California Large Group Annual Aggregate Rate Data Report Form

Version 4, July 16, 2018

(File through SERFF as a PDF or excel. If you enter data on a Word version of this document, convert to PDF before submitting the form. SERFF will not accept Word documents.
Note "Large Group Annual Aggregate Rate Data Report" in the SERFF "Filing Description" field)

The aggregate rate information submission form should include the following:

1) Company Name (Health Plan)
2) Rate Activity 12-month ending date
3) Weighted Average Rate Increase, and Number Enrollees subject to rate change
4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month
5) Segment Type
6) Product Type
7) Products Sold with materially different benefits, cost share
8) Factors affecting the base rate
9) Overall Medical Trend (Plain-Language Form)
10) Projected Medical Trend (Plain-Language Form)
11) Per Member per Month Costs and Rate of Changes over last five years
    - *submit CA Large Group Historical Data Reporting Spreadsheet (Excel)*
12) Changes in Enrollee Cost Sharing
13) Changes in Enrollee Benefits
14) Cost Containment and Quality Improvement Efforts
15) Number of products that incurred excise tax paid by the health plan
16) Covered Prescription Drugs
    - *submit SB 17 - Large Group Prescription Drug Cost Reporting Form (Excel)*
17) Other Comments

1) Company Name:

Cigna Health and Life Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2018.[1]

3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 8.8%
   - Most commonly sold large group benefit design 8.8%

   Weighted average annual rate increase (adjusted)[3]
   - All large group benefit designs 9.2%
   - Most commonly sold large group benefit design[4] 9.2%

[1] Provide information for January 1-December 31 of the reporting year.
[2] Average percent increase means the weighted average of the annual rate increases that were implemented (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives.
[3] "Adjusted" means normalized for aggregate changes in benefits, cost sharing, provider network, geographic rating area, and average age.

4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month

See Health and Safety Code section 1385.045(a) and Insurance Code section 10181.45(a)

1	2	3	4	5	6	7
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected by Rate Change[5]	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted[6]
January	168	54.7%	80,301	1,901	$519	9.6%
February	4	1.3%	977	-	$509	7.9%
March	7	2.3%	2,745	-	$492	4.3%
April	15	4.9%	2,355	1,535	$480	6.1%
May	15	4.9%	7,418	-	$443	15.6%
June	11	3.6%	756	-	$460	9.6%
July	23	7.5%	11,389	-	$504	4.7%
August	11	3.6%	2,344	252	$557	3.7%
September	13	4.2%	3,715	1,827	$583	3.3%
October	15	4.9%	2,780	-	$587	10.1%
November	16	5.2%	2,154	602	$474	7.7%
December	9	2.9%	130	580	$608	0.7%
Overall	307	100.0%	117,064	6,696	$516	8.8%

[4] Most commonly sold large group benefit design is determined at the product level. The most common large group benefit design, determined by number of enrollees should not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

[5] The total number of enrollees/covered lives (employee plus dependents) affected by, or subject to, the rate change.

[6] Average percent increase means the weighted average of the annual rate increases that were offered (final rate quoted, including any underwriting adjustment) (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives in columns 4 & 5.

Place comments below:

(*Include (1) a description (such as product name or benefit/cost-sharing description, and product type) of the most commonly sold benefit design, and (2) methodology used to determine any reasonable approximations used).*

5) Segment type: Including whether the rate is community rated, in whole or in part
See Health and Safety Code section 1385.045(c)(1)(B) and Insurance Code section 10181.45(c)(1)(B)

1	2	3	4	5	6	7
Rating Method	Number of Renewing Groups	Percent of Renewing Groups *(number for each rating method in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)	-	0.0%	-	-	$-	0.0%
Blended (in part)	253	82.4%	45,511	4,243	$538	6.9%
100% Experience Rated	54	17.6%	71,552	2,453	$501	10.0%
Overall	307	100%	117,064	6,696	$516	8.8%

Comments: Describe differences between the products in each of the segment types listed in the above table, including which product types (PPO, EPO, HMO, POS, HDHP, other) are 100% community rated, which are 100% experience rated, and which are blended. Also include the distribution of covered lives among each product type and rating method.

For all PPO, EPO, and HDHP products included in this filing, the experience is used for the renewal calculation. Therefore, at a minimum, each account is at least blended.
Claims above a certain threshold are pooled across accounts, with the pooling point varying by account. The credibility of the account varies by that pooling point and the member months of experience. For those accounts that are considered fully credible, the account has been categorized as 100% experience rated.

Note that the total number of member-months for an account is considered in this calculation, which also includes members under the separate Cigna Healthcare of California (CHC) legal entity. For example, if there are 2,000 members on an HMO plan with CHC and 20 members on a PPO plan with Cigna Health and Life Insurance Company, then the account would receive full credibility reflecting the total account membership.
Distribution is shown in chart above.

6) Product Type:

See Health and Safety Code section 1385.045(c)(1)(C) and Insurance Code section 10181.45(c)(1)(C)

1	2	3	4	5	6	7
Product Type	Number of Renewing Groups	Percent of Renewing Groups *(number for each product type in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
HMO	N/A	N/A	N/A	N/A	N/A	N/A
PPO	255	35%	61,876	3,746	$530	9.4%
EPO	55	8%	7,199	1,307	$495	5.3%
POS	N/A	N/A	N/A	N/A	N/A	N/A
HDHP	167	23%	47,989	1,644	$501	8.5%
Other (describe)	N/A	N/A	N/A	N/A	N/A	N/A
Overall	307	100%	117,064	6,696	$516	8.8%

HMO – Health Maintenance Organization PPO – Preferred Provider Organization
EPO – Exclusive Provider Organization POS – Point-of-Service
HDHP – High Deductible Health Plan with or without Savings Options (HRA, HSA)

Describe “Other” Product Types, and any needed comments here.

Note that a single account can (and often does) have multiple products. For example, the account may offer the choice of a HDHP and a low-deductible PPO. In this case, the account would be listed both in the HDHP and PPO. With the overlap, the number of unique accounts is shown as the "Overall", but the number of groups above will sump to a greater number.

7) The number of plans sold during the 12-months that have materially different benefits, cost sharing, or other elements of benefit design.

See Health and Safety Code section 1385.045(c)(1)(E) and Insurance Code section 10181.45(c)(1)(E)

Please complete the following tables. In completing these tables, please see definition of "Actuarial Value" in the document "SB546 – Additional Information":

HMO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	N/A	N/A	N/A	N/A
0.8 to 0.899	N/A	N/A	N/A	N/A
0.7 to 0.799	N/A	N/A	N/A	N/A
0.6 to 0.699	N/A	N/A	N/A	N/A
0.0 to 0.599	N/A	N/A	N/A	N/A
Total	N/A	N/A	100%	N/A

PPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	83	23,840	36.3%	Rich benefits with customer cost share below 10%
0.8 to 0.899	169	41,534	63.3%	Most common range with customer cost share in the 10%-20% range
0.7 to 0.799	3	249	0.4%	Deductible low enough to not qualify

				as an HDHP, but lean on other benefits
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	255	65,622	100.0%	

EPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	25	5,851	68.8%	Rich benefits with customer cost share below 10%
0.8 to 0.899	30	2,654	31.2%	Most common range with customer cost share in the 10%-20% range
0.7 to 0.799	0	-	0.0%	Deductible low enough to not qualify as an HDHP, but lean on other benefits
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	55	8,505	100.0%	

POS

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	N/A	N/A	N/A	N/A
0.8 to 0.899	N/A	N/A	N/A	N/A
0.7 to 0.799	N/A	N/A	N/A	N/A
0.6 to 0.699	N/A	N/A	N/A	N/A
0.0 to 0.599	N/A	N/A	N/A	N/A
Total	N/A	N/A	100%	N/A

HDHP

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	6	178	0.4%	Deductibles at the lowest range to qualify as HDHP with lean benefits otherwise. Customer cost share below 10%.
0.8 to 0.899	116	41,084	82.8%	Leaner benefits with deductibles in the $1300-$2500 level. Customer cost share 10% to 20%.
0.7 to 0.799	41	8,229	16.6%	Deductibles typically above the

				$2500 level. Customer cost share of 20% to 30%.
0.6 to 0.699	4	142	0.3%	Leanest HDHPs with high deductibles and lean benefits otherwise. Customer cost share between 30% and 40%.
0.0 to 0.599	0	-	0.0%	
Total	167	49,633	100.0%	

Other (describe)

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	N/A	N/A	N/A	N/A
0.8 to 0.899	N/A	N/A	N/A	N/A
0.7 to 0.799	N/A	N/A	N/A	N/A
0.6 to 0.699	N/A	N/A	N/A	N/A
0.0 to 0.599	N/A	N/A	N/A	N/A
Total	N/A	N/A	100%	N/A

In the comment section below, provide the following:

- Number and description of standard plans (non-custom) offered, if any. Include a description of the type of benefits and cost sharing levels.
- Number of large groups with (i) custom plans and (ii) standard plans.

Place comments here:

(1) The large group segment offers a wide array of plan designs to fit the needs of our customers. There are not a limited list of pre-set "standard" plans.

(2) Under this definition, we would consider all large group plans to be custom plans.

8) Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

See Health and Safety Code section 1385.045(c)(2) and Insurance Code section 10181.45(c)(2)

Factor	**Provide actuarial basis, change in factors, and member months during 12-month period.**
Geographic Region (describe regions)	The geographic region factors were adjusted by reviewing actual claims experience relative to expected claims at the region level and setting the factors to more closely reflect experience. The change in factors is based on full year 2016 experience. The regions are Bakersfield, Central Valley, Fresno, Inland Empire, Monterey, North Los Angeles, Central Los Angeles, South Los Angeles, Orange County, Outlier Northern California, Outlier Southern California, Outlier in California near Reno, Palm Springs, Sacramento, San Diego – Core, San Diego - Outlier, San Francisco, San Mateo, Silicon Valley, & Ventura.
Age, including age rating factors (describe definition, such as age bands)	No change in factors
Occupation	N/A
Industry	No change in factors
Health Status Factors, including but not limited to experience and utilization	N/A
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	No change in factors
Enrollees' share of premiums	N/A
Enrollees' cost sharing, including cost sharing for prescription drugs	The cost-sharing calculation uses a Claims Probability Distribution (CPD) methodology. The CPD was not updated this year. The methodology used to calculate cost share for plans with collective deductibles and out-of-pocket maximums was enhanced to be more flexible for more complex plan designs

[7] i.e. premium tier ratios

Covered benefits in addition to basic health care services and any other benefits mandated under this article	No change in factors
Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated	No change in factors
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	The point-of-service (POS) loads, which are applied to in-network claims to calculate the expected total in- and out-of-network claims, were updated using 2016 claims experience. The POS loads were adjusted to account for area-specific changes in out-of-network costs and utilization. New medical management programs, with claim decrements, were introduced

9) Overall large group medical allowed trend factor and trend factors by aggregate benefit category:

Overall Medical Allowed Trend Factor

"Overall" means the weighted average of trend factors used to determine rate increases included in this filing, weighting the factor for each aggregate benefit category by the amount of projected medical costs attributable to that category.

Allowed Trend: (Current Year) / (Current Year – 1)

6.0%

Medical Allowed Trend Factor by Aggregate Benefit Category

The aggregate benefit categories are each of the following – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(A) and Insurance Code section 10181.45(c)(3)(A)

Hospital Inpatient[8]	6.0%
Hospital Outpatient (including ER)	6.1%
Physician/other professional services[9]	3.8%
Prescription Drug[10]	7.0%
Laboratory (other than inpatient) [11]	See comments in #17
Radiology (other than inpatient)	See comments in #17
Capitation (professional)	See comments in #17
Capitation (institutional)	See comments in #17
Capitation (other)	N/A
Other (describe)	9.4%

10) Projected medical trend:

Use the same aggregate benefit categories used in item 9 – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). Furthermore, within each aggregate category quantify the sources of trend, i.e. use of service, price inflation, and fees and risk.

See Health and Safety Code section 1385.045(c)(3)(B) and Insurance Code section 10181.45(c)(3)(B)

Projected Medical Allowed Trend by Aggregate Benefit Category

Allowed Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars (PMPM)	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	**$99**	**1.9%**	**3.9%**		**5.8%**

[8] Measured as inpatient days, not by number of inpatient admissions.
[9] Measured as visits.
[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

[12] Measured as inpatient days, not by number of inpatient admissions.

Hospital Outpatient (including ER)	**$109**	**1.9%**	**4.0%**		**6.0%**
Physician/other professional services[13]	**$109**	**1.9%**	**2.1%**		**4.0%**
Prescription Drug[14]	**$99**	**1.0%**	**5.0%**		**6.0%**
Laboratory (other than inpatient)[15]	**See comments in #17**				
Radiology (other than inpatient)	**See comments in #17**				
Capitation (professional)	**See comments in #17**				
Capitation (institutional)	**See comments in #17**				
Capitation (other)	**N/A**				
Other (describe)	**$46**	**1.9%**	**7.2%**		**9.2%**
Overall	**$463**	**1.7%**	**4.1%**		**5.8%**

11) Complete the CA Large Group Historical Data Spreadsheet to provide a comparison of the aggregate per enrollee per month costs and rate changes over the last five years for each of the following:

(i) Premiums
(ii) Claims Costs, if any
(iii) Administrative Expenses
(iv) Taxes and Fees
(v) Quality Improvement Expenses. Administrative Expenses include general and administrative fees, agent and broker commissions

Complete CA Large Group Historical Data Spreadsheet - Excel

See Health and Safety Code section 1385.045(c)(3)(C) and Insurance Code section 10181.45(c)(3)(C)

[13] Measured as visits.
[14] Per prescription.
[15] Laboratory and Radiology measured on a per-service basis.

12) Changes in enrollee cost-sharing

Describe any changes in enrollee cost-sharing over the prior year associated with the submitted rate information, including both of the following:
See Health and Safety Code section 1385.045(c)(3) (D) and Insurance Code section 10181.45(c)(3)(D)

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

In the Large Group segment, Cigna offers a wide range of benefit options. It is common for a plan to increase enrollee cost-sharing upon renewal. The average impact of this change is discussed in section (ii).

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value based on plan benefits using the company's plan relativity model, weighted by the number of enrollees.[16]

[16] Please determine weight average actuarial value base on the company's own plan relativity model. For this purpose, the company is not required to use the CMS standard model.

The average impact of benefit changes across this block of business is 0.8%.

13) Changes in enrollee/insured benefits

Describe any changes in benefits for enrollees/insureds over the prior year, providing a description of benefits added or eliminated, as well as any aggregate changes as measured as a percentage of the aggregate claims costs. Provide this information for each of the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(E) and Insurance Code section 10181.45(c)(3)(E)

In the Large Group segment, Cigna offers a wide range of benefit options. The primary driver of benefit changes are changes in client elections at the time of renewal, such as increasing cost share, which results in the aggregate change included the response to #12. Additionally, there have been pharmacy formulary updates.

14) Cost containment and quality improvement efforts

Describe any cost containment and quality improvement efforts since prior year for the same category of health benefit plan. To the extent possible, describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. Companies are encouraged to structure their response with reference to the cost containment and quality improvement components of "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract:"

1.01 Coordination and Cooperation
1.02 Ensuring Networks are Based on Value
1.03 Demonstrating Action on High Cost Providers
1.04 Demonstrating Action on High Cost Pharmaceuticals
1.05 Quality Improvement Strategy
1.06 Participation in Collaborative Quality Initiatives
1.07 Data Exchange with Providers
1.08 Data Aggregation across Health Plans

See Health and Safety Code section 1385.045(c)(3)(F) and Insurance Code section 10181.45(c)(3)(F), see also California Health Benefit Exchange, April 7, 2016 Board Meeting materials:
http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

1.01 Coordination and Cooperation

Cigna is an industry leader in medical and pharmacy operational and clinical integration. We deliver better performance for our clients because we know medical and pharmacy covered services are directly connected, and when monitored and managed together, they drive lower cost and better outcomes. To a member, his or her well-being and condition has medical, behavioral, disability, and prescription drug components—they are not separate. We treat members holistically, seamlessly bringing together multiple benefits to be sure members are coached correctly and can navigate a sometimes complicated health care system. Our fully coordinated approach helps clients perform in any regulatory or economic environment by delivering total cost management, improved outcomes, and an exceptional member experience.

Cigna's Commitment to Collaborative Care Partnerships
Cigna Collaborative Care (CCC) meets the needs, goals, and readiness of health care professionals. Our shared, actionable, and member-specific information helps providers identify and focus their resources on opportunities to help patients who need it most. In addition, Cigna clinical consultants are available and dedicated to assisting health care professionals with the identification of quality and medical cost performance improvement opportunities.

CCC also delivers the tools and services that we know health care professionals need to be successful. For example, we hold well-attended quarterly learning collaborative meetings, three virtually and one in person, with every participating primary care provider group. We designed these meetings to gather feedback, share best practices, and brainstorm ideas

between health care professional groups and Cigna. Our dedicated, experienced case managers are also available to help with coordination between the primary care group and every other Cigna-offered service. In addition, our embedded care coordinator model is unique in the industry, as it includes clinicians employed by the provider practice who serve as a valuable resource in coordinating patient needs, identifying opportunities to improve performance, and reaching out to the patients who need it most.

Our Unique Relationship and Influence with Network Doctors Matters
The goal of Cigna Collaborative Care (CCC) is to have the majority of members with high-cost conditions and complex needs receiving care from health care professionals that have a value-based reimbursement with Cigna. To reach that goal, we designed CCC to meet health care professionals at their current level of performance and take them where they need to be—delivering care built on evidence-based standards that improve quality, cost, and patient satisfaction. We offer innovative solutions that span the delivery system—from primary care provider groups, hospital systems, and specialists to everything in between.

Based on our profound experience with CCC, specifically with primary care provider groups, we have learned that not every health care practice or facility has the same resources, goals, or leadership support or is in the same stage of readiness. Consequently, we developed arrangements that are committed to driving change and that work for every group.

We will continuously improve and evolve our CCC initiatives using a disciplined and rigorous test-and-learn methodology, and we will emphasize our unique ability to collaborate and connect with health care professionals.

1.02 Ensuring Networks are Based on Value

Cigna has had isolated pay-for-performance payment provisions in its participating health care professional agreements for many years. Over the last several years, however, the national focus has moved from traditional fee-for-service (FFS), volume-based payment to value-based payment models. As a result, Cigna worked with participating health care professionals to develop payment models that reward quality and cost effectiveness rather than volume.

As performance-based payment takes the form of payment in connection with covered services provided pursuant to participating health care professional agreements, we treat the payment as a claim expense. In addition, because value-based payment arrangements have grown and will continue to grow in the future, we describe these payment arrangements in the administrative services agreement to allow our clients visibility into the changing participating health care professional payment landscape. To facilitate this transparency, we added the following language to Cigna's administrative services agreement:

"Amounts paid by Cigna Health and Life Insurance Company with its own funds on behalf of Employer/the Plan with respect to charges for which Employer/Plan is obligated to pay under this Agreement including Plan Benefits, Bank Account Payments (including

capitated and pay-for-performance payments to Participating Providers), or governmental taxes or assessments."

Primary Care Provider Groups
At Cigna, we take a unique approach to the Accountable Care Organization (ACO) model, collaborating with primary care provider groups to improve health care quality, lower total medical costs, and improve patient satisfaction. We designed CCC to include the broad spectrum of ways we collaborate with health care professionals—sharing responsibility and accountability for the population we serve. With our model, we combine the right care with the right rewards and resources to achieve the triple aim of improved health, affordability, and experience of care. We first began collaborating with a primary care group in 2008. We are still testing the approach and gaining expertise and knowledge about what really works.

We currently have 226 initiatives, reaching over 2.6 million Cigna members across 32 states. Our latest results are promising:

- In aggregate, groups with at least one year of experience demonstrated an ROI of 2:1
- More than twenty percent of groups, effective for greater than one year, beat the market by a trend of 3 percent or better
- Our top five performing groups had 11 percent better quality compliance with evidence-based medicine (EBM) guidelines
- Our top performing group, accounting for more than 2,500 aligned Cigna members, demonstrated a 25 percent reduction in hospitalizations
- Our top performing group, accounting for more than 2,500 aligned Cigna members, demonstrated a 56 percent reduction in hospital readmissions

Specialty Care
Approximately 2 percent of medical costs are spent on orthopedics, OB/GYN, cardiology, gastroenterology, and oncology specialties. CCC currently includes over 200 arrangements with specialist practices around the country. Cigna also launched retrospective episode-of-care arrangements using a bundled payment methodology. We designed these arrangements to have aligned incentives that promote quality, safety, and efficiency for members seeking care from a specialty group. We negotiated different types of arrangements that meet the group where they are in the evolution from FFS to value-based arrangements. We designed these arrangements so client costs will not exceed what they would have paid with a traditional FFS model.

Cigna collaborates with specialists to:

- Decrease variation in service delivery and improve outcomes
- Ensure that process-of-care standards, best-practice protocols, and EBM guidelines are met
- Encourage advantageous steerage

CCC has flexible payment structures for specialists, as we understand that groups are at varying stages in the evolution to pay-for-value. Descriptions of partnership structures include the following:

- Care coordination reimbursements for meeting cost and quality goals
- Episodes-of-care global reimbursement for meeting cost and quality goals

Hospitals
Twenty-five percent of members with high-cost conditions or complex needs receive treatment in a hospital. Our CCC initiatives with 485 hospitals (and growing) are value-based arrangements that promote quality, safety, and efficiency. We negotiated different types of CCC arrangements that meet the hospital where they are in the evolution from fee-for-service (FFS) to value-based payments. We designed these arrangements so client costs will not exceed what they would have paid with a traditional FFS model.

Cigna collaborates with hospitals through clinical resource consultation and actionable information to:

- Decrease variation in service delivery and improve outcomes
- Ensure that process-of-care standards, best-practice protocols, and EBM guidelines are met
- Support national patient-safety initiatives, such as the national Partnership for Patients and the CMS Hospital Value-Based Purchasing program

Depending on goals of each arrangement, we measure hospital performance through variety of metrics:

- Quality process of care measures
- Readmission rates
- Hospital-acquired complications
- Patient-experience measures
- Primary maternity cesarean section rate
- Electronic medical record (EMR) access to better co-manage the admission
- Medicare spending per beneficiary (above, below, or at average cost)

1.03 Demonstrating Action on High Cost Providers

Cigna's valuable role as a convener between customers, employers and health care professionals is critical to improving the quality and costs of the US health care system, including focusing contracted health care professionals on delivering care based on evidence-based standards that improve quality, cost, and patient satisfaction. Evolving from a fee-for-service to a pay-for-value reimbursement strategy means extending the reach of our initiatives to meet customers wherever they seek care, large physician groups, hospitals, specialists or small physician practices, by using our innovative test and learn methodology to connect and collaborate with all stakeholders to deliver industry leading results.

- Cigna's Collaborative Care (CCC) arrangements are developed for the purpose of helping customers achieve health easier, more effectively, and more affordably
- Cigna has more Collaborative Care arrangements than any competitor
- 2.9 percent saved through total medical cost reduction by groups in a CCC arrangement greater than 1 year
- The top performing groups realized 51% better than market avoidable ER visits per thousand; 32% lower hospital inpatient admission rates

Choosing where to receive care is an important personal decision for health care customers. As high deductible and coinsurance plans become more prevalent, customers

are demanding tools and information on quality and cost-efficiency to help them make more informed decisions about where to seek care. Cigna Healthcare has developed customer support tools to help meet this growing customer demand.

Quality and Cost-Efficiency Displayed in Directory
Cigna uses a suite of analytical tools to profile doctor quality, track, and compare practice patterns, and monitor cost and utilization. We can compare doctors to their specialty groups in their own geographic areas. Our tools provide insight into varying practice patterns and can account for clinical differences in patient populations. When we understand these differences, we can better identify opportunities for improvement. Our tools help us to:
Identify trends that assist with contracting or medical management to manage our health care professional networks

- Identify potential best practices and benchmark members or groups
- Identify doctors who are high and low outliers
- Identify quality-of-care issues by targeting under care situations, and tracking specific clinical conditions from episode-of-care results
- Conduct consultative sessions with doctors to help them understand the results, how they vary from their peers, and how they can improve

We use evidence-based medicine (EBM) 99 measures and ETGs to profile doctors and measure performance for quality and cost. Cost savings have been realized by the customers who utilize these customer support tools.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Total Cost and Value Management
Success moving forward demands a new and different approach to health and productivity management; it is one where success is not measured by drug cost discounts alone but rather by a more important measure: total cost savings.

Our approach features the following:

- Focus on total medical cost—not just on the cost of the drug
- Value-based contracts and aligned incentives with pharmaceutical manufacturers, doctor groups, and pharmacies
- Strong negotiating ability, operational expertise, and innovative network strategies
- Client options that will improve affordability but stay true to company culture

Cigna Pharmacy Management is an industry leader in coverage integration. By aligning and leveraging incentives, tools, and information across pharmacy, medical, behavioral, and disability plans, we are poised to deliver better results and lower health care costs and increase participation among our clients, our members, and health care professionals. This also allows us to ease administration tasks for clients and health care professionals alike. Cigna focuses on total health care costs, not just on drug costs. We demonstrate this every day in our connection to network doctors and our emphasis on keeping people healthy and productive as we work to manage the progression of disease for high-risk members.

Cigna's Formulary Strategy

A disciplined and active drug list strategy is an important focus at Cigna: We lower overall claim costs by moving drugs with hyper-inflated costs and/or those with viable alternatives off drug lists. We do this regardless of pharmaceutical company incentives. In 2016, our drug list strategy saved clients over $11 million just by removing just two drugs (which one of our largest competitors kept on its lists), and we decreased overall trend for our clients by 2–3 percent.

Although this position may decrease our competitiveness when consultants look at spreadsheet rebate value, we believe it is right for our clients because it will help significantly lower their claim costs immediately and over time.

We also apply a wait period on new FDA-approved drugs. We conduct an extensive review to assess whether the newly approved drug meets both clinical and affordability standards before we consider adding it to our drug lists.

Clinical Management
Improving outcomes goes beyond managing drug costs. Payers and employers must demand that care meets quality standards and rewards those whose efforts improve health and health spending outcomes. We improve health through:

- Interventions at every member touch point to help members save money and to counsel those most at risk (Integrated Touchpoint program)
- Improved adherence and shared health risk data through HealthEview that drives combined medical, disability, behavioral, and pharmacy discussions and coaching
- End-to-end alignments with outcome-based incentives for every stakeholder
- Personalized outreach to promote smart spending decisions

Although Cigna's successful approach to improving health and lowering costs has for years emphasized the member, we are now even more committed to simplifying the health care journey. This is because research shows that consumers are becoming more involved in their health and health finances, and this brings with it a higher demand for real-time personalized communication and services. To this end, we provide the following:

- One ID card, service number, health coach, and pharmacist team
- Medical and pharmacy resources, including a personalized and simple-to-use drug cost compare tool, available online and on the go
- Preference-specific communications and personalized coaching to educate members on optional cost-savings therapies

1.05 Quality Improvement Strategy

Cigna strives to improve the health, well-being, and sense of security of the members we serve. We accomplish this through an integrated approach to health care quality and affordability, and by providing relevant information to our members and health care professionals to engage them in achieving superior clinical outcomes that exceed industry standards. The quality and medical management program promotes and supports systematic assessment and continuous quality improvement (CQI) in phases of our business.
The Quality and Medical Management Program establishes standards that encompass all quality management oversight activities across the organization and is an integral

component of Cigna's health benefits delivery system. The quality program provides direction to management for coordinating quality improvement and quality management activities across departments, matrix partners, health services affiliates, and delegates. The program outlines quality monitoring standards and provides guidance in initiating process improvements when we identify opportunities. We design and document quality studies to objectively and systematically monitor, evaluate, and improve the quality and appropriateness of care and service.

Quality Program Measurement Activities

- Reviewing performance against key indicators as specifically identified in the quality work plan
- Promotion of quality clinical care and service, both in/outpatient services, provided by hospitals and health care professionals
- Evaluating satisfaction information, including survey data and complaint and appeal analysis
- Evaluating access to services provided by the plan and its contracted health care professionals
- Identify strategies to improve the health and health care disparities of the members we serve

Behavioral Programs

Of every four individuals who visit a primary care doctor, one has a mental health disorder. With fully connected pharmacy, medical, and behavioral coverage, Cigna offers significant savings, including through the following:

- Complex Psychiatric Management - achieves total cost savings of $3,800 per participant, with the majority of savings from avoided outpatient and ER visits
- Narcotics Therapy Management - achieves total cost savings of $2,300 per participant, with the majority of savings from avoided outpatient and ER visits
- Cigna Pharmacy Management - acts on potential misuse of narcotics and overuse of psychiatric medications when and where appropriate. We reach out to doctors to make them aware of these issues and the potential for drug misuse, and we send them a report on patient activity that includes doctor visits and prescribed medications. (This is at no cost to clients with Personal Health Solutions Plus [PHS+].)
- Bipolar Medication Adherence - achieves a 15 percent decrease in hospital admissions per member

1.06 Participation in Collaborative Quality Initiatives

The goal of Cigna Collaborative Care (CCC) is to have the majority of members with high-cost conditions and complex needs receiving care from health care professionals that have an incentive relationship with Cigna. To reach that goal, we designed CCC to meet health care professionals at their current level of quality, cost, and patient satisfaction and take them where they need to be. We offer innovative solutions that span the delivery system—from small and large doctor practices, hospitals, and specialist groups to everything in between.

Based on our profound experience with CCC, specifically with large doctor practices, we have learned that not every health care group or facility has the same resources, goals, and/or leadership support or is in the same stage of readiness. We collaborate through our

actionable, member-specific information and clinical consultative services to motivate doctors to improve quality and lower costs.

We will continuously improve and evolve CCC using a disciplined and rigorous test-and-learn methodology, and we will emphasize our unique ability to collaborate and connect with health care professionals.

1.07 Data Exchange with Providers

We continually, actively work to increase electronic claim submission volumes. Submitting claims electronically can help reduce health care professionals' paperwork, eliminate printing and mailing expenses, and improve claim processing accuracy. Health care professionals can view, track, and monitor claim status reports through electronic data interface (EDI). Health care professionals have two options for submitting claims: connect directly to our systems using a web-based free service called Post-N-Track®, or connect indirectly by using a clearinghouse, such as Emdeon®.

1.08 Data Aggregation across Health Plans

Information pertaining to this specific request is unavailable.

15) Excise tax incurred by the health plan

Describe for each segment the number of products covered by the information that incurred the excise tax paid by the health plan - applicable to year 2020 and later.
See Health and Safety Code section 1385.045(c)(3)(G) and Insurance Code section 10181.45(c)(3)(G)

Applicable to year 2020 and later

16) Complete the SB 17 - Large Group Prescription Drug Cost Reporting Form to provide the information on covered prescription drugs dispensed at a plan pharmacy, network pharmacy or mail order pharmacy for outpatient use for each of the following:

(i) Percent of Premium Attributable to Prescription Drug Costs

(ii) Year-Over-Year Increase, as Percentage, in Per Member Per Month, Total Health Plan Spending
(iii) Year-Over-Year Increase in Per Member Per Month Costs for Drug Prices Compared to Other Components of Health Care Premium
(iv) Specialty Tier Formulary List
(v) Percent of Premium Attributable To Drugs Administered in a Doctor's Office, if available
(vi) Health Plan/Insurer Use of a Prescription Drug (Pharmacy) Benefit Manager, if any

Complete SB 17 - Large Group Prescription Drug Cost Reporting Form - Excel

See Health and Safety Code section 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C) and Insurance Code section 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C)

17) Other Comments

Provide any additional comments on factors that affect rates and the weighted average rate changes included in this filing.

In the responses to questions 9 and 10 regarding trend:
- The Professional category includes Laboratory and Radiology,
- A de minimis amount of Capitation (professional and institutional) is included in Professional and Inpatient/Outpatient costs
- The Other category includes: DURABLE MEDICAL EQUIPMENT, DRUGS ADMINISTERED, HOME HEALTH CARE, SERVICES AND SUPPLIES, TRANSPORTATION SERVICES, OTHER SERVICES, UNMAPPED MSC MINOR, OTHER MEDICAL SERVICES