COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 21, 2024

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CIGNA HEALTH AND LIFE INSURANCE COMPANY,
Defendant

2024 AUG 21 P 2:29

CASE NO. INS-2024-00064

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), the Bureau has alleged that Cigna Health and Life Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia, in certain instances violated §§ 38.2-316 A and 38.2-316 C 1 of the Code of Virginia ("Code") by delivering or issuing for delivery in the Commonwealth insurance policies using application forms that had not been filed with and approved by the Commission; § 38.2-502 (1) of the Code by misrepresenting the benefits, advantages, conditions, or terms of any insurance policy; § 38.2-510 A 6 of the Code by failing to attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear with such frequency as to indicate a general business practice; § 38.2-514 B of the Code by failing to provide to an insured, claimant, subscriber or enrollee, an explanation of benefits which clearly and accurately discloses the method of benefit calculation and the actual amount which has been or will be paid to the provider of services; § 38.2-604 B 4 of the Code by failing to include in the notice required by subsection A of this section, a description of rights established under §§ 38.2-608 and 38.2-609 of the Code and the manner in which those rights may be exercised; § 38.2-1812 A of the Code by paying commission or other valuable

consideration to any person for services as an agent within this Commonwealth that at the time of the transaction out of which arose the right to such commission or other valuable consideration, did not hold a valid license as an agent, for the class of insurance involved; § 38.2-1833 A 1 of the Code by failing to, within 30 calendar days of the date of execution of the first insurance application or policy submitted by a licensed but not yet appointed agent, either reject such application or policy or file with the Commission a notice of appointment in a form acceptable to the Commission; § 38.2-1834 D of the Code by failing to notify the agent of the termination of his/her appointment within five calendar days and the Commission, except as provided in subsection B of this section, within 30 calendar days in a manner acceptable to the Commission; § 38.2-3405 B of the Code by improperly allowing a contract to contain any provision requiring the beneficiary of any such contract or plan to sign any agreement to pay back to any company issuing such a contract or creating a health services plan any benefits paid pursuant to the terms of such contract or plan from the proceeds of a recovery by such beneficiary from any other source; § 38.2-3407.1 B of the Code by failing to pay interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto at the legal rate from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment; § 38.2-3407.3 A of the Code by failing to calculate the insured, subscriber, or enrollee's specified percentage of the cost of covered services based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, subscriber, or enrollee; § 38.2-3407.4 A of the Code by failing to file explanation of benefits forms for approval prior to use; § 38.2-3407.4 B of the Code by failing to provide explanation of benefits that accurately and clearly set forth the benefits payable under the contract; §§ 38.2-3407.15 B 1 - 10 of the Code by failing to include, adhere to, and comply with specific required provisions

related to minimum fair business standards in its provider contracts; §§ 38.2-3407.15:1 B 1 - 9 of the Code by failing to include specific required provisions in carrier contracts with pharmacy providers; § 38.2-3407.15:1 C of the Code by failing to include specific required provisions relating to audits in carrier contracts with pharmacy providers; §§ 38.2-3407.15:2 B 1 - 8 of the Code by failing to include specific required provisions related to prior authorization in its provider contracts; §§ 38.2-3407.15:3 B 2 and 38.2-3407.15:3 B 4 of the Code by failing to include specific required provisions in carrier and intermediary contracts with pharmacy providers; §§ 38.2-3407.15:3 C 1 and 38.2-3407.15:3 C 3 of the Code by failing to include specific required provisions in "[a]ny contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost . . . that require the intermediary or carrier to provide a process for an appeal, investigation, and resolution of disputes regarding maximum allowable cost drug pricing that includes: 1. [a] time period of 14 days from the date of initial claim adjudication for the participating pharmacy provider to file its dispute request . . . [and] 3. [a] telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing dispute requests," §§ 38.2-3407.15:4 C 1 and 38.2-3407.15:4 C 3 of the Code by failing to disclose to an enrollee information relating to the provisions of provider contracts between a health carrier or its pharmacy benefits manager and a pharmacy or its contracting agent and the availability of a more affordable therapeutically equivalent prescription drug and failing to offer and provide direct and limited delivery services to an enrollee as an ancillary service of the pharmacy in accordance with § 54.1-3420.2; § 38.2-3412.1 B of the Code by failing to provide coverage for mental health and substance use disorder benefits in parity with medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008;

§§ 38.2-5804 A and A 1 of the Code by failing to establish and maintain a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints and failing to maintain a record of complaints for no less than five years; as well as 14 VAC 5-90-40 of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* of the Virginia Administrative Code ("Rules"), by failing to disclose required information conspicuously and in close conjunction with the statements to which the information relates and that does not minimize, render obscure, or present in an ambiguous fashion, or intermingle with the context of the advertisement as to be confusing or misleading; Rule 14 VAC 5-90-90 C by failing to identify the source of any statistics used in an advertisement; 14 VAC 5-216-40 E 2 of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.* of the Virginia Administrative Code, by failing to notify the covered person of its post-service claim review final benefit determination decision within 60 days after receipt of the appeal; 14 VAC 5-400-70 A of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.* of the Virginia Administrative Code, by failing to provide a claim denial to a claimant in writing, Rule 14 VAC 5-400-70 E by failing to reasonably pay claims in accordance with the provisions of the policy, Rule 14 VAC 5-400-100 B by failing to provide to an insured, for accident and sickness claims, an explanation of benefits describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy; and Rule 14 VAC 5-400-100 C by failing to make available a summary of prescription drug claims electronically or provide a written summary at the request of the insured, including a description of the amounts covered under the policy, amounts denied, and amounts payable by the insured and insurer.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting or denying any violation of Virginia law, has made an offer of settlement to the Commission. Through its settlement offer, the Defendant has agreed to complete corrective action items 22, 30, 31, and 32 and provide satisfactory documentation of completion thereof to the Bureau by December 31, 2024, or additional penalties may be assessed by the Bureau. The Bureau further notes that the Defendant, through its settlement offer, timely provided documentation currently under review by the Bureau to demonstrate its completion of corrective action items 1, 4, 7, 8, 14, 15, 26, 28, 29, 34, 35, 37, 39, 40, and 42, has tendered to the Treasurer of Virginia the amount of Two Hundred Thirty-Six Thousand and Nine Hundred Dollars ($236,900); and has waived the right to a hearing.

The Bureau has recommended that the Commission accept the Defendant's settlement offer pursuant to the authority granted to the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered this matter, is of the opinion and finds that the Defendant's settlement offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The Defendant's settlement offer is hereby accepted.

(2) The Commission shall retain jurisdiction in this matter for all purposes, including the institution of a show cause proceeding or taking such other action it deems appropriate on account of any failure on the part of the Defendants to comply with the terms of the settlement.

A COPY hereof shall be sent by the Clerk of the Commission by electronic mail to: Jessica Kearney, Market Conduct, Legal Compliance Senior Manager, Cigna Healthcare Legal & Corporate Affairs, jessica.kearney@cignahealthcare.com; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.