Responses to Objections

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Objection 1

Comment:
As shown under "Rate Review Detail" of SERFF submission, the weighted average prior rate is $582.33 PMPM. Please illustrate how this amount reconciled to the approved rate from the prior filing.

Response:

The difference between the projected premium and actual premium is $37.95, primarily due to higher medical costs ($33.99 PMPM) and slightly higher Admin/Marketing/Profit ($3.96 PMPM) as compared to our expectations at the time of the 2019 filing. The main driver of the discrepancy is we projected the 2019 premium using 2017 case mix and we are now forecasting the premium using 2018 case mix.

2019 Projected Premium	$544.38
Claim Cost Increase	$33.99
Admin/Marketing/Profit	$3.96
Total Premium Increase beyond Projection	$37.95
2019 Actual Premium	$582.33

Objection 2

Comments:

We have noted some changes in the pharmacy rating methodology. Please outline the changes made from the previously approved filing.

Response:

As a result of both our Express Scripts acquisition and recently developed products and capabilities Cigna has made the following modifications to the pharmacy section of our rate filing. We believe these adjustments improve our pricing accuracy.

- In the Rx manual rating formula we broke out Preferred and Non-preferred brand scripts and AWP into additional Preventative and non-Preventative categories
- Deleted Misc. Adjustments steps, except for Rx Clinical Management Adjustment.
- Deleted the prior Table 59 -- Rx Exclusive Specialty Home Delivery (ESHD) Adjustment
- Created new Misc. Adjustments Table 59 (see below) and added it to step 7.20.
- Added SSRIs to Misc. Adjustments Table (for IRS Preventive Expansion)
- Changed Table 60 -- Pharmacy: Clinical Management Adjustment Assumption to Table 59 -- Pharmacy: Clinical Management Adjustment Assumption.
- Added new Table 60 -- Pharmacy: Additional Benefit Adjustments, which includes the following new adjustments
    - IRS Preventative Expansion - Adding additional medical services that can be covered at 100% for HSA plans based on IRS Notice 2019-45
    - Cost-Share Waiver (Medication Assisted Treatment) - Allows plans to waive part of/all of the member cost-share for opioid use disorder treatment/reversal prescriptions
    - Out-of-Pocket Adjuster Program Adjustment - Allows plans to have manufacturer coupons excluded from the deductible and OOPM.
    - Patient Assurance Program - Allows plans to cap member cost-share at $25 per 30-day prescription or $75 per 90-day prescription.
    - Express Scripts Platform Adjustment - Plans that are moved to the ESI platform receive a decrement due to improved utilization management capabilities.

Table 1 – Pharmacy: Clinical Management Adjustment Assumption

Grandfathering Options		
Category	Package	Adjustment
RxGrandfatheringPriorAuthorization	Excluded	0.0%
	Nondrug Removal Drugs Only (12 months)	30.0%
RxGrandfatheringStepTherapy	All Step Therapy Classes	20.0%
	Sensitive Step Therapy Classes Only	0.0%

Specialty Management Program		
Category	Package	Adjustment
RxNonSpecialtyManagementProgram	Complete	-3.25%
	Essential	-2.75%

	Limited	-2.0%
	None	0.0%
	Non Standard or Customed	0.0%
RxSpecialtyManagementProgram	Non Standard	2.5%
	Specialty	0.0%
	Specialty Plus	0.0%

Table 2 – Pharmacy: Additional Benefit Adjustments

Benefit	Description	Adjustment
Mail Order Deductible Waiver	Plan designs that waive the deductible for mail order prescriptions receive an increment due to decreased member cost-sharing.	1.05
Mail Order Specialty Drug 30 Day Limit	Limiting specialty drugs to 30 day supplies reduces waste.	1.004
Mandatory Mail for Maintenance Drugs	When customers obtain their maintenance medications through Cigna's mail order pharmacy, costs increase due to overhead expense costs associated with filling a script through mail.	1.005 to 1.01
Rx Exclusive Specialty Home Delivery (ESHD) Adjustment	When clients choose to fill specialty drugs exclusively through Cigna Home Delivery service, they receive a decrement.	0.995 to 1.000
Out of Pocket Adjuster Program Adjustment	Clients that elect to have manufacturer coupons excluded from the deductible and out of pocket max will receive a decrement to claims.	0.9996 to 0.97
Patient Assurance Program	Clients that elect to cap the customer cost-share for insulin at $25 per 30-day prescription and $75 per 90-day prescription receive an increment to claims.	1.000 to 1.006
Medication Assisted Therapy/Opioid Use Disorder/Reversal Drug Benefit Option	Clients that elect to wave a portion of or the entire member cost-share from certain medication assisted therapy, opioid use disorder, or overdose reversal drugs will receive an increment to claims.	1.0003 to 1.0025
Express Scripts Platform Adjustment	Clients that are on the Express Scripts claim platform receive a claim decrement due to improved utilization management.	0.99
Selective Serotonin Reuptake Inhibitors (SSRIs)	Clients that elect to waive a portion of or the entire member cost-share from certain Selective Serotonin Reuptake Inhibitors receive a claim increment.	1.001 to 1.004

Objection 3

Comment:
Regarding the breakdown of the requested rate increase on page 3 of the actuarial memorandum, please provide the following:

a. A further breakdown of the 'Rating Variable' line item to show the percent change attributed to updated experience base claims vs updating each of the other rating variables that were changed from the previously approved filing. Please explain the reason(s) behind why each rating variable is changing.

b. A further breakdown of the '% Expense Change' line item to show the percent change attributed to updating profit margin vs updating HIF and each of the expense items that were changed from the previously approved filing. Excluding profit margin and HIF, please explain the reason(s) behind why each expense line item is changing.

Response:

The overall rate impact of 15.0% represents the weighted average of our proposed actuarial pricing methodology for the state of VT, relative to previously filed and approved rates. This impact is calculated by comparing the filed and approved manual rates for an illustrative effective date of 5/09/2019 to the proposed manual rates for an illustrative effective date of 1/1/2020 for a representative sample of VT situsedbusiness.

There are three main categories of change that help us analyze the 15.0%. Updated rating variables on a 1/1/2020 basis (including area factors and trend), previously filed and approved 2020/2019 trend, and the change in proposed MLR. Please see the table below for more analysis.

Category	Change
Rating Variables	0.8%
Med+Rx Filed Trend	6.5%
Expense Change	7.1%
Total Impact[1]	**15.0%**

[1]Total Impact = (1+Rating Variables) * (1+Med+Rx Filed Trend) * (1+Expense Change) -1

Response a. - Rating Variables: In this proposed filing, we are reflecting a slight increase to our area factors as a result of our periodic experience rate reviews, which looked at full-year 2018 experience relative to our manual rating expectation. Generally, claims were slightly higher compared to the manual, which results in increasing our medical and rx area factors.

Med+Rx Filed Trend: This is the weighted average trend increase for the membership in VT Sitused Cases.

Category	Average VT Sitused Acct Change in Trend	Medical Trend	Rx Trend
Claims Trend	6.5%	6.1%	7.9%

Response B - Expense Change:

Retention Category	Proposed 2020	Prior Filed 2019	Change
Administrative Expenses	6.3%	5.3%	1.0%
Optional Buy-ups	0.2%	0.1%	0.1%
PPACA Fees*	2.5%	0.0%	2.5%
Risk Charge	0.0%	0.0%	0.0%
Premium and Income Taxes	2.0%	2.0%	0.0%
Profit	3.5%	1.0%	2.5%
State Assessments	1.9%	2.0%	-0.1%
Total	16.4%	10.4%	6.0%

Significant Changes by Retention Category:

- Administrative Expense: 1.0% increase due to an increase in expenses driven by cost inflation. Also, we included the average cost of our behavioral health access fee and medical management which had not been included in prior filings.

- Optional Buy-ups: 0.1% increase due to including the average cost of our One Guide and Health Advisor buy ups which had not been included in prior filings.

- PPACA Fees: PPACA fees are primarily associated with the Health Insurance Industry Fee (HIIF), which is assumed to be 2.5% for 2020 calendar months, and 0% for 2021+ calendar months due to recent legislative changes. The remainder is for the PCORI, which is currently a small amount (<0.1%), and assumed to continue for 2020 and beyond

- State Assessments: Decrease of 0.1% driven by the Removal of General Agent fees for <200 lives.

- Profit: The profit assumption in our filed and approved rating methodology is 1.0%. In this proposed filing, we are submitting assumptions for retention which includes a profit assumption of 3.5% (consistent with our requested profit in prior filings).

Objection 4

Comments:
Please provide additional support for each of the components identified in breakdown of the requested rate increase, including the additional breakdowns requested in question #3, with detailed sources of the referenced figures and/or derivation, as well as any other information that may be helpful with our review. For example, if there is any impact from neutralizing the methodology impact between national and Vermont rating, or if the baseline has changed, please specify.

Response:

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 15.0% 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.

When calculating the requested rate increase for the state of VT, we forecast local medical cost trends which are significantly influenced by the contracted rates we obtain at providers within the state. Increases in provider rates increase our cost structure and require us to submit increases to our premium.

Objection 5

Comments:
Please provide at least 3 years of historical actual-to-expected retention, separately for profit vs. all other retention. Actual profit should be as reported in the Supplemental Health Care Exhibit.

Response:

VT Filings - Actual To Expected Profit				
	From Rate Filings		From SHCEs	
Year	Expected Retention	Expected Profit	Actual Retention	Actual Profit
2016	15.4%	1.0%	27.5%	10%
2017	12.9%	2.0%	-20.3%	-18%
2018	13.4%	1.0%	15.8%	5%
2019	10.4%	1.0%	8.5%	-2%
4 Year average	**13.0%**	**1.3%**	**7.9%**	**-1.3%**

Over the last 4 years Cigna has averaged a -1.3% profit on its large group business in VT. This compares to a forecasted profit of 1.3% at the time we filed our SHCEs. During this time Actual Retention of 7.9% was significantly lower than Expected Retention of 13.0%

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 are expected to result in a loss ratio within +/- 29.3% of the expected loss ratio.

Objection 6

Comments:
Please provide the derivation of the projected federal MLR for 2020, starting with the target loss ratio.

Response:

Projected MLR	**83.6%**
- TPV Admin	-0.5%
+ QI Expenses	0.8%
+ PPACA Fees	2.2%
+ Premium Tax	1.5%
+ Fed Income Tax	1.1%
Federal MLR	**88.7%**

The following assumptions apply to the projected federal MLR for 2020:

1. Third Party Vendor administrative expenses are deducted from claims in the federal MLR. Assumption of -0.5% of premium based on final 2018 results.

2. QI expenses set to 0.8% of premium, based on HHS guidance.

3. PPACA fees assumptions:
    a. Reinsurance PMPM of $0 since the reinsurance assessment is only applicable from 2014 through 2016.
    b. HII Fee set to 2.5% of premium due to the HII fee return in 2020.

4. Premium and other state income, excise, and business taxes are in total of 1.6% of premium based on VT historical results.

Federal income tax is based on a 21% tax rate on projected taxable income.

Objection 7

Comments:
Please provide a comparison of the Medical, Rx, and Combined trends (separately by cost trend, utilization trend, and total trend) as filed in this filing versus the previously approved filing. Please provide quantitative and qualitative support for the changes.

Response:

2019 Filing	Medical		Pharmacy		Total (assumes 80/20 weight)	
	2018/2017	2019/2018	2018/2017	2019/2018	2018/2017	2019/2018
Cost Trend	2.6%	3.4%	6.4%	7.5%	3.4%	4.2%
Utilization Trend	2.8%	2.6%	1.5%	0.4%	2.5%	2.1%
Total Trend	**5.5%**	**6.0%**	**8.0%**	**7.9%**	**6.0%**	**6.4%**

2020 Filing	Medical		Pharmacy		Total (assumes 80/20 weight)	
	2019/2018	2020+/2019	2019/2018	2020+/2019	2019/2018	2020+/2019
Cost Trend	3.7%	4.1%	7.3%	6.1%	4.5%	4.5%
Utilization Trend	3.5%	3.8%	1.1%	0.6%	3.0%	3.2%
Total Trend	**7.3%**	**8.0%**	**8.5%**	**6.7%**	**7.6%**	**7.8%**

Above is a table of our Medical Pharmacy and Total Pricing Trends (Assuming an 80% weight of medical spend and 20% weight of Pharmacy spend) for the state of Vermont.

When forecasting local medical cost trends we rely on the contracted rates we obtain at providers within the state as well as nationally contracted rates for vendors providing medical services. Contracting trends for 2019 were slightly higher than originally forecasted at the time of our 2019 filing.

Medical Utilization and Mix 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 pricing competitiveness.

In 2019, nationally as well in VT, we saw increased utilization above previous trends and expected forecasts leading to an increase vs. plan.

The categories that had the largest impact on increased trend were cancer treatments, musculoskeletal treatments, infectious diseases such as HIV/AIDS and mental health/substance abuse.

Pharmacy trends are composed of several pieces:

1. Cost trend: the change in the average ingredient cost per script of drugs due to:
    a. 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.

   b. 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.
   c. 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 are higher than the previous filing for 2019 due to higher utilization for non-specialty and specialty drugs. For 2020+, pharmacy trends are lower than the previous filing due to lower expected utilization for non-specialty drugs and drug mix shifting towards generics. This shows Cigna's continued efforts to better manage our drug lists to steer customers to the lowest cost drug.