

Responses to Objections

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Objection 1

Comment:

Please list and quantify the reasons for the overall rate impact of -3.70%, and explain why policyholders could receive a rate increase/decrease that ranges from -9.70% to 0.10%.

Response:

The overall rate impact of -3.70% represents the weighted average of our proposed actuarial pricing methodology for the state of VT, relative to previously filed and approved pricing. This impact is calculated by comparing the filed and approved manual rates for an illustrative effective date of 1/1/2016 to the proposed manual rates for an illustrative effective date of 1/1/2017 for a representative sample of VT sitused business.

There are three main categories of change that help us analyze the -3.70%: updated rating variables on a 1/1/2017 basis (including area factors and trend), previously filed and approved 2017/2016 trend, and the change in proposed MLR. Please see the table below for more analysis.

Category	Change
Rating Variables	-11.0%
Med+Rx Filed Trend	9.4%
MLR Impact	-1.1%
Total Impact¹	-3.7%

¹Total Impact = (1+Rating Variables) * (1+Med+Rx Filed Trend) * (1+MLR Impact)

Rating Variables: In this proposed filing, we are reflecting reductions to our area factors as a result of our periodic experience rate reviews, which looked at full-year 2015 experience relative to our manual rating expectation. Generally, claims were favorable as compared to the manual, which results into lowering our medical and rx area factors. Secondly, as represented in the filing, we have taken reductions to our trend assumptions relative to previous expectations. Please see the supplemental trend exhibits for more information.

By design of the rate review process, methodology changes are neutralized out at the rating area level, such that the average impact of methodology changes are 0% at the rating area level (i.e. the average manual is aligned to the average experience). However, at the case level methodology changes can cause a difference in manual rating between filings. Additionally, the -3.7% represents the impact to the average VT situs case, which include membership inside and outside of VT. Geographic mix at the case level (e.g. a single account having greater/lower % VT membership) can drive variance to the average. Methodology changes and geographic mix are the main drivers behind the range between the minimum and maximum filed rate changes.

Objection 2

Comment:

As indicated in the actuarial memorandum and evidenced in Table 1, the medical base claims have changed from the last approved filing:

- a. Please explain in more detail about the updates, including but not limited to experience period and data source.
- b. Quantify the impact of updating base medical claim assumptions and the CPD table respectively and their combined effects.

Response:

The updates to base medical claim assumptions, in this year's filing are a mechanical result of rolling forward the base year from 2014 to 2015. The current filed an approved "manual base rates" are based in 2014. The proposed "manual base rates" are based in 2015. Each year, we roll forward the national base medical claims by national trend, and consequently roll off that year of trend from the calculation, i.e. 2015/2014 trend is no longer used in rate calculations. As such, there is no rating impact of this change. There were no changes made to the CPD this filing.

Our rate review process is further used to calibrate the combination of our base rate, methodology, and area factors to our claims experience at the rating area level. The combination of all pricing methodology changes (including area factors and base rates, trend, and retention) result in an overall rate change of -3.70%, as stated in the SERFF.

National methodology changes are analyzed based on Cigna's National book of business, using full year 2015 claims experience, which represents about 58 million member months.

Objection 3

Comments:

Regarding the medical trend assumptions,

- a. Please provide detailed quantitative and qualitative support for them;
- b. Please quantify the impact of updating medical trend assumptions

Response:

a.

Pricing Trend Assumptions

Below provides detail into the buildup of our Vermont pricing trend assumptions for 2016/2015 and 2017/2016.

Vermont In-Network Trend			Vermont In-Network Trend		
2016/2015	Weight	Unit	2017/2016	Weight	Unit
IP ¹	17.7%	4.3%	IP ¹	17.7%	3.0%
OP ²	43.7%	5.7%	OP ²	44.4%	2.8%
Pro ³	25.1%	0.1%	Pro ³	24.0%	2.9%
OMS ³	13.6%	7.2%	OMS ³	14.0%	7.2%
Unit Cost	100.0%	4.2%	Unit Cost	100.0%	3.5%
Util		2.2%	Util		1.9%
Mix		1.2%	Mix		1.2%
Total Trend		7.9%	Total Trend		6.8%

¹ IP (Inpatient) unit trends are created using a weighted average of IP cost per day by facility with that facilities % weight in the market. Weights are calculated using Vermont customers \$ FFS spend . The IP unit cost trend is the year over year comparison of the weighted average IP cost per day . For example: 2016 IP unit cost trend= 2016 IP cost per day/2015 IP cost per day.

² OP (outpatient) unit trends are created using weighted average of OP discounts by facility with that facilities % weight in the market. Weights are calculated using Vermont customers \$ FFS spend The OP unit cost trend is the year over year comparison of the weighted average discounts (more specifically 1- discounts) after normalizing for known differences in billed charges a.k.a charge master trends.

³ Pro (Professional) and OMS (Other Medical Services) unit trends are created in a similar fashion to IP and OP.

Historical Claims Experience for Vermont

Vermont Monthly Medical Claims Experience		
Incurring Month (YYYYMM)	Incurring Claims	Members
201401	\$11,717,742	38,104
201402	\$10,695,582	37,894
201403	\$11,091,401	37,874
201404	\$11,143,853	37,912
201405	\$12,194,115	37,364
201406	\$11,169,364	37,337
201407	\$12,003,806	36,986
201408	\$10,649,623	37,028
201409	\$11,613,918	36,987
201410	\$12,535,190	36,941
201411	\$10,986,846	36,013
201412	\$13,885,459	36,068
201501	\$11,055,548	35,775
201502	\$9,347,812	35,627
201503	\$12,019,499	35,607
201504	\$12,111,415	35,626
201505	\$12,254,541	35,506
201506	\$12,751,583	35,425
201507	\$12,725,351	35,262
201508	\$10,591,326	35,102
201509	\$11,608,054	35,058
201510	\$12,900,988	34,828
201511	\$12,354,168	34,692
201512	\$14,148,749	34,542
201601	\$10,453,674	35,627
201602	\$11,148,123	35,533
201603	\$12,008,461	35,680
201604	\$10,907,825	35,498
201605	\$11,880,538	35,323
201606	\$11,774,433	35,312
201607	\$12,193,718	37,235
201608	\$13,162,975	37,193
201609	\$12,734,749	37,025
201610	\$13,646,506	37,096
201611	\$0	0
201612	\$0	0

The table above represents three years of historical monthly claims experience for Vermont. We've also provided the monthly view of membership. The membership displayed here will not agree with the membership provided in the SERFF because this membership represents members who reside in VT for all funding types and the membership displayed in the SERFF represents the members who are situated in VT for fully insured products only. This information is not normalized for demographics or plan design.

Below is a summarized view of trend and normalized trend. The normalization factor represented below includes benefit changes, demographics and geographies. **Benefit changes** measures the impact of plan design changes on Cigna's observed trend. To compute this adjustment, we compare the manual community rates for the plan designs in the two periods. Note that we use the same demographic and geographic distribution of the population to ensure we are isolating out only the effect of plan design changes. **Demographics** measures the impact that changes in age/gender has on Cigna's observed trend. To compute this adjustment, we compare the manual rating age/gender factors for the populations in the two periods. **Geographies** measures the impact that changes in the geographic distribution of customers has on Cigna's observed trend. To compute this adjustment, we compare the manual rating geographic factors for the population in the two periods

The following calculation is based on normalizing an open block of business. Normalizing an open block can cause some volatility and this view alone is not directly comparable to our prospective trend story. We rely heavily on our knowledge of our unit cost position and forecasting in the market to set an appropriate prospective trend.

Vermont Medical Trends	FY 2014 PMPM	FY 2015 PMPM	15/14 Trend	3Q15 YTD PMPM	3Q16 YTD PMPM	16/15 Trend
Total Observed (Net) Trend	\$ 313	\$ 340	8.7%	\$ 313	\$ 340	8.5%
Normalization Factor			-0.6%			0.2%
Total Normalized (Gross) Trend			9.3%			8.3%

Please see more information in the “CONFIDENTIAL – VT 2017 Supplemental Trend Info” workbook.

- b. Please see below the analysis of the change in medical trend assumptions for the 2016/2015 trend and 2017/2016 trend:

Trend Filing Impact		
Filing Year	2016/2015	2017/2016
2016	8.9%	8.9%
2017	7.9%	6.8%
Medical Trend impact²		-2.8%

²Medical Trend impact = $((1+0.079)*(1+0.068))/((1+0.089)*(1+0.089))-1$

Objection 4

Comments:

As indicated in the actuarial memorandum, the methodology for rating pharmacy benefits has significantly changed.

- a. Please provide a summary of the major changes from the last approved filing, and explain the reasons for these changes;
- b. We have noticed a few new formulary types listed in the current filing. What are the reasons for the new formulary types, and how are they mapped to the current formulary types?
- c. How are the data for mail order drugs being reported and trended?
- d. What are the overall pharmacy cost and utilization trend for 2016 and 2017 respectively? Please provide a comparison of the pharmacy trends to those used in the last approved filing and explain in more details the driving forces of the changes in the pharmacy trend assumptions.

Response:

a. Summary of major changes:

- Reduction of product difference by platform: In the last approved filing, there were a series of tables that had separate assumptions for the FACETS and non-FACETS platforms. There are no longer substantial product differences between the two claim platforms so it is unnecessary to have separate pricing assumptions. These changes impact the following sets of tables:
 - i. Retail and Mail Order AWP per Script Assumptions
 - ii. Retail and Mail Order Discounts and Dispensing Fees
 - iii. Retail and Mail Order Script Count PMPY Assumptions
- Combined the AWP per script and annual script count per member assumption tables: In the last approved filing, there are separate base AWP per script and annual script count per member assumptions for both Retail and Mail-Order Delivery for each formulary. Since the last filing, however, Cigna's Retail 90 – a service allowing customers to fill up to a 3 month prescription at a Retail pharmacy – has grown significantly. To accurately rate for scripts filled in this channel, we revised the existing methodology to better incorporate the cost impact of adopting Retail 90. It was determined that the best course of action was to have one AWP per script assumption table and one script count per member assumption table where all scripts are assumed to be a 30-day supply. These single assumption tables are allocated to the different distribution channels (Retail 30, Retail 90, and Mail-Order), varying by the client's plan design. For every three 30-day supply prescriptions allocated to the mail order and retail-90 channels, only 1 90-day prescription is assumed to be filled.
- Updated the methodology for clinical programs (i.e. clinical management and global step therapy):
 - i. In the last approved filing, clinical program savings were captured through a decrement applied to the calculated expected pharmacy claims. In the new filing, the savings are captured through a set of assumptions that shift high cost non-preferred brand scripts to lower cost generic scripts. This new methodology was calibrated to produce similar savings to the prior decrements.

- Introduced separate trend assumptions for Generic, Brand, and Specialty drugs:
 - i. In the last approved filing, there is only a single cost and a single unit trend assumption for pharmacy. Historic pharmacy trends, however, show material differences in trend for Generic, Brand, and Specialty drugs. Because of this observation, separate trend assumptions are introduced for each drug type (i.e. Generic, Brand, Specialty).
- b. See the table below with the appropriate formulary mappings:

New Filing	Old Filing
Legacy	Legacy
Standard	Standard
Performance	Performance
Value	Value
Advantage	Advantage
Value DRT	Value DRT
Advantage DRT	Advantage DRT
Generics Only	Generics Only
Performance 4Tier	Performance
Advantage 4Tier	Advantage

Neither the Performance 4 Tier nor the Advantage 4 Tier drug lists are new. These drug lists simply have a different tiering structure than what is offered on the performance and advantage drug lists respectively. Note that the drug lists were outlined in two separate tables in prior filings – one for the Facets platform and one for the non-Facets platform.

- c. The base AWP/script and script count PMPY tables are on a 30-day supply basis. The base tables reflect utilization across all channels (retail-30, retail-90, mail order). For every 3 30-day prescriptions allocated to the mail order channel, 1 mail order script is assumed. Trend assumptions do not vary by channel.

d.

Pharmacy Trend Assumptions

The chart below outlines the current trend factors needed to adequately price the pharmacy benefit.

	2016/2015	2017/2016
Cost Trend	9.00%	10.00%
Utilization Trend	1.80%	1.70%
Total Trend	11.00%	11.90%

Pharmacy trends are composed of several pieces:

1. Cost trend: the change in the average ingredient cost per script of drugs due to:
 - i. Inflation – the change in cost per unit for medications used in both the base period and current period, isolating against changes in days’ supply and mix shift.
 - ii. Mix shift – the change in cost due to patients filling different medications in the current period vs. the prior period. This is caused by a loss of exclusivity (patent expirations) which results in a shift from brand utilization to generic utilization,

as well as a shift in utilization from existing generic medications to new generics after patent expirations.

- iii. Pipeline – The approval and launch of pipeline drugs causes a shift in utilization from older therapies to novel therapies and causes the emergence of new claims from previously untreated populations.

2. Utilization trend: the change in the number of prescriptions filled on a PMPM basis
Pharmacy trends continue to remain elevated as a result of the proliferation of high cost specialty medications. Specifically, Rheumatoid Arthritis and Multiple Sclerosis medications have significant price increases and the expected utilization of new specialty medications used in the treatment of cancer will result in specialty trends holding around 20%. The chart below outlines our expectations for specialty and non-specialty trends.

Trend Category	2016/2015	2017/2016
Specialty	19.90%	21.70%
Non-Specialty	8.80%	8.80%
Total Trend	11.00%	11.90%

Non-specialty trends are expected to remain the same year-over-year. Although many brand medications continue to see significant cost-per-script increases, efforts made to better manage our drug lists to steer customers to the lowest cost drug should result in overall consistent non-specialty trends.

Actual observed trend for 2015, and YTD 2016 was 11.1% and 6.2% respectively. Observed trends vary from pricing trends due to a variety of reasons including but not limited to changes in benefits and/or plan designs, demographics, and geographies. Normalizing for some of these factors would cause the observed trend to shift upwards .

Observed (raw and/or normalized) historical trends are not directly comparable to prospective pricing trend. We rely heavily on our knowledge of our unit cost position and forecasting the components mentioned above to set an appropriate prospective trend.

Objection 5

Comments:

Provide the derivation of the projected federal MLR for 2017, starting with your target loss ratio.

Response:

Projected MLR	85.6%
+ Risk Charge	0.2%
- TPV Admin	-1.1%
+ QI Expenses	0.2%
+ PPACA Fees	0.0%
+ Premium Tax	1.8%
+ Fed Income Tax	2.3%
Federal MLR	89.0%

The following assumptions apply to the projected federal MLR for 2017:

- Risk charges are a component of policy holder product design within the shared returns product. If a clients' claims experience runs at or better than set expectations inclusive of the risk charge, the client shares in the favorable experience up to 100%.
- Third Party Vendor administrative expenses are a deduction from the claims in the federal MLR. Assumption of 1.1% of premium based on final 2015 results.
- QI expenses assumed to be 0.14% of premium, based on final 2015 results.
- PPACA fee assumptions:
 - o Reinsurance PMPM of \$0 since the reinsurance assessment is only applicable from 2014 through 2016
 - o HII Fee set to 0% of premium due to the 2017 HII fee suspension
- Premium tax of 2.0% based on VT historical results
- Federal income tax is based on a 35% tax rate adjusted for non-tax deductibility of HII fee.

Objection 6

Comments:

Please explain any significant changes in the retention assumptions, and explain how the retention assumptions in this filing compare to experience.

Response:

	Prior	Proposed	Change
Administrative Expenses	6.0%	6.4%	0.4%
Optional Buy-ups	0.6%	0.6%	0.0%
PPACA Fees	3.5%	0.0%	-3.5%
Risk Charge	0.4%	0.2%	-0.2%
Premium and Income			
Taxes	2.0%	2.0%	0.0%
State Assessments	1.5%	1.4%	-0.1%
Commissions	0.4%	0.3%	-0.1%
Profit	1.0%	3.5%	2.5%
Total	15.4%	14.4%	-1.0%
MLR	84.6%	85.6%	

Significant Changes:

- **PPACA Fees:** PPACA fees decreased due to decrease of Reinsurance and Health Insurance Industry Fees to 0% for 1/1/2017 quotes. Accounts with coverage that includes months in the 2018 calendar year will be prorated with 2018 Health Insurance Industry Fees. The Health Insurance Industry Fee is 0% of premium for 2017 calendar months and 3.5% of premium for 2018 calendar months.
- **Profit:** Per the requirement of the GMCB, the profit assumption in our filed and approved rating methodology is 1.0%. In this proposed filing, we are re-submitting assumptions for retention which includes a profit assumption of 3.5% (consistent the assumption used in all non-VT filings). Please see reference to Cigna's position regarding this assumption in the below link:

http://ratereview.vermont.gov/sites/dfr/files/2016/Other/GMCB_001_16rr/Cigna%20Motion%20of%20Consideration.pdf

CHLIC did not pay a rebate in 2014 or 2015 and does not anticipate paying a rebate in 2016 or 2017.