Illinois Department of Insurance

JB Pritzker
Governor

Ann Gillespie
Acting Director

VIA ELECTRONIC MAIL

May 8, 2024

David Cordani, Chief Executive Officer
c/o Jessica Kearney
CIGNA Health Group
900 Cottage Grove Road
Bloomfield, CT. 06002

Re: Cigna Healthcare of Illinois Inc., NAIC 95602
Cigna Health & Life Insurance Company, NAIC 67369
Market Conduct Examination Report Closing Letter

Dear David Cordani:

The Department has received your Company's proof of compliance. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Chief Market Conduct Examiner
Illinois Department of Insurance
320 West Washington St., 5th Floor
Springfield, IL 62767
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ILLINOIS DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION

of

Cigna Healthcare of Illinois Inc.
Cigna Health and Life Insurance Company

NETWORK ADEQUACY MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	October 14, 2021, through September 29, 2023
EXAMINATION OF:	Cigna HealthCare of Illinois, Inc. NAIC #95602 Cigna Health and Life Insurance Company NAIC #67369
LOCATION:	900 Cottage Grove Road Bloomfield, CT 06002
PERIOD COVERED:	Plan Years 2020-2022
EXAMINERS:	Michele Amstutz Ingrid Franklin Brad Shoop Susanna Stevens Tanya Sherman, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner

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I. FOREWORD

This is a market conduct examination report of Cigna HealthCare of Illinois, Inc., NAIC Code 95602, and Cigna Health and Life Insurance Company, NAIC Code 67369 (collectively, "the Company"). This examination was conducted at authorized offsite locations.

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, or files does not constitute approval thereof by the Illinois Department of Insurance ("IDOI" or "Department").

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

II. SCOPE OF NETWORK ADEQUACY EXAMINATION

The Department has the authority to conduct this examination pursuant to, but not limited to, 215 ILCS 5/132.

The purpose of the examination was to determine if the Company complied with the Illinois Insurance Code (215 ILCS 5/1 et seq.), the Illinois Administrative Code (50 Ill. Admin. Code 101 et seq.), the Network Adequacy and Transparency Act (215 ILCS 124/1 et seq.), and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review was Plan Year 2021 unless otherwise noted. Errors outside of this time discovered during the course of the examination, however, may also be included in the report.

The lines of business of the private and commercial group and individual health insurance were reviewed in this examination.

The scope of this examination focused on a review including the following areas:

A. Company Operations and Management
B. Complaints
C. Provider Relations
D. Network Adequacy

In performing this examination, the examiners reviewed a sample of the Company's practices, procedures, products, and files. Therefore, some non-compliant events may not have been discovered. As such, this report may not fully reflect all the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or non-compliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

III. SUMMARY OF FINDINGS

A network adequacy market conduct examination was performed to determine compliance with Illinois statutes, the Illinois Administrative Code, as well as federal statutes and rules related to network adequacy. The following table represents general findings with specific details in each section of the report.

TABLE OF TOTAL VIOLATIONS					
Crit #	**Statute/Rule**	**Description of Violation**	**Samples**	**Violations**	**Error %**
2	215 ILCS 124/10 (b)(4) 215 ILCS 124/25(c) 215 ILCS 124/25(a)(1) 45 CFR 156.230 (b)(2)	Failed to provide the public access to a prospective consumer to view all of the mental health providers approved for the PPO plans on the public website without requiring a login.	N/A	N/A	100%
4	215 ILCS 124/25(a)(6)	The network plan and the various naming conventions do not make it clear which provider directory applies to which plan, nor is it easy for a consumer to easily discern which providers participate in which plans and which provider networks.	N/A	N/A	100%
7	215 ILCS 124/25(a)(4) 45 CFR §156.230(b)(2)(i)	Failed to make available the HMO provider directory in print for members or prospective members.	N/A	N/A	100%
8	215 ILCS 124/25(a)	Failed to ensure that the addresses or contact information for providers listed in the electronic directory was up-to-date and accurate.	83	16	19%
10	215 ILCS 134/45	Failed to provide a timely response to an internal appeal.	520	188	36%
11	215 ILCS 134/45(c)	Failed to notify the parties filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision verbally at the time the decision was made.	520	10	2%
12	215 ILCS 5/143d(b)	Failed to provide a written response to written inquiries and complaints within 21 days of receipt.	38	1	3%
13	45 CFR § 156.230(b)(2)	Printed provider directory, mental health specialists not in printed provider directory (HMO plan).	N/A	N/A	100%
14	215 ILCS 124/25(b)(1)(K)	Electronic provider directory does not have a filter option or display for medical providers using telehealth.	N/A	N/A	100%

IV. COMPANY BACKGROUND

Cigna Health and Life Insurance Company ("CHLIC") is a wholly-owned subsidiary of Connecticut General Life Insurance Company ("CGLIC"), which is an indirect wholly-owned subsidiary of Cigna Corporation ("Cigna"). CHLIC is a major provider of health care and related benefits in the U.S., the majority of which are offered through employers and other groups. CHLIC's principal product offers are group health insurance and individual Medicare.

Cigna HealthCare of Illinois, Inc. ("CHCIL") is a health maintenance organization ("HMO") that provides health insurance services throughout the region. Principal products and services include managed care products and services. CHCIL is a wholly owned subsidiary of Healthsource, Inc. ('the Parent"), which is a wholly-owned subsidiary of Cigna Health Corporation ("CHC"), which is an indirect wholly owned subsidiary of Cigna.

Cigna does business in the State of Illinois as Cigna HealthCare of Illinois, Inc. and Cigna Health and Life Insurance Company.

V. METHODOLOGY

The network adequacy market conduct examination process places emphasis on an insurer's systems and procedures used in dealing with insureds and beneficiaries. The private and commercial group and individual health insurance were reviewed in this examination. Self-funded, Medicare Supplement, or Medicare/Medicaid plans were not reviewed.

The scope of this examination focused on a review including the following areas:

A. Company Operations and Management
B. Complaints
C. Provider Relations
D. Network Adequacy

The review of these categories was accomplished through examination of material related to the Company's operations and management, consumer and provider complaint files, and network adequacy filings, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, information requests and criticisms. Each of the categories listed above was examined for compliance with Illinois statutes and the Illinois Administrative Code.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from Company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third-party vendors, internal audits, record retention policy and procedures, certificate of authority, previous market conduct examinations and annual statements. These documents were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. No exceptions were noted in the report.

Complaints

The Company was requested to identify all consumer, Illinois Department of Insurance complaints and consumer complaints related to network adequacy received during the period of January 1, 2021, to October 31, 2021. All complaint files were received. The files were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. Exceptions are noted in the report.

The Company was requested and provided a log of all internal appeals. The logs were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. Exceptions are noted in the report.

Provider Relations

The Company was requested to provide policies and procedures for handling provider concerns, inquiries, and complaints. In addition, the Company was requested to provide examples of provider relations analyses, reports and summaries prepared on a regularly recurring basis. The Company reported it had no provider complaints during the period of January 1, 2021, to October 31, 2021. No exceptions were noted in the report.

Network Adequacy

The Company was requested to provide policies and procedures that it maintains a network that is sufficient in number, files an access plan, and provides all required contracts and forms, as well as provide policies and procedures or other documentation demonstrating that the health carrier provides at enrollment a provider directory that lists all providers who participate in its network. The Company identified a universe for all providers during the examination time period of Plan Year 2021. Random samples were selected from all the providers for the nine plans. The random samples included at least one provider from each of the nine plans for the following categories: Primary Care, Pediatrician, OB-GYN, Hospital, Behavioral Health, Mental Health, Substance Abuse Disorder Facility, and a selection from all the other required categories for Illinois. Examples of other required specialty categories selected for further review were Cardiology, Gastroenterology, Neurology, Oncology/Radiation, Ophthalmology, Urology, Dermatology, Endocrinology, and Infectious Disease. The network adequacy files and responses to information requests were received and reviewed for compliance with Illinois statutes and the Illinois Administrative Code. Exceptions are noted in the report.

VI. SELECTION OF SAMPLES

Survey	Number Reviewed	Percentage Reviewed
Complaints		
Department of Insurance Complaints	38	100%
Consumer Complaints	25	100%
Internal Appeals	520	100%
Network Adequacy		
Provider Data	83	<1%

VII. NETWORK ADEQUACY FINDINGS

A. Company Operations and Management

a. There were no criticisms in the review of operations and management for network adequacy.

B. Complaints

1. Department of Insurance Consumer Complaints
    a. Criticism #12 - In one (1) instance of the thirty-eight (38) network adequacy direct consumer complaints reviewed, for an error percentage of 3%, the Company failed to provide a written response to written inquiries and complaints within 21 days of receipt. In the one (1) file, the Company failed to provide a written response within 21 days. This is a violation of 50 Ill. Adm. Code 926.40(a).

2. Consumer Complaints Received Directly by the Company
    a. There were no criticisms in the consumer complaints survey for network adequacy.

3. Internal Appeals
    a. Criticism #10 – Of the 520 internal appeals received, the Company responded to 188 appeal files after the required timeline, in a violation of 215 ILCS 134/45.

    b. Criticism #11 – In 10 instances of the 520 internal appeals reviewed, the Company failed to render a decision on the appeal within 15 days after receipt of the required information and notified the respective party. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician and any health care provider who recommended the health care service involved in the appeal orally of its decision followed by a written notice of the determination. This is a violation of 215 ILCS 134/45(c).

C. Provider Relations

a. There were no criticisms in the review of provider relations for network adequacy.

D. Network Adequacy

1. Time and Distance Standards
    a. No violations were noted for time and distance standards.

2. Providers without Claims
    a. There were no criticisms related to the audit of providers without claims.

3. Provider Directory
    a. Criticism #2 - The Company failed to list all mental health providers for any of the Preferred Provider plans (PPOs) on the online directory and required that consumers log in to see if a plan is accepted at that location. This is a violation of 215 ILCS 124/10(b)(4) and 215 ILCS 124/25(c) and 215 ILCS 124/25(a)(1) and 45 CFR 156.230(b)(2).

    The Company responded to Criticism #2 that the online provider directory for any of the PPO plans does allow prospective consumers to search for a mental health provider by plan, however, the data displayed is inconsistent. The directions provided include eight steps: identify coverage (employer/school, Healthcare.gov/Direct Purchase, or Medicare), enter a location, select Doctor by

Type (select a mental health option), log in if you have an account or continue as a guest if you do not, select a provider specialty, choose from mental health options, select a plan or continue without a plan and then available provider options will display.

The examiners confirmed that a consumer is able to conduct a search, by a plan and find providers in their network, however, when the consumer goes to the detail page for that provider for the PPO plan, the message states, "Log in to See if Your Plan is Accepted at this Location." For other provider categories, other than mental/behavioral health, such as primary care physicians, there is a link that displays the medical plans and whether they are in-network and accepting new patients.

b. Criticism #4 - The Company failed to make clear which of its electronic provider directories applies to which network plan available for Illinois. The consumer or beneficiary must know the correct acronym and name as it is categorized in the system for each network plan to choose the applicable network plan. This is a violation of 215 ILCS 124/25(a)(6).

   The IL053, Cigna Care Network naming conventions are confusing for consumers, and not clear, as the plan name is listed differently for print and online searching. The IL053 plan is identified as Cigna Care Network (on the directory) and Network, Network POS (on Cigna's provider search website) and then internally referenced with the electronic directory as OAP Greater Chicago and OAP Flex, also Chicago NW. The network plan and the various naming conventions to do not make it clear which provider directory applies to which plan, nor is it easy for a consumer to easily discern which providers participate in which plans and which provider networks.

c. Criticism #7 – The Company did not provide a copy of the HMO directories to a prospective consumer (examiner) upon request and did not include the PDF of the provider directory in the QHP annual filing. This is a violation of 215 ILCS 124/25(a)(4) and 45 CFR §156.230(b)(2)(i).

d. Criticism #8 – The examination team conducted random samples of the providers supplied by Cigna to verify the accuracy of both the online and printed directories. The results of the examination were that 10 of the 83 providers did not have accurate data listed within the printed provider directory, 22 of the 83 providers did not display on the provider directory and 16 of the 83 providers were either not in the Company website or were incorrect. The result is that the error ratio for the printed provider directory was 39% and for the Company website 19%. This is a violation of 215 ILCS 124/25(a).

   The examiners reviewed the non-suppressed data received by the Company in response to Information Request 17.1. The examination team conducted a random sample of the non-suppressed providers utilizing the methodology found in the NAIC Market Regulation Handbook. The total number of providers supplied for all the plans was 904,732. The selection of providers included six major categories and another category of all the remaining provider types, "other." The six major categories included Primary Care Providers, OB/GYN, Pediatrics, Mental Health, Substance Abuse Facilities, and Acute Care Hospitals. The remaining provider

types included: Cardiology, Gastroenterology, General Surgery, Neurology, Oncology/Radiation, Ophthalmology, Urology, Allergy, Immunology, Chiropractic, Dermatology, Endocrinology, Ears, Nose and Through (ENT)/Otolaryngology, Infectious Disease, Nephrology, Neurosurgery, Orthopedic Surgery, Physiatry/Rehabilitative, Plastic Surgery, Pulmonary and Rheumatology. There were several random samples selected for each plan for the six major categories and additional random samples from the "other" category to equal 83 random samples.

e. Criticism #13 – The Company failed to list all available providers for any plans in the printed directory or provide an explanation that mental health providers are only available online within their printed directory. This is a violation of 45 CFR § 156.230(b)(2).

   The Company stated that the printed provider directory for any of the plans does not display mental health providers. The Company explained that there is only one Behavioral Network, and all providers are included and there is no need for a customer to log in to verify if a provider is in their network. Not listing mental health specialists in the printable provider directory and only listing them in the online version creates an extra step for consumers. In addition, the mental health provider's detail for the online version includes information that tells consumers they must call to verify if their plan is accepted.

4. Audit of 25% of providers
   a. There were no criticisms in the certification survey for network adequacy.

5. Accrediting Entity Certification by Health and Human Services (HHS)
   a. There were no criticisms in the certification survey for network adequacy.

6. Availability of Telehealth Telemedicine
   a. Criticism #14 – The examiners reviewed the electronic provider directory and were unable to find indicators for a prospective consumer to see whether a medical provider is using telehealth. This is a violation of 215 ILCS 124/25(b)(1)(K), which went into effect July 9, 2021.

      The Company agrees that there is no display option for medical providers in either the printable directories or the online provider directory indicating whether the provider utilizes telehealth. The Company did provide evidence that within the online provider directory, there is an indicator for behavioral/mental health providers that are offering telehealth services.

VIII. OBSERVATIONS

A. Observation #1 - The Company's response to the Network Adequacy Handbook request for Transition of Care (B.7) focuses exclusively on behavioral health transition of care. Although the Company did respond that many of the procedures in other areas are the same for medical and surgical providers, it does not specifically mention scenarios where a provider may continue services for an interim period such as pregnancy or during cancer treatments, as examples. The language provided is very specific to behavioral health situations.

   It is recommended that the Company create either a separate transition/continuity of care document for medical/surgical and a separate document for behavioral health or divide the existing one into two sections. It is also recommended that the continuity of care should address the continuity of care statute 215 ILCS § 134/25 which allows for enrollees to continue to seek treatment from a current doctor for a period of 90 days from receipt of notice from health care plan or if the enrollee is in her third trimester of pregnancy, she can keep her current doctor through delivery and postpartum care directly related to the delivery.

B. Observation #2 - The Company's response to the Network Adequacy Handbook request for Network Shortfalls (B.14), the Network Adequacy Provisions Policy (B.16), and in the response to Information Request 013, the documentation focuses exclusively on Behavioral Health providers. Although the Company did respond in response to Information Request 13 that the procedures listed are the same for medical and surgical providers, it does not specifically mention any of the new provisions required in Illinois related to updates to Network Adequacy. Revisions to Illinois regulations occurred on January 1, 2022, for 215 ILCS 124/10(d-5) regarding timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and other parity requirements of Section 370c.1 of the Illinois Insurance Code, as well as the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Within the updated Network Adequacy statute 215 ILCS 124/10(d-5), there is further guidance for companies on what should occur if there are no in-network facilities or providers available for beneficiaries to receive timely and proximate care treatments and the exception policies. The response to B.16 (Network Adequacy Authorizations) contains no guidance listed specifically for the State of Illinois, nor the state-specific requirements. In addition, there have been updates to the federal standards for time/distance for providers, as well as changes coming from the Consolidated Appropriations Act that will impact processes on the usage of out-of-network providers.

   It is recommended that the Company review the recent state and federal changes and modify their standards and procedures to ensure that network shortfalls and network adequacy authorization requests include these detailed changes that took effect within the last few years.

EXAMINATION DRAFT REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Michele Amstutz
Ingrid Franklin
Brad Shoop
Susanna Stevens
Tanya Sherman, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

Respectfully submitted,

Tanya Sherman

TANYA SHERMAN
EXAMINER-IN-CHARGE

Shelly Schuman

SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

CIGNA HEALTH & LIFE INSURANCE COMPANY
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT. 06002

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Cigna Health & Life Insurance Company, ("the Company"), NAIC 67369, and Cigna Healthcare of Illinois Inc., NAIC 95602, are authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report covering the examination period of network plan years 2020, 2021 and 2022, which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, they waive any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS AGREED by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Network Adequacy and Transparency Act (215 ILCS 124/1 et seq.), and the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures whereby the Company shall provide the public access to a prospective consumer to view all of the mental health providers approved for the PPO plans on the public website without requiring a login. 215 ILCS 124/10(b)(4), 215 ILCS 124/25(c), 215 ILCS 124/25(a)(1), 45 CFR 156.230(b)(2)

2. Institute and maintain policies and procedures whereby the Company shall ensure that the network plan and the various naming conventions, make it clear which provider directory applies to which plan. 215 ILCS 124/25(a)(6)

3. Institute and maintain policies and procedures whereby the Company shall make available the HMO provider directory in print for members or prospective members. 215 ILCS 124/25(a)(4), 45 CFR §156.230(b)(2)(i)

4. Institute and maintain policies and procedures whereby the Company shall ensure that the addresses or contact information for providers listed in the electronic directory was up-to-date and accurate. 215 ILCS 124/25(a)

5. Institute and maintain policies and procedures whereby the Company shall provide a timely response to an internal appeal. 215 ILCS 134/45

6. Institute and maintain policies and procedures whereby the Company shall ensure mental health specialists are in printed provider directory (HMO plan). 45 CFR § 156.230(b)(2)

7. Institute and maintain policies and procedures whereby the Company shall ensure electronic provider directory has a filter option or display for medical providers using telehealth. 215 ILCS 124/25(b)(1)(K)

8. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above seven (7) orders within thirty (30) days of execution of this Order.

9. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $95,900.$\underline{00}$ to be paid within ten (10) days of execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code including, but not limited to, levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of CIGNA HEALTHCARE OF ILLINOIS INC., and CIGNA HEALTH & LIFE INSURANCE COMPANY

Kristin Jordal
Signature

Kristin Jordal
Name

R.V.P. - Sales
Title

Subscribed and sworn to before me this 27 day of March 2024.

Doris Daiello
Notary Public

Doris Daiello
NOTARY PUBLIC
State of Connecticut
My Commission Expires March 31, 2026

DATE 4/2/2024

DEPARTMENT OF INSURANCE of the State of Illinois:

Dana Popish-Severinghaus
Director