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Baltimore
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January 10, 2018

Matthew D. Danziger, FSA, MAAA
Actuarial Director
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, CT 06002

Re: Cigna Health and Life Insurance Company
Company NAIC # 67369; FEIN # 59-1031071
VT - Cigna LG Major Medical Filing 2018
SERFF Tracking # CCGP-131268605

Dear Mr. Danziger:

Lewis & Ellis, Inc (L&E) have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced Large Group product filing submitted on 12/29/2017. Upon review of the actuarial memorandum and related information submitted, the following additional information is needed:

1. While the overall rate impact is 6.20% with a minimum of 1.90% and a maximum of 9.70% rate increase, for each of the three fully insured accounts sitused in VT respectively, please explain the following:
    a. What are the member months, overall rate impact and range of rate increases for each of the accounts?
    b. For any account with partial credibility, please provide their recent four years' historical claim experience in VT. At a minimum, this should include incurred claims, earned premiums, and loss ratios.
2. Please provide a breakdown of the 6.20% overall rate impact by major category of change, as well as the additional support for each of the components included in the breakdown. Please make sure to include the source of any figures, if they were from a prior year's filing, or

otherwise provide the derivation of them with information that can be traced back from prior years' filings.

3. Please provide detailed qualitative and quantitative support for the medical utilization trend.
4. Please explain in more details the updates made to medical claims probability distribution.
5. As indicated in "Changes to Methodology for the 2018 Cigna Rate Filing", the enhanced non-par claims adjustment has been updated; however, we see that an adjustment factor of 0 was shown in table 32 for VT, which is the same as last year. Please clarify.
6. What are the reasons of using a different utilization dampening methodology and formula? What impact will this change have on pricing?
7. Provide the derivation of the projected federal MLR for 2018, starting with the target loss ratio.
8. Please explain any significant changes in the retention assumptions, in particular the risk charge and the decrease in admin expense assumptions, and explain how the retention assumptions in this filing compare to experience.

Please respond no later than January 17, 2018.

Our review of filing will be placed in suspense pending your response. Contact me if you have any questions.

Sincerely,

Xiaoxiao Lisa Jiang, FSA, MAAA
Consulting Actuary
Lewis & Ellis, Inc.
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Responses to Objections

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Objection 1

Comment:
While the overall rate impact is 6.20% with a minimum of 1.90% and a maximum of 9.70% rate increase, for each of the three fully insured accounts sitused in VT respectively, please explain the following:

a) What are the member months, overall rate impact, and range of rate increases for each of the accounts?
b) For any account with partial credibility, please provide their recent four years' historical claim experience in VT. At a minimum, this should include incurred claims, earned premiums, and loss ratios.

Response:
The overall rate impact of 6.20% 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 1/1/2017 to the proposed manual rates for an illustrative effective date of 1/1/2018 for a representative sample of VT sitused business. Within this representative sample of VT-sitused clients, only 3 clients are fully insured as reported in the Supplemental Healthcare Exhibit (SHCE). The minimum of 1.90% and maximum of 9.70% are the minimum and maximum rate increase for the representative sample.

The three fully insured accounts sitused in VT have the following properties:

Account	Member Months	Rate Increase Requested
(1)	3,019	4.7%
(2)	3,372	9.0%
(3)	2,332	6.5%
Total	**8,723**	**6.9%**

For a look at historical incurred claims, earned premiums, and loss ratios, please refer to the VtExh exhibit that we submitted with the original filing (reattached below).

CGLIC and CHLIC Combined

Vermont (in 000s)

	Earned Premium	Incurred Losses	Loss Ratio
5th prior year 2013	$27,866	$22,860	82.0%
4th prior year 2014	$15,241	$10,215	67.0%
3rd prior year 2015	$12,131	$9,786	80.7%
2nd prior year 2016	$4,366	$3,165	72.5%
1st prior year 2017	$4,131	$3,640	88.1%

2017 SHCE is not available yet. 2017 is projected based on current filed and approved methodology

Objection 2

Comment:
Please provide a breakdown of the 6.20% overall rate impact by major category of change, as well as the additional support for each of the components included in the breakdown. Please make sure to include the source of any figures, if they were from a prior year's filing, or otherwise provide the derivation of them with information that can be traced back from prior years' filings.

Response:
The overall rate impact of 6.20% 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 1/1/2017 to the proposed manual rates for an illustrative effective date of 1/1/2018 for a representative sample of VT sitused business.

There are three main categories of change that help us analyze the 6.2%: updated rating variables on a 1/1/2018 basis (including area factors and trend), previously filed and approved 2018/2017 trend, and the change in proposed MLR. Please see the table below for more analysis.

Category	Change
Rating Variables	-6.5%
Med+Rx Filed Trend	7.8%
MLR Impact	5.4%
Total Impact[1]	**6.2%**

[1]Total 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 2016 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. However, at the case level methodology changes can cause a difference in manual rating between filings. Additionally, the 6.2% 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.

Med+Rx Filed Trend: This number is the filed and approved trend that was submitted within last year's filing.

MLR Impact: Please refer to Objection 8 below for the changes from the prior filing to the current filing. The major changes include increasing the PPACA fee charges from 0% to 3.0%, and increasing the profit requested from the mandated 2.0% (approved profit margin in last year's filing) to 3.5%.

The above view is helpful, in that, it demonstrates that ‘point-in-time’ (i.e. excluding the baseline impact of previously approved trend), the requested change in our premium rating is (1+-6.5%)*(1+5.4%) = -1.5%. As noted, our filing includes previously approved trends to illustrate the year over year change with 12 months of trend, which yields +6.2%.

Objection 3

Comments:

Please provide detailed qualitative and quantitative support for the medical utilization trend.

Response:

Medical Utilization and Mix(i.e. severity) trend is set nationally through a retrospective study of our closed block of business coupled with knowledge of prospective factors such as national and local initiatives which aim to lower utilization, leading indicators such as drugs which treat influenza, industry trends, as well as competitive insights from trend studies that assess the relative competitiveness of our pricing trend.

Note: While we have historically separated utilization and mix in illustrative exhibits we combine them in factor development.

Nationally, our 2018 medical pricing trend is unchanged from prior filings at 7.0%
The calculation for trend is as follows:

$$(1 + Total\ Trend) = (1 + Unit\ Cost\ Trend) * (1 + Utilization\ \&\ Mix\ Trend)$$
$$(1 + Total\ Trend) = (1 + 4.1\%) * (1 + 2.8\%)$$
$$(Total\ National\ 2018/2017\ Trend) = 7.0\%$$

At the local level, we account for differences in local vs. national initiatives that serve to deflect the utilization/mix trend. Examples of these initiatives include but are not limited to

- Expand and enhance our collaborative accountable care relationships
- Expand savings opportunities for out of network claims
- Expand our national laboratory network
- Expand clinical reviews pre-service to ensure appropriate and efficient care
- Provide improved guidance on
  - High cost specialty injections to clinically appropriate, affordable settings
  - High tech radiology to clinically appropriate, affordable settings
  - Appropriate use of ER versus urgent care versus convenience care clinics

For Vermont, the value of these initiatives is ~0.4% less than the national impact. This yields a utilization trend pick for VT of ~3.2%. Vermont's unit cost trend is 3.4% as detailed in the filed supplemental exhibit. Total 2018 Trend for Vermont is then calculated as 6.8% for 2018/2017 trend.

$$(1 + Total\ Trend) = (1 + Unit\ Cost\ Trend) * (1 + Utilization\ \&\ Mix\ Trend)$$
$$(1 + Total\ Trend) = (1 + 3.4\%) * (1 + 3.2\%)$$
$$(Total\ Vermont\ 2018/2017\ Trend) = 6.8\%$$

Objection 4

Comments:
Please explain in more details the updates made to medical claims probability distribution.

Response:

The medical claims probability distribution was updated using full year 2016 claims data. The review of the CPD updates the frequency and severity of claim experience within each claim bucket in the distribution. The methodology used involving the CPD has not changed, just the underlying data. The changes in the CPD generally flatten the cost share curves such that leaner plan designs are expected to have a relatively higher manual cost and rich plan designs are expected to have a relatively lower manual cost compared to the prior file and approved CPD.

As previously mentioned in objection 2, 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.

Objection 5

Comments:
As indicated in "Changes to Methodology for the 2018 Cigna Rate Filing", the enhanced non-par claims adjustment has been updated; however, we see that an adjustment factor of 0 was shown in table 32 for VT, which is the same as last year. Please clarify.

Response:

The "Changes to Methodology for the 2018 Cigna Rate Filing" portion of the actuarial memorandum highlights any changes to our national methodology. We conducted a review across all markets regarding enhanced non-par claims. In compliance with Rule H-2009-03, Cigna does not offer enhanced non-par benefits in VT due to the possibility of balance billing. Therefore, this is factor is not applicable. As noted, there is no change in this table for VT and the factor is 1.0 (0). Please refer to Table 33 for a state-by-state analysis of the enhanced non-par claims adjustment.

Objection 6

Comments:
What are the reasons of using a different utilization dampening methodology and formula? What impact will this change have on pricing?

Response:

The coefficients in the formula were updated using full year 2016 claims data. The methodology changes result in more severe utilization dampening factors such that those with leaner benefits are expected to utilize fewer services, lowering their manual rates, and those with richer benefits utilize more services and raise their rates. This is particularly notable for ER services, which previously did not have any utilization dampening factors. The formula changes are stylistic and have no impact on rates. As previously mentioned in objection 2, 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.

Objection 7

Comments:
Provide the derivation of the projected federal MLR for 2018, starting with your target loss ratio.

Response:

Projected MLR	**83.6%**
- TPV Admin	-0.4%
+ QI Expenses	0.2%
+ PPACA Fees	2.6%
+ Premium Tax	1.6%
+ Fed Income Tax	1.4%
Federal MLR	**89.0%**

The following assumptions apply to the projected federal MLR for 2018:

- Third Party Vendor administrative expenses are a deduction from the claims in the federal MLR. Assumption of -0.4% of premium based on final 2016 results.

- QI expenses assumed to be 0.19% of premium, based on final 2016 results.

- PPACA fee assumptions:
    - Reinsurance PMPM of $0 since the reinsurance assessment is only applicable from 2014 through 2016
    - HII Fee set to 3.0% of premium due to the 2018 HII fee suspension

- Premium tax of 1.8% based on VT historical results

- Federal income tax is based on a 21% tax rate adjusted for non-tax deductibility of HII fee.

Objection 8

Comments:
Please explain any significant changes in the retention assumptions, in particular the risk charge and the decrease in admin expense assumptions, and explain how the retention assumptions in this filing compare to experience.

Response:

	Prior	Proposed	Change
Administrative Expenses	5.4%*	4.8%	-0.6%
Optional Buy-ups	0.6%	0.1%	-0.5%
PPACA Fees	0.0%	3.0%	3.0%
Risk Charge	0.2%	0.8%	0.6%
Premium and Income Taxes	2.0%	2.0%	0.0%
State Assessments	1.4%	1.3%	-0.1%
Commissions	0.3%	0.9%	0.6%
Profit	2.0%	3.5%	1.5%
Total	**11.9%**	**16.4%**	**4.5%**
MLR	88.1%	83.6%	

Significant Changes:

- Administrative expense*: Note: Prior year target loss ratio above is 1% higher than last year's filed target loss ratio due to actual lower 2017 admin expenses than erroneously documented in prior filings. The core change of 5.4% to 4.8% is mostly due to fundamentally lower administrative expenses.

- Risk Charge: 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%. Due to the shrinking book, we have seen a proportional shift to more Shared Returns member months in the three accounts in this year's filing as compared to the twelve accounts in last year's filing. In the calendar year 2015, there was one account that had a shared returns product out of the twelve fully insured accounts. In calendar year 2016, there was still one account that had a shared returns product out of three fully insured accounts, therefore increasing the proportion of members allocated to the shared returns product. The change in this component is due to mix rather than a fundamental change in the factor.

- Profit: Per the requirement of the GMCB, the profit assumption in our filed and approved rating methodology is 2.0%. In this proposed filing, we are re-submitting assumptions for retention which includes a profit assumption of 3.5% (consistent with our requested profit in prior 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%20for%20Consideration.pdf

It should be noted that due to the size of Cigna's book of business, historic loss ratio and profitability results should not be considered credible. Loss ratios are not used as a basis for adjusting rates. Actuarially, 95% of cohorts with ~10,000 MMOS(830 lives) are expected to result in a loss ratio within +/- 29.3% of the expected loss ratio. In 2016, our filed target loss ratio was 84.6%, which with experience of 8,759 MMOs, would result in an expected loss ratio between 55.3% and 113.9%. As shown within Objection 1, the actual VT loss ratio results have been within that expected volatile range.

CHLIC did not pay a rebate in 2015 or 2016 and does not anticipate paying a rebate in 2017 or 2018.