CIGNA Forced to Re-evaluate Long-Term Disability Insurance Claims Handled Between 2008 to 2010, and Set Aside $77 Million to Pay Previously Denied Claims

Following an investigation conducted by the California Department of Insurance via a market conduct examination, as well as insurance regulators from Connecticut, Maine, Massachusetts and Pennsylvania, CIGNA and these states' insurance regulators, reached a settlement over its improper handling of claims for long-term disability ("LTD") insurance. This resulted in a Regulatory Settlement Agreement ("Agreement") between CIGNA and its affiliates and these insurance regulators. The companies involved in the evaluation and settlement include CIGNA Health and Life Insurance Company (formerly known as Alta Health and Life), and Connecticut General Life Insurance Company, Life Insurance Company of North America (collectively, "CIGNA Companies"). In the examinations of CIGNA Companies, insurance department officials found that the CIGNA Companies engaged in numerous claim-handling irregularities, including not giving due consideration to the medical findings of independent physicians, discounting information provided by Social Security Disability decisions and not giving appropriate consideration to Workers' Compensation records.

In addition to paying $500,000 penalty to the California Department of Insurance and $150,000 to reimburse the department for the cost of ongoing monitoring, the CIGNA Companies are settling aside $77 million for projected payments to policyholders potentially nation-wide whose claims were not handled properly. This money is being set aside for claims improperly handled between January 1, 2008 and December 31, 2010.

In addition to paying the fine and re-evaluating previously denied LTD claims, under the Agreement the companies are required to:

- Enhance claim procedures to improve the claims handling process to benefit current and future policyholders.
- Establish a remediation program in which the companies' enhanced claim procedures will be applied to certain previously denied or adversely terminated claims.
- Participate in a 24-month monitoring program, including random sampling and ongoing consultation by the five states' insurance departments.
- Undergo a re-examination upon completion of the monitoring period.
- Pay fines and administrative fees totaling $1,675,000 to the five lead state states.

The "enhanced claims procedures" that the CIGNA Companies must implement include:

- Procedures regarding the weight to be given to awards of Social Security Disability Income benefits;
- Enhanced procedures regarding the gathering of medical information and the documentation of conclusions;

- Guidelines/or Use of External Medical Resources (i.e., following guidelines when utilizing Independent Medical Examinations or Functional Capacity Evaluations and providing claims personnel and outside professionals (such as consulting physicians) with all available medical, clinical and vocational evidence, including both objective and subjective evidence of impairment);
- Ongoing objectives (such as the CIGNA Companies' claim procedures shall include focus on policies and procedures relating to medical and related evidence, as specifically described in the Agreement and clear and express notice to claimants of the information to be provided by the claimants and the information to be collected by the CIGNA Companies);
- Selection of Evaluation Personnel;
- Professional Certification; and
- Providing Medical, Clinical, and/or Vocational Evidence.

The insurance regulators have implemented procedures to ensure that the CIGNA Companies comply with the "enhanced claims procedures" as described above.