MARKET CONDUCT REPORT ON EXAMINATION

OF

CIGNA HEALTH AND LIFE INSURANCE COMPANY

AS OF

DECEMBER 31, 2018

EXAMINERS: **HUZAIFA CHAUDHURY**

JEFFREY USHER

DATE OF REPORT: **AUGUST 27, 2024**

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August 27, 2024

Honorable Adrienne A. Harris
Superintendent of Financial Services
New York, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31808, dated September 19, 2018, and attached hereto, I have made an examination into the affairs of Cigna Health and Life Insurance Company, a life, accident and health insurance company licensed pursuant to Article 42 of the New York Insurance Law, as of December 31, 2018. The Company is a foreign insurer domiciled in the State of Connecticut. The following report is respectfully submitted thereon.

The examination was conducted at the home office of Cigna Health and Life Insurance Company located at 900 Cottage Grove Rd. Bloomfield, Connecticut.

Wherever the designations "CHLIC" or the "Company" appear herein, without qualification, they should be understood to indicate Cigna Health and Life Insurance Company.

Wherever the designation "CGLIC" appears herein, without qualification, it should be understood to indicate Connecticut General Life Insurance Company, a wholly-owned subsidiary of Cigna Corporation ("Cigna") and parent Company of CHLIC.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

This market conduct examination of CHLIC was conducted as of December 31, 2018, and covers the period January 1, 2014 through December 31, 2018. Where deemed appropriate by the examiner, events subsequent to December 31, 2018 were also reviewed. There was no prior report on examination on this Company.

This report deals with the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants. This report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE COMPANY

Cigna Health and Life Insurance Company is a wholly-owned subsidiary of Connecticut General Life Insurance Company ("CGLIC"), which is an indirect wholly-owned subsidiary of Cigna Corporation ("Cigna"). The Company and its subsidiaries are major providers of health care and related benefits in the U.S., the majority of which are offered through employers and other groups. Principal products and services offered by the Company are group life and health insurance. The Company also offers Medicare Prescription Drug program ("PDP") products and has international operations that offer products to businesses and individuals in selected markets. The Company is domiciled in the State of Connecticut and is licensed in all states. On April 1, 2008, CGLIC entered into an asset and stock purchase agreement with Great-West Life & Annuity Insurance Company ("Great-West") whereby CGLIC acquired the health care division of Great-West through a fully assumed indemnity reinsurance agreement and acquired Alta Health and Life Insurance Company ("Alta"), an Indiana-domiciled life and health insurer, through a stock purchase. As a result, Alta became a direct wholly-owned subsidiary of CGLIC and an indirect subsidiary of Cigna. On March 5, 2010, Alta was re-domesticated to Connecticut and renamed Cigna Health and Life Insurance Company.

3. UNDERWRITING AND RATING

Section 4235(h)(1) of the New York Insurance Law states:

> "Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or

> allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state. A group accident and health insurance policy providing disability and family leave benefits pursuant to article nine of the workers' compensation law shall be subject to the requirements of subsection (n) of this section."

The experience rate formula utilized by the Company in establishing premium rates for New York large groups includes a factor called "Pricing Action Exhibit" ("PAE"), that is not included or described in the approved rate formula filed with the Department. Further, the Company stated that the PAE has been used in its experience rate calculations for more than 10 years. The Company does not have a formal policy and procedure that describes the calculation of the PAE. The resulting rates using PAE deviate significantly from the formula filed with the Department, and therefore violated of Section 4235(h)(1) of the New York Insurance Law.

It is recommended that the Company comply with Section 4235(h)(1) of the New York Insurance Law and refrain from deviating from the experience rate formula filed with the Department.

4. UTILIZATION REVIEW

CHLIC has two third party administrators ("TPA"), American Specialty Health Group, Inc., and CareCentrix, Inc. The TPAs were used to conduct and provide utilization review ("UR") services for the Company. Additionally, CHLIC perform in-house utilization reviews. The examiner reviewed UR cases for the year 2018 for CHLIC and its TPAs. The examiner selected samples, forty-five (45) cases each, for prospective, concurrent, and retrospective UR cases.

Section 4903(b)(1) of the New York Insurance Law states, in part:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information…"

The examiner's review of the selected forty-five (45) sampled prospective UR cases, found that for ten (10) cases, the prospective determination for services requiring pre-authorization was not determined within three business days as required by New York Insurance Law Section 4903(b)(1).

As a result of the finding, the Company was asked to review the 2018 UR data provided to the examiners. The Company found eighteen thousand six hundred two (18,602) prospective UR cases that were not processed within three business days, as required by the aforementioned Statute.

The table below illustrates the result of the prospective review:

CHLIC and TPAs	**Prospective UR Cases**
Total number of prospective review cases	58,169
Total number of cases not in compliance with Section 4903(b)(1) of the New York Insurance Law, per CHLIC	18,602
Percent of cases not in compliance with Section 4903(b)(1) of the New York Insurance Law, per CHLIC	31.98%

It is recommended that CHLIC comply with Section 4903(b)(1) of the New York Insurance Law by making prospective determinations for services requiring pre-authorization within three business days of receipt of the necessary information.

In addition, Section 4903(c) (1) of the New York Insurance Law states:

> "A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date."

The examiner's review of the selected forty-five (45) sampled concurrent UR cases, found that for five (5) cases the concurrent determination involving continued services was not determined within one (1) business day, in violation of New York Insurance Law Section 4903(c)(1).

As result of the finding, the Company was asked to review the 2018 UR data provided to the examiner. The Company found two thousand one hundred fifty-eight (2,158) concurrent UR cases that were not completed within the required time frame of one business day, as required by the Statute.

The table below illustrates the result of the concurrent review:

CHLIC and TPAs	**Concurrent UR Cases**
Total number of concurrent review cases	12,180
Total number of cases not in compliance with Section 4903(c)(1) of the New York Insurance Law, per CHLIC	2,158
Percent of cases not in compliance with Section 4903(c)(1) of the New York Insurance Law, per CHLIC	17.72%

It is recommended that CHLIC comply with Section 4903(c)(1) of the New York Insurance Law by making concurrent determinations for continued services within one business day of receipt of the necessary information.

Further, Section 4903(d) of the New York Insurance Law Section 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."

The examiner's review of the selected forty-five (45) sampled retrospective UR cases, found that for three (3) cases retrospective determination for services that have been delivered was not completed within the thirty (30) days as required by New York Insurance Law Section 4903(d).

As a result of the finding, the Company was asked to review the 2018 UR data provided to the examiners. The Company found one thousand eighty-seven (1,087) retrospective UR cases that were not performed within the required time frame of thirty days, as required by the Statute.

The table below illustrates the result of the concurrent review:

CHLIC and TPAs	**Retrospective UR Cases**
Total number of retrospective review cases	15,680
Total number of cases not in compliance with Section 4903(d) of the New York Insurance Law, per CHLIC	1,087
Percent of cases not in compliance with Section 4903(d) of the New York Insurance Law, per CHLIC	6.93%

It is recommended that CHLIC comply with Section 4903(d) of the New York Insurance Law by making retrospective determinations involving health care services which have been delivered within the thirty days of receipt of the necessary information.

Section 4903(b)(1) of the New York Insurance Law states, in part:

> "A utilization review agent shall…provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

In addition, Section 4903(c)(1) of the New York Insurance Law Section states, in part:

> "A utilization review agent shall…provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within one business days of receipt of the necessary information."

The examiner's review of the selected forty-five (45) sampled UR cases, found that for fourteen (14) cases the Company did not provide notice of the determination to the insured's health care provider as required by Sections 4903(b)(1) and 4903(c)(1) of the New York Insurance Law.

As a result of the finding, the Company was asked to review the 2018 UR data provided to the examiners. The Company found twenty-one thousand two hundred fifty-five (21,255) cases where it failed to provide notice of the determination to the insured's health care provider as required by the Statute.

The table below illustrates the result of the UR notice of the determination:

CHLIC and TPAs	**Notice of UR Determination**
Total number of prospective and concurrent review cases	70,931

Total number of cases CHLIC failed to send notice of the UR determination	21,255
Percent of cases not in compliance with 4903(b)(1) and (c)(1) of the New York Insurance Law, per CHLIC	29.97%

It is recommended that CHLIC comply with Sections 4903(b)(1) and 4903(c)(1) of the New York Insurance Law by providing a notice of determination as required by the Statute.

5. UTILIZATION REVIEW ADVERSE DETERMINATION LETTER

Section 4904(b)(2) of the New York Insurance Law Section states, in part:

> "(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this title; (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination…"

Section 4904(b)(2) of the New York Insurance Law states that expedited appeals are available for any adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. However, this language and information was excluded from the Company's UR adverse determination letters.

As a result of the findings, the Company was asked to review the 2018 data provided to the examiner. The Company found 14,072 cases of UR adverse determination letters out of a population of 51,201 cases, which were not in compliance with Section 4904(b)(2) of the New York Insurance Law.

It is recommended that the Company comply with the requirements of Section 4904(b)(2) of the New York Insurance Law of the New York Insurance Law by ensuring that the required information is included in its UR adverse determination letters.

Further, Federal Regulation 29 CFR § 2560.503-1(i)(2)(ii) and (iii) states:

> "(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided no later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, no later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.
> (iii) Post-service claims.
> (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided no later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, no later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination."

During the review of UR adverse determination letters, it was revealed that the Company's letter states that the insurer may extend the time to make the determination on appeal. However, Federal Regulation 29 CFR 2560.503-1(i)(2)(ii) and (iii) prohibits the insurer from extending the time to make a determination on appeal.

As a result of the findings, the Company was asked to review the 2018 data provided to the examiner. The Company found 14,072 cases of UR adverse determination letters out of a

population of 51,201, that were not in compliance with Federal Regulation 29 CFR 2560.503-1(i)(2)(ii) and (iii) in 2018.

It is recommended that the Company comply with Federal Regulations 29 CFR 2560.503-1(i)(2)(ii) and (iii) and cease from extending the time to make a determination on appeal beyond the limits allowed by the Regulation.

6. UTILIZATION REVIEW APPEAL

Section 4904(c) of the New York Insurance Law Section states, in part:

> "…The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing…"

The examiner reviewed UR appeals cases for the year 2018 for CHLIC and the TPAs and selected twelve (12) UR appeals cases. The examiner found in five (5) cases the Company failed to provide written acknowledgement within 15 days of receipt of an appeal of a utilization review determination as required by Section 4904(c) of the New York Insurance Law.

As a result of the finding, the Company was asked to review the 2018 data provided to the examiner. The Company found 695 cases from a population of 3,623 where the acknowledgement letter was not provided, which is in violation of Section 4904(c) of the New York Insurance Law.

It is recommended that the Company comply with Section 4904(c) of the New York Insurance Law and issue the acknowledgement letter in the required timeframe.

In addition, Section 4904(c) of the New York Insurance Law states, in part:

> "…The utilization review agent…shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal."

The examiner's review of the selected twelve (12) sampled UR appeal cases found that for two (2) cases, the Company failed to perform the appeal determination within the required time frame of sixty days.

As a result of the finding, the Company was asked to review the 2018 data provided to the examiner. The Company found 431 cases of appeal determination out of a population of 3,623 that were not performed within sixty days of the receipt of necessary information to conduct the appeal, which is in violation of Section 4904(c) of the New York Insurance Law.

It is recommended that the Company comply with Section 4904(c) of the New York Insurance Law and provide the appeal determination within the required time frame of sixty days.

Further, Section 4904(c) of the New York Insurance Law states, in part:

> "…The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination."

The examiner's review of the selected twelve (12) sampled UR appeal cases found that for two (2) cases, the Company failed to notify the insured/ insured's designee of its appeal determination within two business days of making such determination.

As a result of the finding, the Company was asked to review the 2018 data provided to the examiner. The Company found 240 cases out of a population of 3,623, where the insured/ insured's designee was not provided within two business days, as required by the Statute.

It is recommended that the Company comply with Section 4904(c) of the New York Insurance Law and notify the insured/ insured's designee of its appeal determination within two business days of making such determination.

7. EXHIBIT OF GRIEVANCES AND UTILIZATION REVIEW APPEAL

New York Supplement instructions require that insurers report the number of utilization review denials as per Section 4904 of the New York Insurance Law.

The Company provided the examiner with the utilization review appeal data file for calendar year 2018 for cases involving several of its entities and delegated entities. The appeal data file indicated that there were 4,090 utilization review appeals cases for 2018. However, the 2018 Annual Statement Supplement, Exhibit of Grievances and Utilization Review Appeals - Part Two indicated that there were a total of 3,476 utilization review appeals, which is 614 appeal cases less than the data file provided.

It is recommended that the Company accurately complete the Exhibit of Grievances and Utilization Review Appeals – Part Two in the New York Supplement.

8. GRIEVANCE

During the review of grievance cases the examiner noted that the Company uses an incorrect Department mailing address on its documentation and written correspondences relative to the grievance process. The address used in the Company's correspondence is the Department's old mailing address at 25 Beaver Street, New York, NY 10004. The examiner informed the Company that the Department's mailing address is One State Street, New York, NY 10004. It should be noted that the Department's address is reflected in all documentation sent to the Company.

It is recommended that the Company update all its correspondence to include the Department's correct address.

The Company informed the examiner that it has since corrected the mailing address to reflect the current address of the Department.

9. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Section 3216(i)(17)(E) of the New York Insurance Law and additional implementing regulations require non-grandfathered group health plans offering health insurance coverage in the group market to provide certain benefits but to prohibit the imposition of cost-sharing requirements for those benefits. These include the following guidelines, which are prepared jointly by the United States Departments of Labor, Health and Human Services, and the Treasury:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

The examiner reviewed 70 elements of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims and payment policy for CHLIC with regard to the aforementioned 70 elements for co-pay, deductible and coinsurance costs attributed to the member.

The examiner performed compliance testing on Pharmacy claims and Medical/ Hospital claims adjudicated by CHLIC during calendar year 2018. The chart below shows the population of Medical/ Hospital claims reviewed, and total violation:

CHLIC 2018	**Total Population Reviewed**	**Total Violations**
Medical/ Hospital	8,639	204
Pharmacy	13,774	1,209
Total	22,413	1,413

CHLIC indicated that the errors resulted from benefits for various preventive service claims that were loaded into the claim system incorrectly.

It is recommended that CHLIC comply with the requirements of Section 3216(i)(17)(E) of the New York Insurance Law and Patient Protection and Affordable Care Act by not applying, where applicable, member cost-sharing to preventive care claims.

It is also recommended that CHLIC perform Quality Assurance testing of the effectiveness of their claims payment policies/ procedures in order to ensure compliance with Section 3216(i)(17)(E)) of the New York Insurance Law.

10. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE SERVICES ("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" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt of a claim that is transmitted via the internet or electronic mail or within 45 days of receipt for a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the CHLIC's compliance with Section 3224-a, was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material issues were noted by the examiner.

11. CLAIMS DATA AND RECONCILIATION

As part of the review of claims processing, a request for the detail on all claims paid between January 1, 2018 and December 31, 2018 was requested from the Company on January 22, 2019. The claims reconciliation to the Annual Statement was not provided to the examiner until December 13, 2019. The Company noted that difficulties encountered in the reconciliation process was due to the complexities in compiling an enormous amount of data and multiple claims processing sources.

While the examiner acknowledges the challenges that can be encountered in accumulating claims data, such requests are a routine part of any Market Conduct examination and the Company should establish procedures in place to expedite the process.

It is recommended that Company establish procedures to expedite the claims reconciliation process for future examinations.

12. CIRCULAR LETTER NO. 9 (1999) – ADOPTION OF PROCEDURE MANUALS

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 Organization and insurers licensed to write health insurance in New York State. The Circular Letter states, in part:

> "It is recommended that the board obtain the following certifications annually:
> (i) from either the company's director of 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 Circular Letter further states, in part:

> "Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations. Examples of additional key areas include: …underwriting and rating…"

CHLIC was unable to provide the examiner with any of the certifications required by the aforementioned Circular Letter, for any year during the examination period.

It is recommended that the board of directors of CHLIC obtain the appropriate annual certifications required by Circular Letter No. 9 (1999).

13. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ("MHPAEA")

Federal Regulation 45 C.F.R. §146.136(a) states the following, in part:

> "…Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).
> …Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines)…"

Sections 3216(i)(30)(A) and 3216(i)(31)(A) of the New York Insurance Law – Individual accident and health insurance policy provisions, state, in part:

> "(i)(30)(A) Every policy that provides hospital, major medical or similar comprehensive coverage must provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a). Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy…
> (i)(31)(A) Every policy that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy…"

Sections 3221(l)(6)(A) and 3221(l)(7)(A) of the New York Insurance Law – Group or blanket accident and health insurance policies; standard provisions, state, in part:

> "(l)(6)(A) Every policy that provides hospital, major medical or similar comprehensive coverage must provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a). Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy…
> (l)(7)(A) Every policy that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy..."

Further, Sections 4303(k)(1) and 4303(l)(1) of the New York Insurance Law - Benefits, state, in part:

> "(k)(1) Every contract that provides hospital, major medical or similar comprehensive coverage must provide inpatient coverage for the diagnosis and

> treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a). Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract…
> (l)(1) Every contract that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract…"

The Company administers and processes certain services (occupational therapy, physical therapy, speech therapy, urgent care and lab services) for diagnosed Mental Health and Substance Abuse Disorder ("MH/ SUD") members under medical/ surgical benefits/ coverage rather than MH/ SUD health benefit/ coverage. These services are classified and categorized by the Company as medical/ surgical services regardless of whether the diagnosis is for MH/ SUD or not. However, this may result in the inappropriate application of Non-Quantitative Treatment Limits ("NQTLs") to MH/ SUD services without the appropriate analyses to demonstrate compliance for such application.

Federal Regulation 45 CFR §146.136(a) defines MH/ SUD benefits as "benefits with respect to items or services for MH/ SUD conditions as defined under the terms of the plan/ health insurance coverage and in accordance with applicable Federal and State law." Therefore, if the prescribed item or a service is performed for a MH/ SUD condition, it is subject to parity requirements. Whether a provider is considered a physical health provider, or a mental health provider does not determine whether the benefit is a Med/ Surg or MH/ SUD benefit; the only

factor that needs to be considered pursuant to the regulatory definition, is whether a particular service was prescribed to treat a MH/ SUD condition or a Med/ Surg condition.

Additionally, if the Company includes MH/ SUD treatments within the Med/ Surg benefit, the expected claim dollar amounts within the Med/Surg service categories within one of the six benefit classifications would include MH/ SUD claims [45 CFR §146.136(c)(3((i)(C)]. The expected claim dollar amounts referenced is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. Therefore, if the plan includes MH/ SUD services as a Med/Surg benefit, the NQTL testing data for compliance with MHPAEA is incorrect.

It is recommended that the Company comply with Federal Regulation 45 CFR §146.136(a) and New York Insurance Law §§ 3216(i)(30)(A), (i)(31)(A), 3221(l)(6)(A), (l)(7)(A) and 4303(k)(1), and (l)(1), by revising claims processing procedures to allow for the proper classification of MH/ SUD treatments as MH/ SUD benefits.

14. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

Respectfully submitted,

_____
Huzaifa Chaudhury

Supervising Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Huzaifa Chaudhury, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____
Huzaifa Chaudhury

Subscribed and sworn to before me

This _____ day of _____2024

Respectfully submitted,

_____/S/_____

Jeffrey Usher, CFE

Supervising Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Jeffrey Usher, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____/S/_____

Jeffrey Usher, CFE

Subscribed and sworn to before me

This _____ day of _____2024

APPOINTMENT NO. **31808**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Froilan Estebal*

as a proper person to examine the affairs of

Cigna Health and Life Insurance Company

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

Company

with such other information as he shall deem requisite.

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

this 19th day of September, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

****Retired as of April 2022, and the examination was completed by Jeffery Usher***