STATE OF ARIZONA
FILED
SEP 30 2008
DEPT OF INSURANCE
BY

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
NAIC #62308

Respondent.

Docket No. 08A-156-INS

CONSENT ORDER

On April 4, 2005 the Department of Insurance ("Department") called a healthcare insurance compliance examination ("Examination") of Connecticut General Life Insurance Company ("CGLIC") covering the time period from January 1, 2004 through June 30, 2005 ("Examination Period"). The Examination Period was divided into three six-month periods ("Partial Examination Periods" or "PEPs") as follows:

PEP 1: January 1, 2004 – June 30, 2004

PEP 2: July 1, 2004 – December 31, 2004

PEP 3: January 1, 2005 – June 30, 2005

The Report of the Compliance Examination of Connecticut General Life Insurance Company dated January 25, 2007 ("Report"), which is included herein by reference, is a report by exception. It does not include CGLIC practices, procedures or files subject to review with regard to which the Examiners found no violation. The report alleges that CGLIC violated A.R.S. §§ 20-2533 through 20-2536, and A.R.S. § 20-3102. CGLIC wishes to resolve this matter without formal proceedings. CGLIC admits the following Findings of Fact are true and consents to the entry of the following Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to the entry of the following Order.

FINDINGS OF FACT

I. Jurisdiction.

CGLIC is, and throughout the Examination Period was, authorized to operate as a disability insurer pursuant to a Certificate of Authority issued by the Arizona Insurance Director ("Director").

II Utilization Review and Health Care Appeals.

A. During PEPs 1 and 3, in certain health care appeals files the Department reviewed, CGLIC failed to provide a health care appeals information packet to a member or the member's treating provider on request within five business days of the member initiating an appeal. The Department did not find a significant number of the same error in the files it reviewed for PEP 2.

B. During PEPs 1 and 2, in certain health care appeals files the Department reviewed, (requests for expedited medical reviews), CGLIC failed to inform the member and the member's treating provider of the expedited decision within one business day.

C. During the Examination Period, in certain health care appeals files the Department reviewed (requests for informal reconsideration), CGLIC failed to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

D. During PEPs 2 and 3, in certain health care appeals files the Department reviewed (informal reconsiderations), CGLIC failed to mail notice of its decision to the member within thirty days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's

treating provider within thirty days after receiving a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision. The Department did not find a significant number of the same error in the files it reviewed for PEP 1.

E. During the Examination Period, in certain health care appeals files the Department reviewed (formal appeals), CGLIC failed to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal.

F. During PEPs 2 and 3, in certain health care appeals files the Department reviewed (adverse decisions in formal appeals relating to claims for services that already had been provided), CGLIC failed to provide written notice of its adverse decision to the member within sixty days after receiving the written appeal, or to include the criteria used and the clinical reasons for the decision. The Department did not find a significant number of the same error in the files it reviewed for PEP 1.

III. Provider Timely Payment and Provider Grievances.

A. During the Examination Period, in certain clean claims that CGLIC approved but paid late, CGLIC failed to pay interest or paid too little interest.

B. During the Examination Period, in certain claims requiring additional information, CGLIC failed to request information before it denied the claim.

C. During PEP 1, in certain clean claims that CGLIC originally denied, CGLIC delayed the payment of the clean claims without reasonable justification. The Department did not find a significant number of the same error during PEPs 2 and 3.

D. During the Examination Period, CGLIC failed to resolve certain provider grievances.

CONCLUSIONS OF LAW

I. Jurisdiction.

The Director has the authority to enter and enforce this Order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals.

A. During PEPs 1 and 3, CGLIC violated A.R.S. § 20-2533(C) by failing, in certain health care appeals files the Department reviewed, to provide a health care appeals information packet to a member or the member's treating provider on request within five business days of the member initiating an appeal.

B. During PEPs 1 and 2, CGLIC violated A.R.S. § 20-2534(B) by failing, in certain health care appeals files the Department reviewed (requests for expedited medical reviews), to inform the member and the member's treating provider of the expedited decision within one business day.

C. During the Examination Period, CGLIC violated A.R.S. § 20-2535(B) by failing, in certain health care appeals files the Department reviewed (requests for informal reconsideration), to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

D. During PEPs 2 and 3, CGLIC violated A.R.S. § 20-2535(D) by failing, in certain health care appeals files the Department reviewed (informal reconsiderations), to mail notice of its decision to the member within thirty days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty days after

receiving a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision.

E. During the Examination Period, CGLIC violated A.R.S. § 20-2536(B) by failing, in certain health care appeals files the Department reviewed (requests for formal appeals), to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal.

F. During PEPs 2 and 3, CGLIC violated A.R.S. § 20-2536(E)(2) by failing, in certain health care appeals files the Department reviewed (adverse decisions in formal appeals relating to claims for services that already had been provided), to provide written notice of its adverse decision to the member within sixty days after receiving the written appeal, or to include the criteria used and the clinical reasons for the decision.

III. Provider Timely Pay and Grievances.

A. During the Examination Period, CGLIC violated A.R.S. § 20-3102(A) by failing in certain of the clean claims that CGLIC approved but paid late, to pay interest or paid too little interest.

B. During the Examination Period, CGLIC violated A.R.S. § 20-3102(B), by failing, in certain claims requiring additional information, to request information before it denied the claim.

C. During PEP 1, CGLIC violated A.R.S. § 20-3102(C) by delaying, in certain of clean claims that CGLIC originally denied, payment of the claims without reasonable justification.

D. During the Examination Period, CGLIC violated A.R.S. § 20-3102(F) by failing to resolve certain provider grievances.

ORDER

IT IS HEREBY ORDERED THAT:

1. Health Care Appeals Practices.

Within 90 days of the filed date of this Order, CGLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 1) that provides specific steps CGLIC will take by certain dates to assure that by a specified implementation date, CGLIC is:

a. Providing a health care appeals information packet to the member and the members treating provider within five business days of the members initiating an appeal.

b. Informing the member and the member's treating provider of the expedited medical review decision within one business day of receiving a member's request for expedited medical review.

c. Mailing a written acknowledgment to the member and the member's treating provider within five business days after receiving a request for an informal reconsideration.

d. Mailing notice of an informal reconsideration decision to the member and to the member's treating provider within thirty days after receiving a request for informal reconsideration and including the criteria used and the clinical reasons for the decision.

e. Mailing a written acknowledgment letter to the member and the member's treating provider within five business days after receiving a formal appeal.

f. In formal appeals relating to a claim for services already provided, providing the member with written notice of a denial, including the criteria used and the clinical reasons for the decision within sixty business days after receiving the written appeal.

2. Provider Timely Pay.

Within 90 days of the filed date of this Order, CGLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 2) that provides specific steps CGLIC will take by certain dates to assure that by a specified implementation date, CGLIC is:

a. Paying the correct amount of interest on clean claims that it approves and pays late, including claims it approves and pays late after receiving additional information.

b. Pending rather than denying unclean claims before it requests additional information from the provider.

c. Accurately identifying and approving clean claims it is obligated to pay rather than denying them and delaying payment without reasonable justification.

3. Provider Grievances.

Within 90 days of the filed date of this Order, CGLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 3) that provides specific steps CGLIC will take by certain dates to assure that by a specified implementation date, CGLIC shall establish and maintain a grievance resolution system that without limitation:

1. Categorizes grievances accurately.

2. Resolves non-claims/other contractual grievances.

4. Corrective Action Plan Requirements.

Each CAP described above shall:

a. Contain enough detail to allow the Director to determine whether the CAP will accomplish its purpose.

b. Include testing before final implementation of the CAP.

c. Include quality improvement review and follow-up.

d. Identify one individual responsible and accountable for implementation of the CAP.

e. Provide for CGLIC to report to the Director each month starting thirty days from the date of this Order, regarding development and implementation of the CAP, in a form that includes documentation and is approved by the Director.

f. Provide that within 10 business days of receiving notice that the Director has approved the CAP, CGLIC shall submit to the Director evidence that CGLIC has communicated the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memos, bulletins, e-mails, correspondence, procedure manuals, print screens and training materials.

5. Civil Penalty.

CGLIC shall pay a civil penalty of $101,000 to the Director for deposit in the State General Fund for violations cited above as Conclusions of Law. CGLI C shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report of the Compliance Examination of CGLIC upon the filing of this order.

DATED at Phoenix, Arizona this 29th day of September 2008.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. CGLIC has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. CGLIC believes that it is able and prepared to comply fully with the order, notwithstanding any of its other business and regulatory requirements.
2. CGLIC admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact and consents to the entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.
3. CGLIC is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. CGLIC irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.
4. CGLIC states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.
5. CGLIC acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.

6. Jeffrey S. Terrill, who holds the office of Vice President of CGLIC, is authorized to enter into this Order for CGLIC and on its behalf.

Sep 18, 2008
Date

By _____
Jeffrey S. Terrill
Vice President
Connecticut General Life Insurance Company

COPY of the foregoing mailed/delivered
this 30th day of Sept., 2008, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Helene I. Tomme
Market Oversight Division
Dean Ehler
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
David Lee
Chief Financial Examiner
Alexandra Shafer
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Cinney Burton