REPORT ON EXAMINATION

OF

CIGNA HEALTHCARE OF NEW YORK, INC.

AS OF

DECEMBER 31, 2008

DATE OF REPORT	**JANUARY 24, 2011**
EXAMINER	**FROILAN L. ESTEBAL**

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

Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

January 24, 2011

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30311, dated June 2, 2009, attached hereto, I have made an examination into the financial condition and affairs of CIGNA HealthCare of New York, Inc., a for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, as of December 31, 2008, and respectfully submit the following report thereon.

The examination was conducted at the administrative office of CIGNA HealthCare of New York, Inc., located at 900 Cottage Grove Road, Bloomfield, Connecticut.

Wherever the terms the "HMO" or "CHCNY" appear herein, without qualification, they should be understood to indicate CIGNA HealthCare of New York, Inc.

Wherever the term the "Department" appears herein, without qualification, it

should be understood to indicate the New York State Insurance Department.

1. SCOPE OF THE EXAMINATION

This examination covers the five-year period from January 1, 2004 through December 31, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner. A previous examination of the financial condition and affairs of the HMO was conducted as of December 31, 2003. A concurrent review of CHCNY's computer systems and related operations was conducted as of December 1, 2003, by Ernst and Young, as directed by the Insurance Department. In addition, a special market conduct examination was conducted to review compliance with Section 4308(b) of the New York Insurance Law and Department Regulation No. 62 ((11 NYCRR 52) - "Minimum Standards for Form, Content and Sale of Health Insurance..."). The examination focused upon CHCNY's rating practices for its large group experience rated business and entailed a review of the compensation for agents and brokers involved with the selling of this product. The examination covered the period January 1, 2003 to September 30, 2004, however, transactions prior to and subsequent to this period were reviewed where deemed appropriate.

This examination comprised a verification of assets and liabilities as of December 31, 2008, in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the HMO's independent certified public accountants.

A review or audit was also made of the following items as called for in the *Financial Condition Examiners Handbook of the National Association of Insurance Commissioners* ("NAIC"):

History of the HMO
Management and controls
Corporate records
Territory and plan of operation
Loss experience
Reinsurance
Accounts and records
Financial statements
Market conduct activities

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, rules or regulations, or which are deemed to require explanation or description. A review was also made to ascertain what actions were taken by the HMO with regard to comments and recommendations contained in the prior reports on examination.

2. DESCRIPTION OF THE HMO

CHCNY is a for-profit health maintenance organization ("HMO"), licensed pursuant to the provisions of Article 44 of the New York Public Health Law, which commenced operations on October 1, 1986. It filed an application for a Certificate of Authority on May 14, 1985, which was granted by the New York State Department of Health, effective July 30, 1986. On July 1, 1987, the HMO attained Federal qualification under Title XIII of the Public Health Service Act. The HMO voluntarily relinquished its Federal qualification effective July 1, 1995. The HMO provides health care services, primarily managed care products and related services, in New York City and Orange,

Putnam, Rockland, Westchester, Nassau and Suffolk Counties.

Effective June 20, 1991, the HMO's name was changed to CIGNA Healthplan of New York, Inc., and, on July 1, 1992, its Certificate of Authority was amended to include the territories of Orange, Putnam, Rockland and Westchester counties. Subsequently, on September 10, 1993, the HMO's name was changed to CIGNA HealthCare of New York, Inc.

A. Management and Controls

At December 31, 2008, the HMO's board of directors consisted of the following five members:

Name and Residence	Principal Business Affiliation
Joan L. Arena-Mastropaola New York, NY	Assistant Vice President, CIGNA HealthCare of NY, Inc.
Charles Ronald Catalano Greenwich, CT	President, CIGNA HealthCare of NY, Inc.
William Charles Hutchinson* Valley Stream, NY	Director, Sales & Marketing, Albert Kemperle, Inc.
Aslam Mohammad Khan Northfield, IL	Vice President, CIGNA Health Corporation
Daniel Jules Nicoll Plainview, NY	Medical Director, CIGNA HealthCare of NY, Inc.

*Enrollee representative - Part 98-1.11(f) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(f)) requires that a minimum of twenty percent (20%) of the board of directors of an HMO be comprised of enrollee representatives. The HMO is in compliance with said Regulation.

The principal officers of the HMO as of December 31, 2008, were as follows:

Name	Title
Charles Ronald Catalano	President
Joseph Louis Lessard	Assistant Secretary

Scott Ronald Lambert Treasurer

B. Territory and Plan of Operation

CHCNY was granted a Certificate of Authority to operate as a health maintenance organization ("HMO") in the five boroughs of New York City, as well as in the counties of Nassau, Suffolk, Orange, Putnam, Rockland and Westchester in New York State. It operates as an Independent Practice Association ("IPA") model HMO. An IPA is an organization that contracts with physicians and other providers of medical services, which then contracts with a managed care organization such as CHCNY, to make such services available to the managed care organization's enrollees. The HMO also enters into contracts directly with individual hospitals, physicians and other third party and affiliated health care professionals to provide health care services to its enrollees.

Enrollees are free to select any primary care physician ("PCP") affiliated with the HMO and to transfer from one PCP to another. All medical care received by an enrollee, including referrals to specialists and hospital care, are coordinated by the enrollee's selected PCP. As of December 31, 2008, the HMO covered 5,507 enrollees.

C. Plan of Withdrawal of Cigna HealthCare of New York, Inc.

The HMO submitted a Plan of Withdrawal ("Plan") to both, the New York State Departments of Health and Insurance. The Plan calls for the termination of the HMO's group membership, commencing with renewal dates of January 1, 2009. Groups will be offered other group coverage provided by an affiliate company, Connecticut General Life

Insurance Company ("CGLIC"). According to the Plan, all Healthy New York (Group, Sole Proprietor and Individual) members, as well as direct pay members would be terminated on January 1, 2009. Likewise, any members with renewal dates after January 1, 2009, would not be allowed to renew. By following this course of action, the HMO will have no members as of December 31, 2009. A two year run-out period, starting January 1, 2010, will ensue during which the HMO will continue to wind-down its business using the same processes as are currently in effect.

The annual decline in the HMO's enrollment during the examination period is shown below:

2004	**2005**	**2006**	**2007**	**2008**
36,977	34,901	26,950	16,999	5,507

Since 2004, the HMO experienced a steady decline in membership, which according to the HMO is due to decrease in sales volume as well as the HMO's decision to maintain underwriting discipline.

D. Holding Company System

CIGNA HealthCare of New York, Inc. was originally incorporated as Total Health HMO, Inc. ("Total Health") under the laws of the State of New York on April 24, 1985. However, Total Health was a de facto corporation beginning August 31, 1984 (date of inception). Total Health Systems, Inc. ("THS"), its parent at that time, was organized as a business corporation under the laws of the State of New York on October 23, 1985. Effective April 17, 1986, existing stockholders of Total Health transferred all of their

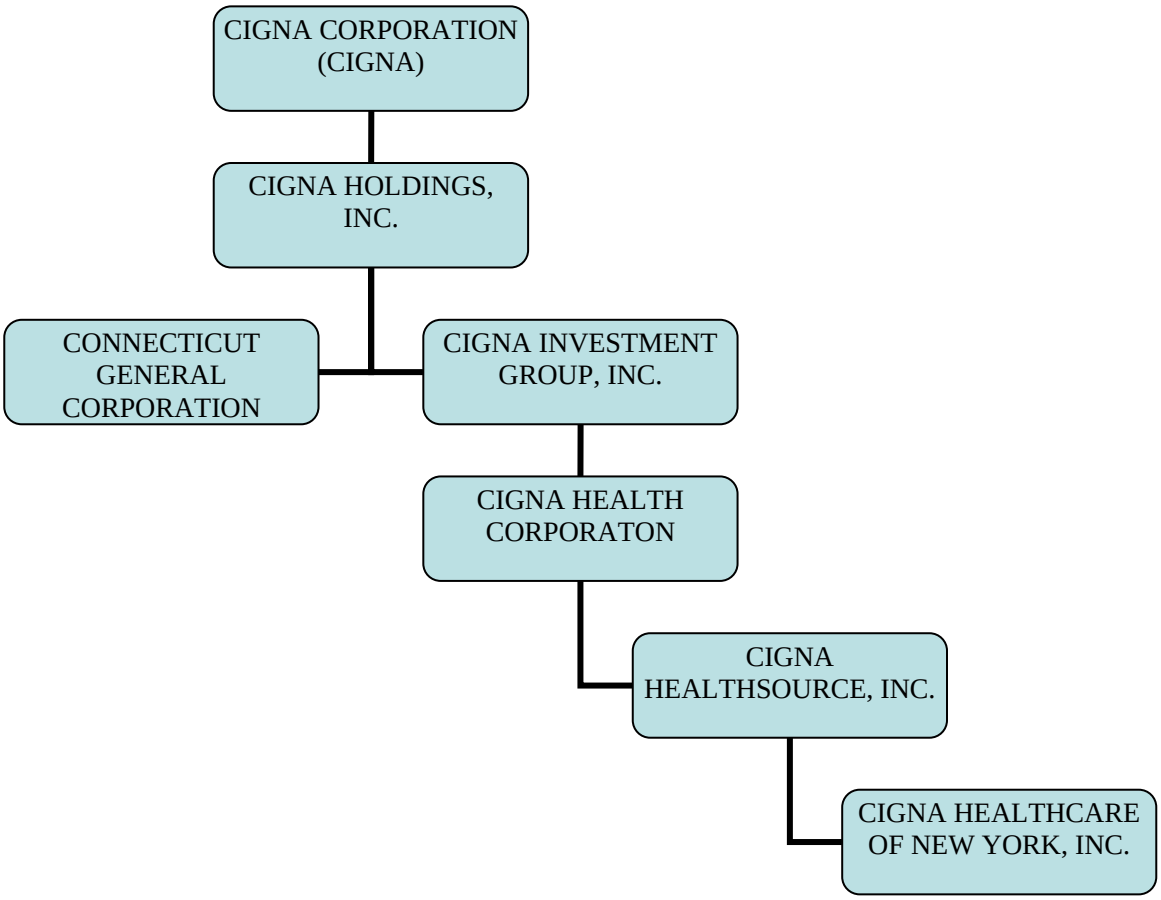
shares of common stock to THS in exchange for common shares of THS, and accordingly, Total Health became a wholly-owned subsidiary of Total Health Systems, Inc.

On February 20, 1990, Equicor Health Corporation ("Equicor") acquired all of the outstanding stock of Total Health Systems, Inc. Subsequently, on March 8, 1991, Total Health changed its name to CIGNA Healthplan of New York, Inc., which was later changed to CIGNA HealthCare of New York, Inc. In addition, effective July 1, 1991, Equicor was renamed CIGNA Health Corporation ("CHC"), which is currently the Parent of the HMO. On December 18, 2000, the New York State Department of Health approved a merger of Healthsource HMO of New York, Inc., an affiliated company, and CHCNY, effective June 30, 2001. The HMO is a wholly-owned subsidiary of Cigna Healthsource, Inc., which is a wholly-owned subsidiary of CIGNA Health Corporation ("CHC"), which is a subsidiary of CIGNA Corporation ("Corporation"), the ultimate parent.

As of December 31, 2008, the HMO had the following approved agreements with its Parent and affiliates:

1. Cigna Health Corporation ("CHC"), its Parent company - Administrative Service Agreement.
2. Cigna Behavioral Health ("CBH") - Mental health and substance abuse services.
3. International Rehabilitation Assoc., Inc. ("Intracorp") - Utilization management, case management and disease management.
4. Connecticut General Life Insurance Company ("CGLIC") - Access to the provider networks.
5. Mail Order Pharmacy Agreement ("Tel-Drug") - Provide mail order pharmacy services.
6. Cigna Dental Health, Inc. - Dental consultations.
7. Cigna Investments, Inc. - Investment advisor.

The chart below depicts the HMO and its relationship to other members of its holding company system as of December 31, 2008.



The relationship illustrated above makes CHCNY a "controlled HMO" under the definition set forth in Part 98-1.2(n) of the Administrative Rules and Regulations of the New York State Health Department (10 NYCRR 98-1.2(n)). The HMO filed the holding company documents required by Part 98.1-16(e) of the Administrative Rules and Regulations of the New York State Health Department during the examination period.

E. Reinsurance

At December 31, 2008, the HMO had an excess of loss reinsurance agreement in force with Connecticut General Life Insurance Company ("CGLIC"), an authorized affiliated insurer. Under the terms of the agreement, CGLIC agreed to indemnify the HMO for up to 80% of eligible hospital services, in excess of the deductible of $150,000, for each member, for each contract year. This agreement contained the standard clauses required by the Department, including an insolvency clause meeting the requirements of Section 1308 of the New York Insurance Law. This agreement was approved and filed with the Department prior to the last examination.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination as of December 31, 2008. This statement is the same as the balance sheet filed by the HMO:

Assets	Examination	HMO
Current assets		
Cash and cash equivalents	$ 305,022	$ 305,022
Short-term investments	45,031	45,031
Premiums receivable	891,926	891,926
Investment income receivables	388,091	388,091
Amounts due from affiliates	896	896
Total current assets	$ 1,630,966	$ 1,630,966
Other assets		
Bonds	$ 22,770,584	$ 22,770,584
Other invested assets	2,260,780	2,260,780
Deferred tax asset	1,265,848	1,265,848
Total other assets	$ 26,297,212	$ 26,297,212
Total assets	$ 27,928,178	$ 27,928,178

Liabilities	Examination	HMO
Current liabilities		
Claims payable	$ 5,086,203	$ 5,086,203
Claims adjustment expenses payable	67,055	67,055
Aggregate health policy reserve	500,000	500,000
Unearned premiums	125,978	125,978
General expenses	231,291	231,291
Amounts due to affiliates	1,806,653	1,806,653
Federal income tax liability - current	876,379	876,379
Total current liabilities	$ 8,693,559	$ 8,693,559
Other liabilities		
Escheatable funds	65,696	65,696
Credit balance due policyholders	1,963,554	1,963,554
Commissions to agents due or accrued	19,628	19,628
Total liabilities	$ 10,742,437	$ 10,742,437
Capital and surplus		
Common capital stock	974,950	974,950
Paid-in surplus	51,559,243	51,559,243
Contingent reserves	4,218,001	4,218,001
Retained earnings/fund balance	(39,566,453)	(39,566,453)
Total capital and surplus	$ 17,185,741	$ 17,185,741
Total liabilities, capital and surplus	$ 27,928,178	$ 27,928,178

Note: The Internal Revenue Service has completed its audits of the consolidated income tax returns filed on behalf of the HMO through tax year 2006. Any material adjustments made subsequent to the date of examination and arising from said audits are reflected in the financial statements contained herein. The HMO stated that there were no substantial findings or penalties imposed from the audit. For the years subsequent to this audit, the examiner is unaware of any potential exposure of the HMO to any further tax assessment and no liability has been established herein relative to such contingency.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and surplus decreased $8,207,057 during the five-year examination period from January 1, 2004 through December 31, 2008, detailed as follows:

Revenue		
Premiums earned	$ 521,592,582	
Net investment income	9,892,082	
Other income	33,599	
Realized capital gains	1,025,116	
Total revenue		$ 532,543,379
Medical and hospital expenses		
Medical and hospital benefits	$ 300,584,696	
Other professional services	30,734,006	
Outside referrals	59,146,265	
Emergency room	17,066,092	
Prescription drugs	69,011,144	
Other medical and hospital	28,863,265	
Incentive pool withhold adjustments	(199,999)	
Reinsurance recoverable	(30,135,441)	
Total medical and hospital expenses	$ 475,070,028	
Administrative claims adjustment expenses	15,745,044	
General administrative expenses	43,745,663	
Reserve for accident and health contracts	(3,000,000)	
Total administrative expenses	$ 56,490,707	
Total expenses		$ (531,560,735)
Net income before federal income taxes		$982,644
Provision for federal income taxes		(1,584,870)
Net income		$ 2,567,514

Changes in Capital and Surplus

	Gains in Surplus	Losses in Surplus	
Capital and surplus, per report on examination, as of December 31, 2003			$ 25,392,798
Net income	$ 2,567,514		
Change in deferred income tax		$ 988,414	
Change in non-admitted assets		2,420,798	
Aggregate write-ins for change in surplus	4,634,641		
Dividends to stockholders		12,000,000	
Net decrease in capital and surplus			$ (8,207,057)
Capital and surplus, per report on examination, as of December 31, 2008			$ 17,185,741

4. CLAIMS PAYABLE

The examination liability of $5,086,203 for the captioned account is the same as the amount reported by the HMO in its filed annual statement as of December 31, 2008. The examination reserve was based upon actual payments made subsequent to the examination date, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the HMO's past experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2008. The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the HMO's internal records and in its filed annual statements as verified during the examination.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the HMO conducts its business and fulfills its contractual obligations to subscribers and claimants. The review was general in nature and was directed toward various practices of the HMO.

A. 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 forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

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

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law 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."

A statistical sample of claims not adjudicated within 45 days of submission to the HMO was reviewed to determine whether the payment was in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within 45 days of receipt, during the period January 1, 2008 through December 31, 2008, were segregated. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute.

The claim populations were separated and further divided into medical and hospital claim segments. Two statistical samples were drawn, one from each segment for each entity. It should be noted for the purpose of this analysis, medical costs characterized by CHCNY as "Pharmacy", "Capitated Payments", and "NY Surcharge Accruals" were excluded from the examiner's review. In total, 100 claims were selected for this review (50 each from the medical and hospital claim segments).

The following chart illustrates the HMO's compliance with the Prompt Pay Law as determined by this examination:

Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total Population	127,925	13,933
Population of claim transactions adjudicated past 45 days	1,516	530
Sample size	50	50
Number of claims with violations	31	32
Calculated violation rate	**62.00%**	**64.00%**
Upper violation limit	75.45%	77.30%
Lower violation limit	48.55%	50.70%
Calculated claims in violation	**940**	**339**
Upper limit transactions in violation	1,144	410
Lower limit transactions in violation	736	269

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

The extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt. The population of claims adjudicated over forty-five days from date of receipt consisted of 1,516 and 530 medical and hospital claims, respectively, out of 127,925 and 13,933 medical and hospital claims, respectively, processed during the stated period under review.

It is recommended that CHCNY take steps to ensure compliance with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims.

Further, Section 3224-a(b) of the New York Insurance Law states in part:

> "In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment…"

Two statistical samples (one for medical claims and one for hospital claims) of claims not denied within 30 calendar days of receipt by the HMO were reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were not processed within 30 calendar days of receipt by the HMO during the period from January 1, 2008 through December 31, 2008, were segregated. A statistical sample of each population was then selected to determine whether the

claims were adjudicated in compliance with the requirements of Section 3224-a(b) of the New York Insurance Law. In total, 100 claims were selected for this review (50 each from the medical and hospital claim segments).

Based on this review, the following chart was developed to illustrate the HMO's compliance with the Prompt Pay Law as determined by this examination:

Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total Population	127,925	13,933
Population of claim transactions denied past 30 days	1,516	540
Sample size	50	50
Number of transactions with violations	9	3
Calculated violation rate	**18.00%**	**6.00%**
Upper violation limit	28.65%	12.58%
Lower violation limit	7.35%	N/A
Calculated transactions in violation	**273**	**32**
Upper limit transactions in violation	434	68
Lower limit transactions in violation	111	N/A

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

The extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims denied in excess of 30 calendar days from the date of claim receipt during the period January 1, 2008 through December 31, 2008.

The population of claims denied over 30 calendar days from date of receipt consisted of 1,516 and 540 medical and hospital claims, respectively, out of 127,925 and 13,933 medical and hospital claims, respectively, processed during the stated period under review.

During the examiner's review of the HMO's compliance with the Prompt Pay Law, it was noted that the HMO did not have a systematic procedure that identified the correct "Clock Start Date" for claims that were pended. For example, many of the claims identified by the examiner as statutory violations for the prompt pay compliance review, detailed above, were actually claims where the HMO had received incomplete information and, as such, was unable to process the claim. Upon receipt of the information needed to process the claim, the HMO was found to process those sampled claims within statutory guidelines. However, the date the additional information was received and processing commenced was not tracked by the HMO's claims administration system. As a result, although an extrapolation methodology employed across the population of claims was believed to meet the defined parameters, the resulting determinations as contained in the report, may be skewed as neither the HMO, or the examiner was able to accurately identify and segregate claims that were not denied within the statutory timeframe of 30 calendar days from claim receipt.

It is recommended that CHCNY take steps to ensure compliance with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the prompt denial of claims.

It is further recommended that CHCNY develop a procedure to adjust the "Clock Start Date" for claims that are pended.

B. Utilization Review

Sections 4902, 4903 and 4904 of the New York Public Health Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents respectively for HMOs licensed under Article 44 of the New York Public Health Law.

The examiner randomly selected six Utilization Review files for review. In 3 out of the 6 files, CHCNY failed to send acknowledgment notices within fifteen days as required by New York Public Health Law, Section 4904(3), which states in part;

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

It is recommended that CHCNY provide written acknowledgment to the enrollee or the enrollee's designee within fifteen days after filing of the appeal as required by Section 4904(3) of the New York Public Health Law.

6. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

This section pertains to comments and recommendations from the prior Report on Examination of CHCNY's Financial Condition, which included an Appendix describing findings revealed during a separate review of CHCNY's Computer Systems and related operations by Ernst and Young, and a Special Market Conduct Report on Underwriting and Ratings Practices, performed as of September 30, 2004.

The prior reports contained a combined fifty-five (55) comments and recommendations as follows (page numbers refer to the prior report):

A. Financial Condition Examination (25 Recommendations)

ITEM NO.		PAGE NO.
	Management and Controls	
1.	It is recommended that board members who are unable or unwilling to attend meetings consistently should resign or be replaced. *The HMO has complied with this recommendation.*	5
2.	It is recommended that the Plan's management comply with Section 312(b) of the New York Insurance Law by ensuring that each board member signs the requisite statement that (s)he has received and reviewed said examination report. *The HMO has complied with this recommendation.*	6
3.	It is further recommended that the Plan's management have these statements signed in a timely manner, furnishing the board members with copies of reports on examination no later than the next regularly scheduled board meeting subsequent to the date the report is filed. *The HMO has complied with this recommendation.*	6

ITEM NO. **PAGE NO.**

Circular Letter No. 9 (1999) – Adoption of Procedures Manuals

4. It is recommended that the board of directors of CHCNY obtain the appropriate annual certifications required by Circular Letter No. 9 (1999). 8

The HMO has complied with this recommendation.

5. It is recommended that the Plan submit a plan of corrective action to the Department in response to the comments and recommendations made in all filed reports on examination. 8

The HMO has complied with this recommendation.

6. It is further recommended that the board of directors of CHCNY oversee the corrections and implementation of CHCNY's compliance with the recommendations made in all filed reports on examination. 8

The HMO has complied with this recommendation.

7. The above mentioned issues and resulting comments and recommendations addressing the Plan's board, are also directed to its corporate management and senior officers. The failure to respond to and comply with Insurance Department directives and examination findings is disconcerting. 8

The HMO has complied with this recommendation.

Conflict of Interest Policy

8. It is recommended that the Plan review and amend its current policy regarding conflicts of interest by having statements completed when the person is hired or appointed, and at least annually thereafter. 10

The HMO has complied with this recommendation.

Holding Company System

9. It is recommended that the Plan comply with Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department. 14

Subsequent to the date of this examination, the Plan filed the Intracorp and CBH management services agreements with the Insurance Department.

The HMO has complied with this recommendation.

10. It is recommended that the Plan comply with the requirements of Part 98-1.10(c) of the Administrative Rules and Regulations of the Health Department and refrain from implementing a management services agreement prior to obtaining the requisite approval from the Departments of Health and Insurance. 15

Subsequent to the examination date, this agreement was approved by the Department of Health.

The HMO has complied with this recommendation.

Abandoned Property Law

11. It is recommended that the Plan abide by the prescribed year-end cut-off period when filing its Verification and Checklist Report of Abandoned Property with the New York State Comptroller. 16

The HMO has complied with this recommendation.

12. It is also recommended that the Plan maintain sufficient documentation to allow for the proper identification of all payees reported on its filed Verification and Checklist Report of Abandoned Property escheated to the Office of the State Comptroller of the State of New York. 16

The HMO has complied with this recommendation.

13. It is further recommended that the Plan publish its unclaimed funds in accordance with the requirements of Sections 1315 and 1316 of the New York Abandoned Property Law. 16

The HMO has complied with this recommendation.

ITEM NO. **PAGE NO.**

Location of Records

14. It is recommended that the Plan maintain, at a minimum, copies of its annual statements, and other pertinent financial and corporate records at its statutory home office, pursuant to the requirements of Part 98-1.11(a) of the Administrative Rules and Regulations of the Health Department. 17

The HMO has complied with this recommendation.

15. It is also recommended that the Plan accurately reflect the actual location of the Plan's books and records in its filed annual statement. 17

The HMO has complied with this recommendation.

Accounts and Records

16. It is recommended that the Plan comply with Part 98-1.11(a) of the Administrative Rules and Regulations of the Health Department and develop a method to collect claims data pertaining solely to CHCNY. It is further recommended that this data be reviewed by the Plan's management on a regular basis. 18

The HMO has complied with this recommendation.

17. It is recommended that the correct name of the custodian be reflected in the Plan's custodian agreement and in its annual statements filed with the Department. 19

The HMO has complied with this recommendation.

18. It is recommended that the Plan amend its custodian agreement to include the above mentioned provision. 19

The HMO has complied with this recommendation.

19. It is recommended that the Plan reflect the proper names and correct balances for all financial institutions listed in Schedule E of its annual statements filed with this Department. 20

The HMO has complied with this recommendation.

ITEM NO. **PAGE NO.**

20. It is recommended that the Plan ensure that all Letters of Credit issued on its behalf contain all of the clauses required by Department Regulation No. 133. 20

The HMO has complied with this recommendation.

21. It is recommended that when determining a premium deficiency reserve the Plan comply with the requirements of SSAP No. 54 and recognize a liability for each policy grouping where a premium deficiency is indicated. 21

The HMO has complied with this recommendation.

22. It is recommended that the Plan adhere to the requirements of Section 1407(a)(4) of the New York Insurance Law and not invest in any obligations, shares or other securities of an affiliate. 22

Subsequent to the examination date (March 2005), the Fund was dissolved.

The HMO has complied with this recommendation.

23. It is recommended that the Plan follow the NAIC instructions with regard to proper reporting of its cash and short-term investments in its annual statements filed with this Department. 22

The HMO has complied with this recommendation.

Claims Payable

24. It is recommended that in regard to its "Seamless" product, the Plan improve MEDICOM's capabilities to properly classify and distinguish all applicable claims, so that the actual health plan subject to the claim can be identified and claims can be properly allocated. 28

The HMO has complied with this recommendation.

ITEM NO. **PAGE NO.**

25. It is further recommended that the Plan review all claims processed 28

using its “Seamless” product.

Subsequent to the examination date, the Plan began migrating membership from the MEDICOM (“National”) Platform to its “Endstate” Platform. As of December 31, 2007, all membership resided on the Endstate Platform.

The HMO has complied with this recommendation.

B. Computer Systems and Related Operations (8 Recommendations)

ITEM NO. **PAGE NO.**

PMHS – Change Management Segregation of Duties – Description and Risk

1. It is recommended that individuals who have access to the authorities in Implementer and Aldon not have the ability to move changes from the development, test and production environments, to a live environment. 6

Ernst and Young reviewed the responses and assertions by the HMO and determined that the findings were satisfactorily addressed.

LAN – Logical Security Controls – Description and Risk

2. It is recommended that CIGNA's management maintain all documentation of SCR requests and approvals to the LANs. Further, it is recommended that CIGNA's management ensure that all personnel, including contractors, vendors or employees of affiliated companies, follow SCR procedures to gain access to the LANs. 7

Ernst and Young reviewed the responses and assertions by the HMO and determined that the findings were satisfactorily addressed.

CARBS – Logical Security Controls – Description and Risk

3. It is recommended that CIGNA's management retain all supporting documentation, either the request form or email, of user requests and approvals. In addition, access to CARBS should not be given unless the request form or email has been approved. Also, the process for user recertification should be standardized and conducted on a periodic (e.g. quarterly/annual) basis. Further, management should implement a process by which terminated employees or users that change assignments are terminated as active users on CARBS. 8

Ernst and Young reviewed the responses and assertions by the HMO and determined that the findings were satisfactorily addressed.

ITEM NO. **PAGE NO.**

PMHS – Segregation of Duties Within the Application – Description and Risk

AMISYS follow CIGNA's change management policies and procedures for requesting, testing and approving changes to be promoted into production; particularly when changes are classified as emergency changes.

Ernst and Young reviewed the responses and assertions by the HMO and determined that the findings were satisfactorily addressed.

CARBS – Changes to Application Controls – Description and Risk

8. It is recommended that management ensure that all changes to CARBS follow CIGNA's change management policies and procedures for requesting, testing and approving changes to be promoted into production. Further, CIGNA's management should ensure that changes cannot be implemented into production without approval from the Main Change Control Board. 13

Ernst and Young reviewed the responses and assertions by the HMO and determined that the findings were satisfactorily addressed.

C. Special Market Conduct Examination (22 Recommendations)

ITEM NO. **PAGE NO.**

Misapplication of Filed Formula

1. It is recommended that CHCNY comply with the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62 by utilizing the annual trend rates, stop-loss pooling charges, retention percentages and credibility factors as contained in its formula submitted to and approved by the Superintendent. 8

Testing did not reveal any violations of this recommendation.

2. It is recommended that CHCNY comply with the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62 by charging rates that are based on strict adherence to the provisions of its experience rating formula filed with and approved by the Superintendent. 8

Testing did not reveal any violations of this recommendation.

Deviation from Filed Formula

3. It is recommended that CHCNY discontinue the use of any component of its large group experience rating process that was not filed with the Department and approved by the Superintendent. 13

Testing did not reveal any violations of this recommendation.

4. It is recommended that all features utilized by CHCNY during its rating of large group experience rated policies be filed with the Department for approval according to the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62. 13

Testing did not reveal any violations of this recommendation.

5. It is recommended that CHCNY consistently apply all aspects of its experience rating formula to all of its prospective groups. 13

Testing did not reveal any violations of this recommendation.

ITEM NO. **PAGE NO.**

6. It is recommended that CHCNY comply with Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62 by not utilizing rate caps or other similar designs in its experience rating formula, unless they have been submitted to and 14

approved by the Superintendent.

Testing did not reveal any violations of this recommendation.

7. It is again recommended that CHCNY comply with the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62 by charging rates that are based on strict adherence to the provisions of its experience rating formula filed with the Department and approved by the Superintendent. Further, it is recommended that CHCNY consistently apply all aspects of its experience rating formula to all of its prospective groups. 14

Testing did not reveal any violations of this recommendation.

Other Ratings Issue

8. It is again recommended that the Plan comply with the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62, by not utilizing any feature of its large group experience rating formula unless it has been approved by the Department. 15

Testing did not reveal any violations of this recommendation.

9. It is recommended that all CHCNY accounts that incorporated blended rates with members of its holding company system be reviewed, and where applicable, the difference between the actual premium received by CHCNY and the premium determined by the Plan's rating formula be remitted to CHCNY, with interest. 16

Testing did not reveal any violations of this recommendation.

ITEM NO. **PAGE NO.**

10. It is again recommended that CHCNY comply with the requirements of Section 4308(b) of the New York Insurance Law and Part 52.40(g)(1) of Department Regulation No. 62 by charging rates that are based on strict adherence to the provisions of its experience rating formula filed with and approved by the Department. 16

Testing did not reveal any violations of this recommendation.

11. It is recommended that the Plan and members of its holding company system act in accordance with the requirements of Part 98-1.10(a) of the Administrative Rules and Regulations of the Health Department. 16

Testing did not reveal any violations of this recommendation.

Section 308 Submissions

12. It is recommended that the Plan comply with the 4% commission limitation prescribed by Part 52.42(e) of Department Regulation No. 62. 18

Testing did not reveal any violations of this recommendation.

13. In response to the Department's finding that CHCNY violated Part 52.42(e) of Department Regulation No. 62, CHCNY sent letters to its producers notifying them that as of April 5, 2005 (the date of the letter), CHCNY would no longer pay compensation, in any form, in excess of four percent for any membership covered by CHCNY. CHCNY also provided the Department with documents showing that the Plan initiated various procedures and controls to ensure its compliance with the aforementioned commission limit. However, the Department did not conduct a verification of these procedures and controls. 18

Testing did not reveal any violations of this recommendation.

Excess Commissions

14. It is recommended that the Plan disclose the actual commission rate incorporated into its premiums charged and that its enrolled groups be made aware of the actual commission rate they are paying. 19

Testing did not reveal any violations of this recommendation.

ITEM NO. **PAGE NO.**

15. It is again recommended that the Plan comply with the 4% commission limitation prescribed by Part 52.42(e) of Department Regulation No. 62. 20

Testing did not reveal any violations of this recommendation.

16. It is further recommended that CHCNY's board conduct an 20

investigation of the practices detailed above to determine whether any misconduct took place in negotiating rates and determining/charging related commission rates. A copy of such investigation should be provided to this Department within ninety days of the filing of this report on examination.

Testing did not reveal any violations of this recommendation.

17. It is again recommended that CHCNY comply with the provisions of Section 4308(b) of the New York Insurance Law and Part 52.40 of Department Regulation No. 62. 20

Testing did not reveal any violations of this recommendation.

Adoption of Procedure Manuals – Circular Letter No. 9 (1999)

18. It is recommended that the board of directors of CHCNY obtain the appropriate annual certifications required by Circular Letter No. 9 (1999). 21

Testing did not reveal any violations of this recommendation.

19. It is further recommended that the board of directors of CHCNY directly supervise the corrections and implementation of the processes necessary to have the Plan comply with the recommendations made in this report. Evidence of such oversight should be documented in the minutes of the board of director meetings. 21

Testing did not reveal any violations of this recommendation.

ITEM NO. **PAGE NO.**

Point-of-Service Products – Circular Letter No. 26 (2000)

20. It is recommended that CHCNY comply with the requirements of Circular Letter No. 26 (2000) by having its board of directors formally adopt an experience rated formula for the use of rating the in-network component of its large group POS product. 22

Testing did not reveal any violations of this recommendation.

Department Regulation No. 152

21. It is recommended that the Plan comply with the requirement of Section 243.2(b)(iv) of Department Regulation No. 152 by maintaining complete and accurate underwriting files. 24

Testing did not reveal any violations of this recommendation.

22. It is also recommended that the Plan comply with its policy by ensuring that proper authorization for rate changes be maintained in the underwriting files. 24

Testing did not reveal any violations of this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

A. Prompt Pay Law

i. It is recommended that CHCNY take steps to ensure compliance with the 16

provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of claims.

ii. It is recommended that CHCNY take steps to ensure compliance with the provisions of Section 3224-a(b) of the New York Insurance Law regarding the prompt denial of claims. 18

iii. It is further recommended that CHCNY develop a procedure to adjust the "Clock Start Date" for claims that are pended. 18

B. Utilization Review

It is recommended that CHCNY provide written acknowledgment to the enrollee or the enrollee's designee within fifteen days after filing of the appeal as required by Section 4904(3) of the New York Public Health Law. 19

Appointment No. **30311**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **ERIC R. DINALLO**, 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 condition of the said

Company

with such other information as he shall deem requisite.

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

this 2nd day of June, 2009

Eric R. Dinallo
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR