to eligible businesses with 50 or fewer employees. A review of the HMO's progress relative to the "Healthy NY" Program indicates that the HMO does not attempt to promote this program to the general public or through its sales representatives. The HMO does not include or mention the Healthy NY Program in its web-site or any of its marketing materials. At the time of the review, six months after the inception of the program, there were only eleven subscribers to this product.

It is recommended that Cigna HealthCare make an effort to inform the public of the availability of its Healthy NY product. Exposure of Healthy NY product and facts related to the program should be explained further on its web-site and other marketing materials.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	***EXECUTIVE SUMMARY***	
i.	It is recommended that Cigna HealthCare perform an in-depth review of its information systems structure including operational controls and report its findings to the Department.	3
B.	***INTERNAL CONTROLS***	
i.	It is recommended that Cigna HealthCare's management review internal control procedures and make the necessary modifications to ensure that accurate data is provided to senior management so that appropriate business decision can be made.	10
ii.	It is recommended that Cigna Healthcare of New York establish a process for updating and reviewing the implementation of claims processing procedures in accordance with Circular Letter No. 9(1999).	11
iii.	It is recommended that CHCNY maintain reports pertaining to CHCNY's claims processing performance separate from those of its affiliates.	12
C.	***CLAIMS REVIEW FINDINGS***	
i.	It is recommended that Cigna HealthCare retain all requisite claims information and comply with the requirements of New York State Insurance Department Regulation No. 152 (11 NYCRR 243).	15
ii.	It is recommended that Cigna HealthCare implement the necessary changes to its claims processing system to ensure that deductible and coinsurance information are properly applied.	15

ITEM		PAGE NO.
iii.	It is recommended that as a good business practice, the HMO include the subscribers' "out-of-pocket" information in the EOB statements for the benefit of its subscribers. The statement should include both the subscribers' coinsurance accumulations and maximum coinsurance limits for the contract year.	16
iv.	It is recommended that Cigna HealthCare evaluate its claim processing system relative to its benefit information structure and determine and eliminate causes for inconsistencies between the benefit level shown on the provider contract screen and the benefit level shown on the claim-processing screen.	16
v.	It is recommended that Cigna evaluate its claim processing system with respect to information contained within the in-network and out-of-network systems, specifically with regard to Medicom, to determine and eliminate causes for inconsistencies between systems.	17
vi.	It is recommended that CHCNY make the necessary changes to its claims processing system to ensure deductible limits are properly recorded.	17
vii.	It is recommended that management evaluate and improve upon the current mapping of claim mailing routes, as well as the sorting and forwarding of claims received, with special attention directed to vendor related claims.	18
viii.	It is further recommended that the HMO improve upon communication with its providers regarding proper mailing address for specific claims.	18
ix.	It is recommended that CHCNY implement a process whereby out-of network claims initially received by Cigna HealthCare can be identified and processed in a timely manner.	19
x.	It is recommended that Cigna maintain both current and prior R&C rates in its claims processing system and ensure that proper rates are applied as determined by the date of service indicated on the claim.	19

ITEM		PAGE NO.
xi.	It is recommended that Cigna HealthCare comply with §3234(b)(7) of the New York Insurance Law.	20
xii.	It is recommended that Cigna HealthCare include a fraud warning and disclose on the EOB a toll free number where subscribers can call in the event they suspect that fraud has been committed.	22
xiii.	It is recommended that Cigna HealthCare provide the necessary training to its claim processors to better enable the processor to determine if the assignment provision is applicable.	22
xiv.	It is recommended that the HMO implement the necessary procedures to correctly process claims where address on the submitted claim form differs from address listed on the claims system, and verify the correct address through inquiry to determine the proper mailing address.	23
xv.	It is recommended that Cigna HealthCare provide the necessary training to its claim processors to ensure that proper suffix code is being used.	23
xvi.	It is recommended that Cigna HealthCare evaluate the reasons for claim re-submissions and make the necessary enhancements to its training program and provider outreach efforts, so that the volume of claim re-submissions due to processing errors can be reduced.	24
xvii.	It is recommended that Cigna HealthCare provide the necessary training to its claim processors so that both in-network and out-of-network claims will be adjudicated properly.	24
xviii.	It is recommended that Cigna make the necessary changes to its claims processing systems to ensure that both the in-network and out-of-network systems cannot pay the same claim.	25
xix.	It is recommended that Cigna HealthCare implement the necessary modification to its training program to ensure that both in-network and out-of-network are processed efficiently. It is further recommended that the HMO modify its claims system so that internal messages that are supposed to be suppressed are not printed on the explanation of benefit ("EOB") statements.	26

ITEM		PAGE NO.
xx.	It is recommended that Cigna HealthCare properly adjudicate claims for subscribers who utilize their POS coverage and choose a provider that participates in the CHCNY network.	26
xxi.	It is recommended that Cigna HealthCare make the necessary changes to its claims processing system to ensure that referral counts are properly accounted for.	27
xxii.	It is recommended that Cigna HealthCare make the necessary adjustments to its claims processing system to ensure that chiropractic claims are properly adjudicated and that correct service counts are reflected in the claims processing system.	27
xxiii.	It is recommended that Cigna HealthCare implement the necessary changes to its claims processing system to ensure that the required New York Health Care Reform Act ("HCRA") surcharges are paid to the State of New York Department of Health.	28
xxiv.	It is recommended that Cigna HealthCare comply with §4903(4) of the New York State Public Health Law and complete utilization reviews within thirty days of receipt.	29
xxv.	It is recommended that CGLIC come into immediate compliance with the utilization review and external review rights and protections afforded by Titles I and II of Article 49 of the New York Insurance Law as regards every insured, residing outside New York, covered by a policy form or certificate of coverage delivered or issued for delivery in New York.	32
xxvi.	It is further recommended that CGLIC provide adequate documentation to demonstrate to the Department that it has come into compliance with Article 49 of the Insurance Law.	32
D.	***REVIEW OF PROMPT PAY LAW***	
i.	It is recommended that Cigna HealthCare implement the necessary procedures in order to ensure compliance with §3224-a of the New York Insurance Law ("Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services").	36

ITEM		PAGE NO.
ii.	It is recommended that Cigna HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 2000 through present and, submit a plan to the Department which addresses those claims where interest was due pursuant to §3224-a of the New York Insurance Law.	36
iii.	It is recommended that Cigna HealthCare automate the interest paying process within its claims processing system.	37
iv.	It is recommended that Cigna HealthCare implement the necessary claims processing training in the application of §3224-a of the New York Insurance Law.	37
v.	It is recommended that Cigna HealthCare's Quality Assurance Department establish procedures to periodically test New York claims for compliance with §3224-a of the New York Insurance Law.	37
E.	***AGENTS AND BROKERS***	
	It is recommended that CHCNY take the necessary steps to ensure that all of the HMO's employees who receive a commission or fee based on sales, comply with New York Insurance Law Sections 2102(a)(1) and 2114(a)(3).	38
F.	***FRAUDS PREVENTION AND DETECTION***	
	It is recommended that Cigna HealthCare's SIU include claims processed by the Amisys System in its fraud prevention and detection analysis.	39
G.	***HEALTHY NY***	
	It is recommended that Cigna HealthCare make an effort to inform the public of the availability of its Healthy NY product. Exposure of Healthy NY product and facts related to the program should be explained further on its web-site and other marketing materials.	39

Respectfully submitted,

_____

Froilan L. Estebal

Senior Insurance Examiner

STATE OF NEW YORK)
)SS.
)
COUNTY OF NEW YORK)

Froilan L. Estebal being duly sworn deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
Froilan L. Estebal

Subscribed and sworn to before me
this _____ of _____ 2003

Appointment No. **21950**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **GREGORY V. SERIO** *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Froilan Estebal

as a proper person to examine into the affairs of the

CIGNA HEALTHCARE OF NEW YORK, INC.

and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 15th *day of* November 2002

Gregory V. Serio
Superintendent of Insurance

Appointment No. 21643

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Froilan Estebal

as a proper person to examine into the affairs of the

Cigna HealthCare of NY, Inc.

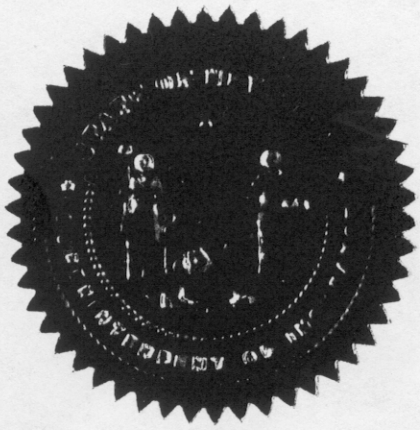
and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York,

this 26th *day of* October *2000*



NEIL D. LEVIN
Superintendent of Insurance

(by) Gregory Serio
First Deputy Superintendent