January 29, 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:

Thank you for your responses. We have the following additional questions regarding this filing:

1. Your response to objection #1 (dated 01/10/2018) indicates that the overall rate increase requested for the total 8,723 member months is 6.9%, which differs from the 6.2% weighted average rate impact as filed. Please explain why and how these two figures would differ.
2. For the three accounts currently in-force in VT, please provide their recent four years' historical claim experience **respectively** in VT. At a minimum, this should include incurred claims, earned premiums, and loss ratios. Please also indicate the credibility of their VT experience.
3. Of the -6.5% impact as a result of updating rating variables on a 1/1/2018 basis, please confirm if any, or all, of the following are the major contributing forces:
    - medical area factors,
    - medical trend,
    - Rx area factors, and
    - Rx trend

If so,

a) for **each** of the above, please specify the pricing impact of updating the factors and provide a detailed quantitative derivation of the pricing impact based on the past two years' approved trend factors.

b) Please illustrate how the -6.5% is derived from the four components included in part a).

4. The utilization trend seems to be on the high end of what we've seen in the large group market. Please provide detailed qualitative and quantitative support for the 2.8% national utilization & mix trend, as well as the historical utilization trend over the past four years (national and VT-only respectively).
5. Please provide additional support for the increase in commission as a percentage of premium, and explain how it is compared to experience.
6. What is the projected profit for the block of Large Group for 2017? Please make sure that the figure will be reasonably backed up by the forthcoming 2017 annual statement.

Please respond no later than February 5, 2018.

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

Sincerely,

Xiaoxiao Jiang

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Consulting Actuary
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<u>Responses to Objections</u>

Contents

Preface

In responding to these objections, we identified an accounting error that resulted in the omission of two fully insured VT sitused accounts from our originally submitted filing. As a result, we are resubmitting all documents that are affected within the filing to account for the addition of these 2 fully insured accounts. Individual components that have changed have been highlighted within the following documents:

- VT 2018 SERFF_restatement
- CHLIC – VTactuarial memo_restatement
- CHLIC-VTexh_restatment

Within these documents, the main categories of change from the original submitted filing are:

- Fully Insured VT Sitused Accounts: 3→5
- Fully Insured VT Sitused MMOS: 8,759→12,271
- 2016 Realized Loss Ratio (CHLIC + CGLIC): 72.5%→85.4%
- 2017 Expected Loss Ratio: 88.1% prior approved target → 127.3% YTD actual
- Requested Rate Change 6.2%→5.8%

Category	Original	Resubmission
Rating Variables	-6.5%	-6.5%
Med+Rx Filed Trend	7.8%	7.8%
MLR Impact	5.4%	5.0%
Total Impact	**6.2%**	**5.8%**

The change to the requested rate is driven by a change to the 2018 target loss ratio. This change is exclusively due to mix of accounts, which is described below.

- Target Loss Ratio (83.6%-->83.9%)

	Original Submission	Restated Submission	Impact of Resubmission
Administrative Expenses	4.8%	5.0%	0.2%
Optional Buy-ups	0.1%	0.1%	0.0%
PPACA Fees	3.0%	3.0%	0.0%
Risk Charge	0.8%	0.5%	-0.3%
Premium and Income Taxes	2.0%	2.0%	0.0%
State Assessments	1.3%	1.3%	0.0%
Commissions	0.9%	0.7%	-0.2%
Profit	3.5%	3.5%	0.0%
Total	**16.4%**	**16.1%**	**-0.3%**
MLR	83.6%	83.9%	

Note: The changes to the proposed target loss ratio are exclusively due mix (i.e. the proportion of the Shared Returns product within our small fully insured book of business). As described in Objection 1, Question 10, there is now 1 of the 5 fully insured accounts(previously 1 of 3) that has elected this product design feature.

Objection 1

Comment:
Your response to objection #1 (dated 01/10/2018) indicates that the overall rate increase requested for the total 8,723 member months is 6.9%, which differs from the 6.2% weighted average impact as filed. Please explain why and how these two figures would differ.

Response:

In short, these figures differ because they represent different samples of accounts. The prior objection 1, requested detail for only the 3 fully insured accounts, whereas the 6.2% represented all accounts within our representative VT sample.

Per the preface, the restated requested rate increase is 5.8%. As a reminder, this is calculated based upon a representative sample of the VT sitused book of business which includes both fully insured as well as self-insured cases. In our representative sample, there are 80 cases total, 5 of which are fully insured. The addition of the ASO cases adds credibility/stability to the smaller fully insured VT sitused book of business. Theoretically, given there are no differences in the demographics, geographic, or benefit makeup of a self-funded case vs. fully insured case, the inclusion of both in the impact calculation adds credibility and is “representative” of a VT sitused population.

Below are revised details for the fully insured population only. As stated, the weighted average of the entire representative sample is 5.8%, whereas the 5 fully insured accounts only average to 6.3%.

Account	Member Months	Rate Increase Requested	Credibility
(1)	3,019	4.3%	57.9%
(2)	3,372	8.6%	61.2%
(3)	2,332	6.0%	46.0%
(4)	2,018	8.8%	47.4%
(5)	1,494	2.5%	40.7%
Total	**12,235**	**6.3%**	

Objection 2

Comment:
For the three accounts currently in-force in VT, please provide their recent four years' historical claim experience **respectively** in VT. At a minimum, this should include incurred claims, earned premiums, and loss ratios. Please also indicate the credibility of their VT experience.

Response:
The most recent four years' experience for the 5 fully insured accounts is as follows:

Year	2013			2014		
Account	Premium	Claims	Loss Ratio	Premium	Claims	Loss Ratio
(1)	430,370	227,510	52.9%	2,591,710	1,993,440	76.9%
(2)	1,142,483	784,347	68.7%	1,457,765	628,814	43.1%
(3)	-	-	0.0%	-	-	0.0%
(4)	574,094	726,904	126.6%	667,964	552,604	82.7%
(5)	-	-	0.0%	-	-	0.0%
Total	2,146,947	1,738,761	81.0%	4,717,439	3,174,858	67.3%

Year	2015			2016		
Account	Premium	Claims	Loss Ratio	Premium	Claims	Loss Ratio
(1)	2,623,298	2,223,567	84.8%	1,927,908	1,091,781	56.6%
(2)	1,513,308	989,534	65.4%	1,662,764	1,595,226	95.9%
(3)	554,812	670,669	120.9%	788,756	701,034	88.9%
(4)	727,962	651,555	89.5%	788,735	947,332	120.1%
(5)	681,587	694,749	101.9%	880,961	727,356	82.6%
Total	6,100,967	5,230,074	85.7%	6,049,125	5,062,729	83.7%

Please reference Response 1 above for MMOs and Credibility for each account within 2016. As stated in Objection Letter 1, Response 8, a cohort of business with ~10,000 MMOs should fall within +/- 29.3% of the expected loss ratio with 95% confidence. Given the case size of these accounts, we would expect normal variation to be the reason that the loss ratios vary by the amount shown above.

Objection 3

Comments:
Of the -6.5% impact as a result of updating rating variables on a 1/1/2018 basis, please confirm if any, or all, of the following are the major contributing forces:

- Medical area factors,
- Medical trend,
- Rx area factors,
- Rx trend

If so,

a) For **each** of the above, please specific the pricing impact of updating the factors and provide a detailed quantitative derivation of the pricing impact based on the past two years' approved trend factors
b) Please illustrate how the -6.5% is derived from the four components included in part a).

Response:
Below is a breakdown of the -6.5% impact and its primary contributing factors. As discussed, the -6.5% is representative of VT sitused cases; which is comprised of 57% VT residents and 43% non-VT residents. The -6.5% impact breaks down into a -7.2% VT resident rating change and a -5.7% non-VT resident rating change. The factors listed are studied at the rating area (i.e. resident level).

For Vermont residents, the -7.2% is driven by the following primary forces:

- Medical Area Factor (AF) Change : -5.5%
- Medical Trend Change: -0.3%
- Pharmacy Area Factor Change: -7.6%
- Pharmacy Trend Change: -6.2%

Note: Generally Pharmacy makes up approximately 20% of the total rate.

$$VTresident\Delta = [80\% * (1 + MedAF\Delta) * (1 + MedTrend\Delta) + 20\% * (1 + RxAF\Delta) * (1 + RxTrend\Delta)] - 1$$
$$-7.2\% = [(1 - 5.5\%) * (1 - 0.3\%) * 80\% + (1 - 7.6\%) * (1 - 6.2\%) * 20\%] - 1$$

Non-VT residents changes are similar in magnitude in the categories listed above. The total change formula and calculation is below:

$$Total\ change = \%VTresidents * VTchange + \%Non - VTresidents * Non - VTchange$$
$$-6.5\% = 57\% * -7.2\% + 43\% * -5.7\%$$

Below are the filed and approved trends for medical and Rx from the most recent filing, and filed trends from this filing:

Medical Trend			
	2017/2016	2018/2017	Total
Filed & Approved April 2017	6.8%	6.8%	14.1%
Filed December 2017	6.5%	6.8%	13.7%
Trend Change	**-0.3%**	**0.0%**	**-0.3%**
Pharmacy Trend			
	2017/2016	2018/2017	Total
Filed & Approved April 2017	11.9%	11.9%	25.2%
Filed December 2017	7.4%	9.4%	17.5%
Trend Change	**-4.0%**	**-2.2%**	**-6.2%**

Objection 4

Comments:
The utilization trend seems to be on the high end of what we've seen in the large group market. Please provide detailed qualitative and quantitative supports for the 2.8% national utilization & mix trend, as well as the historical utilization trend over the past four years (national and VT-only respectively).

Response:

As discussed in Objection Round 1, Question 3, Medical Utilization and Mix(i.e. severity) trend is set nationally through a combination of multiple factors including retrospective study of our closed block of business, 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.

We participate in consultant trend surveys that compile 2018 national pricing trend from major national carriers. The survey revealed that large group competitor's 2018 trend submissions range from ~6% to ~14% for the "OAP/PPO-like "products, with an average of ~9% Our pricing trend falls below that average and at the lower end of the range.

We don't think it's prudent to compare utilization trends between us and our competitors, as we may define unit and utilization trend in different ways. For example, we include mix & severity to capture the shift in services toward more high cost procedures (e.g. x-ray→MRI) in our utilization/mix trend pick, whereas our competitors may bucket that severity into unit. A second example, is utilization metrics are not consistently defined. Metrics such as changes in services, bed days, prescriptions, visits, claim counts, or episodes of care are all reasonable and rationale ways to define utilization but may provide different answers.

We request and recommend that L&E focus on our total trend. As shown in our supplementary exhibits, the normalized gross trend for VT residents for 17/16 was 12.6%. Previous 3 years averaged 9.4% with significant volatility given Cigna's small market share. Our requested total pricing trend falls significantly below these figures at 6.8%.

Objection 5

Comments:
Please provide additional support for the increase in commission as a percentage of premium, and explain how it is compared to experience.

Response:

Commissions are a pass-through expense on behalf of the client to account for the agreement that the client made with their broker to retain them for their broker services. Commissions to brokers are only paid as part of the premium within our Shared Returns product offering. As mentioned in Objection Letter 1, Response 8, due to the shrinking book, we have seen a proportional shift to more Shared Returns member months due to the restated five fully insured accounts in this year's filing as compared to the twelve fully insured accounts in last year's filing. Similar to the risk charge component, the change in the commissions % is due to mix rather than a fundamental change in the factor or its use.

Objection 6

Comments:
What is the projected profit for the block of Large Group for 2017? Please make sure that the figure will be reasonably backed up by the forthcoming 2017 annual statement.

Response:

As discussed in prior years, our 2017 Annual NAIC Supplemental Healthcare Exhibit won't be available until April 2018. Given preliminary cuts from similar data sources we expect FY2017 financials to show the following:
Premium: $3.7M
Claims: $4.7M
Loss Ratio: 127.3%
Gross Margin(pre-expenses): -$1.0M
% profit(pre-expenses) = -27.3%

If we assume expenses account for ~10% of premium, similar to last year's filed expense ratio excluding profit, we will see a before tax loss of about -37.3%.

In addition, please note the following result from the 2016 Supplemental Healthcare Exhibit
Premium: $5.9M
Claims: $5.1M
Loss Ratio: 85.4%
Realized Profit(including expenses): $0.1M
Realized Profit %: 1.3%

VERMONT FILING SUMMARY
CGLIC/CHLIC Combined

Vermont (only)
(000's)

	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	$5,912	$5,048	85.4%
1st prior year 2017	$3,663	$4,665	127.3%

Countrywide
(000's)

	Earned Premium	Incurred Losses	Loss Ratio
5th prior year 2013	$5,572,915	$4,658,535	83.6%
4th prior year 2014	$5,401,277	$4,451,450	82.4%
3rd prior year 2015	$5,594,394	$4,587,931	82.0%
2nd prior year 2016	$5,833,712	$4,853,289	83.2%
1st prior year 2017	$5,445,769	$4,694,253	86.2%

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

EXHIBIT I

ACTUARIAL MEMORANDUM AND CERTIFICATION

Scope and Purpose
The purpose of this filing is to submit CIGNA Health and Life Insurance Company's group manual rating methodology. Our pricing model was developed to provide a consistent rating methodology across products. This filing includes Open Access Plus, PPO, Network, Indemnity, and retiree medical insurance product, and is applicable for groups of 100 or more lives. Methodology is also included for Pharmacy products.

Benefit Description
The benefits covered in this memorandum include group health insurance coverage as described in CIGNA Health and Life Insurance Company forms HP-POL et al, and HC-TOC et al.

Census
Member level census will be used when available. If only subscriber level data is available, penetration and translation assumptions will be used to create a member level census for manual rate development. The penetration and translation assumptions used are developed from studies of our book of business, which includes experience from similar CIGNA Health and Life Insurance Company ("CHLIC") policies. Penetration estimates the number of subscribers that will select the CIGNA Health and Life Insurance Company plan; the translation process develops projected subscribers and members within rating tiers.

Adjustments to Base Claims
The base claim rates by area are adjusted for certain group and member characteristics. These include industry loads and discounts, age and sex demographic adjustments, and trends.

Adjustments for industry (SIC) are developed from a study of our book of business combined with results from an outside consultant's national industry factor assessment study.

Age and sex demographic adjustments are developed from a study of our book of business. The resulting age/sex slopes are normalized to represent the national census.

Trends reflect historical experience from CHLIC's group medical experience and projections for future levels. Medical trend rates are applied on a daily basis.

Benefit Plan Adjustments
Base claims are reduced for specific cost sharing features of the product and benefit plan selected. Copay and other cost sharing benefit design related adjustments are made using assumptions regarding utilization levels by base claim component. Claim distributions are used to determine the impact of deductibles, coinsurance and out of pocket maximums. In addition, a utilization dampening factor is applied to reflect lower utilization levels as cost sharing rises.

Renewability Clause
The benefit plans covered under this memorandum are guaranteed renewable.

Applicability
CHLIC, Inc. anticipates both renewals and new issues from the forms currently filed.

Marketing Method
These products are sold to employer-employee groups, labor union groups and association groups through CIGNA Health and Life Insurance Company group sales offices.

Premium Classes
Premium rates may vary by product, plan design, geographic area, group demographics, industry, effective date, experience, and underwriting discretion.

Issue Age Range
There are no issue age restrictions in our policy forms; however, eligibility requirements must be fulfilled.

Premium Modalization Rules
The CIGNA Health and Life Insurance Company Health Manual produces monthly premiums. Modalization factors are expressed as a function of these monthly rates as follows:

Annual	11.8227
Semi-Annual	5.9557
Quarterly	2.9852

Distribution of Business
Rates vary by geographic location and group specific characteristics, including demographics. Target distribution is to groups with both single employees and employees with dependents, assuming a 40/60 distribution

Rating
The group rates filed represent the rate level we expect to be necessary to achieve a desired average loss ratio for all group contracts. Accordingly, actual rates for groups will vary as a result of a variety of factors. These include variation in benefit plan, age, gender, family composition, size, industry, area, healthplan claim experience, pharmacy indicators and underwriting discretion.

Depending upon group size, case specific claim experience may be used to adjust the rate. Credibility is based on group size, pooling level and months of experience. Rates for partially credible groups are based on a blend of experience and manual rating.

For Minimum Premium plans, the premium paid by the policyholder is reduced for the portion of the total claim amount that is expected to be self-insured.

Anticipated Loss Ratio
The methodology and supporting factors apply to groups of 51 or more employees.

The anticipated large group loss ratio for this policy is 83.9%.

The components of Cigna's retention for our Large Group pricing are as follows:
Administrative Expenses 4.8%
Optional Buy-ups 0.1%
PPACA Fees 3.0%
Risk Charge: 0.5%
Premium and Income Taxes 2.0%
Profit 3.5%
State Assessments 1.5%
Commissions 0.7%
Total 16.1%

Comparison to Status Quo
This filing includes a number of changes to our medical and pharmacy rating methodologies. It is difficult to quantify each change independent of the others. The average expected increase in manual rates in Vermont is 5.8%. This figure was calculated by comparing the current filed and approved manuals using an illustrative effective date of 1/1/2017 to the proposed 1/1/2018 manuals for a representative sample of Vermont sitused business. This figure is inclusive of one year of trend. (Note: The number of fully insured accounts sitused in Vermont in 2016 was 5, consistent with the company’s Supplemental Health Care Exhibits.)

Changes to Methodology for the 2018 Cigna Rate Filing

- Medical
  - Updates to the medical base claims
  - Updates to the medical area factors and trend
  - Updates to the medical capitation percentages
  - Updates to the enhanced non-par claims adjustment
  - Updates to the medical utilization dampening adjustment and methodology
  - Changes to community rate loads
    - Revision:
      - ER/UC Steerage assumption
      - Your Health First disease management savings adjustment
    - Addition:
      - One Guide adjustment
    - Removal:
      - Case-size adjustment for NY & FL
  - Updates to the base rates for all medical riders
  - Updates to medical claims probability distribution
  - Updates to the POS Load coefficients
  - Updated methodology for multiple offering loads
  - Updates to the collective deductible and collective out-of-pocket maximum methodologies
- Behavioral
  - Updates to the MHSUD trend and rates
- Vision
  - Updates to the Vision cost and service utilization
- Pharmacy
  - Update to average wholesale price per script
  - Update to average script count per customer
  - Update to pharmacy cost trend
  - Update to pharmacy utilization trend
  - Update to pharmacy area factors
  - Added methodology for pharmacy Exclusive Specialty Home Delivery adjustment
  - Added methodology for pharmacy clinical management adjustment assumption
  - Removed:
    - Retail discounts and dispensing fees tables

Credibility Formula Revision

Cigna Health and Life Insurance Company uses experience rating on large employer commercial customers to set future rates based on the past experience of the customer, where a customer is defined as the aggregation of all Cigna Health and Life Insurance Company accounts associated with a given employer, nationwide.

For prospectively rated accounts, the number of member months at which the experience is considered fully credible depends on the pooling point, shown in the chart below. Partial credibility (blending experience with manual) would be reflected using the following formula:

$$Credibility = \sqrt{\frac{Member\ Months}{Upper\ Bound}}$$

Where the upper bound varies based on pooling point as follows:

Pooling Point Range	Upper Bound
\$0-\$29,999	5552
\$30,000 -\$59,999	7000
\$60,000 - \$89,999	9000
\$90,000 - \$139,999	11000
\$140,000 +	12000

There is a minimum of 5 months of experience for paid claims and 4 months for incurred claims as well as a minimum overall of 100 member months to have any credibility. If member months are greater than or equal to the upper bound, credibility is 100%.

ACTUARIAL CERTIFICATION

Opinion

In my opinion, the rates were developed using reasonable actuarial assumptions, and the rate levels are reasonable in relationship to the benefits provided. The actuarial data and experience will be maintained by the company and available for review by the Green Mountain Care Board upon request.

I certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the State. In summary, I believe that the rating assumptions proposed will produce rates which are not excessive, inadequate, or unfairly discriminatory

Matthew Danziger

Matthew D. Danziger, FSA, MAAA   Date: 12/29/2017
Actuarial Director

SERFF Filing Required Data Elements

General Information	
Field	**Combined CG and CHLIC**
HHS Issuer ID (Company Name)	n/a
Product Name	PPO, OAP & NWK
Trend Factors	7.3%
New Policy Forms	n/a
Affected Forms for Closed Blocks	n/a
Other Affected Forms	
Change Period (annual, quarterly)	Annual
Member Months	12,271
Benefit Change	n/a
% Change Requested-Min	1.5%
% Change Requested-Max	9.3%
% Change Requested-Weight Average.	5.8%

Prior Rate	
Total Earned Premium	$6,605,744
Total Incurred Claims	$5,819,661
Annual $-Min	$278.68
Annual $-Max	$766.38
Annual $-W.A.	$538.31

Requested Rate	
Projected Earned Premium	$6,986,450
Projected Incurred Claims	$5,864,481
Annual $-Min	$282.94
Annual $-Max	$837.64
Annual $-W.A.	$569.34
Overall % of last rate revision	-5.4%
Effective date of last rate revision	4/7/2017
PPACA filing?	
If yes, grandfathered or no?	
Effective Date:	1/1/2018
Company Rate Change	6.1%
Overall % Indicated Change	5.8%
Overall % Rate Impact	5.8%
Written premium change for program	$380,706
Premium Written for this program	$6,986,450
Maximum change required	9.3%
Minimum change required	1.5%

**Product Types (choose from below)*
(PPO, HMO, EPO, POS, HAS, HDHP, FFS, other)

Membership	
# Covered Lives (by product)	
Total	794
# Accounts (by product)	
Total	5