Don Curry
President & General Manager of New England

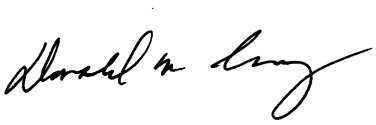
Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

Enclosed please find Cigna's written testimony in response to the Health Policy Commission's letter dated August 16, 2013. We have enclosed our responses to Exhibits B, C, and D, as well as supporting documentation and data in appendices. If you have any questions about our response, please contact Daniel Vigil, State Government Affairs Manager, at 347-271-0767 or daniel.vigil@cigna.com.

As President & General Manager of New England, at Cigna, I am legally authorized and empowered to represent Cigna for the purposes of this testimony. To the best of my knowledge, the enclosed written testimony and supporting documentation is complete and accurate. I sign under the pains and penalties of perjury.

Sincerely,



Don Curry

Exhibit B - Responses to the Questions from the Health Policy Commission

1. **C. 224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.**
    a. **What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?**
    b. **What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?**
    c. **What systematic or policy changes would help your organization operate more efficiently without reducing quality?**
    d. **What steps have you taken to ensure than any reduction in health care spending is passed along to consumers and businesses?**

1a and 1b:

Cigna is committed to achieving the "triple aim of improving health care outcomes, reducing health care costs, and improving patient satisfaction." To achieve this goal, we have made a commitment to moving health care reimbursement away from rewarding doctors and hospitals for volume of services provided to rewarding doctors and hospitals for value in terms of improving health. Part of that commitment is demonstrated by our activities in the accountable care organization area, which we refer to as Collaborative Accountable Care (CAC).

On July 1, 2013, Cigna established its first CAC in western Massachusetts by partnering with Baycare. The partnership will serve more than 17,000 individuals covered by a Cigna health plan who receive care from Baycare's 413 primary care physicians. Cigna will compensate Baycare Health Partners for the medical and care coordination services it provides. Additionally, the medical group may be rewarded through a "pay for value" structure if it meets targets for improving quality and lowering medical costs.

For additional information on Cigna's partnership with Baycare, please see Appendix 1.

1c:

We believe that a reformed health care system must have sufficient flexibility to allow marketplace participants, such as insurers, health care professionals, hospitals and other service providers, to compete and distinguish themselves based on relevant criteria such as quality, cost, accessibility and other innovation. To help foster this competition, policymaking should promote data transparency and sharing, support the formation of and remove barriers to innovative delivery structures, and build upon progress Massachusetts is already making in the areas of payment reform and benefit modernization.

1d:

Both our CAC initiatives and our Patient Care Collaboration pilot program foster, support and encourage the relationship between a primary care physician and the patient. This is important for a company such as Cigna where the bulk of our business is administrative services only (ASO) rather than the traditional HMO primary care physician gatekeeper model. In the ASO environment, savings from cost reductions are passed back to the employer.

2. **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increase in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of the actions?**

Our experience has shown that health care costs can be controlled and reduced when we successfully partner with our clients to improve the health of their employees. One of the tools we use to achieve this goal is deploying our "Your Health First" (YHF) chronic condition management program. Launched in 2012, YHF helps patients manage 16 disease states divided across five clinical categories. The program moves away from a previously siloed approach to healthcare coaching to one in which each employee with a chronic condition has access to a single coach who can address health care coaching needs across multiple conditions. Some of the results we have seen with this novel approach include appropriate use of controller medications among 88 percent of asthmatics in YHF, appropriate medication management for 91 percent of individuals with heart failure, and appropriate Hemoglobin A1c measurement among 80 percent of diabetics enrolled in the program.

Recognizing that some patients will require hospitalization, in 2011, Cigna embarked on an investigation to look for new ways to reduce re-hospitalization. What we found was that when we place a care coordination follow-up phone call to patients within 24 hours of being discharged from the hospital, we were able to successfully reduce readmission rates by 22 percent. The program, which initially involved almost 4,000 Cigna members with high-risk gastrointestinal, heart or lower respiratory health problems, remains very important in our effort to reduce health care costs. The results of our study were published in the January 2013 issue of the *American Journal of Managed Care*. Hospital readmissions represent a huge portion of unnecessary--and preventable—health care costs, accounting for 30 percent of total inpatient costs among commercial health insurance members. This continues to allow us to reduce health care costs and save money for our administrative services only clients.

3. **C. 224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions have your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?**

Although fee-for-service remains the primary means of physician reimbursement in the Commonwealth, the reimbursement model referenced in our responses to Question 1 is one of the ways that Cigna is steering the industry away from straight fee-for-service in Massachusetts. Recognizing the need to continue this effort, in July 2013, Cigna began experimenting with a reimbursement model that provides specific financial incentives for primary care physicians in Connecticut when they provide documentation reflecting improved patient outcomes, such as compliance with evidence based medicine treatment guidelines. We expect to learn valuable information from this pilot which will allow this method to expand.

Both systemic limitations and a high propensity of administrative services only funding can limit execution of these strategies.

4. **C. 224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line how your organization is meeting this expectation, including, as of July, 1, 2013, The number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.**

Cigna attributes all members to a primary care provider, as long as there has been some experience to do so. For a detailed description of our methodology, please see Appendix 2.

5. **Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?**

The Cigna Care Designation is Cigna's high performance network that identifies high performing doctors in 22 of the most common specialties, including three primary care categories using industry standard metrics. Every member has access to Cigna Care Designated physicians provided that it is within one of the 32 states in which we provide the designation. Only the western part of Massachusetts is included in the program. Cigna uses board certification and other third-party quality measures to identify those doctors/specialists who are proven to improve outcomes such as lower hospitalization rates, fewer readmissions and better cardiac, diabetes, stroke, and women's health care. Cigna Care designated doctors are 16 percent more cost-efficient on average than non-designated doctors, which helps customers and clients save on health care costs.

Additionally, our innovative Centers of Excellence program helps members make more informed health care decisions by providing them with hospital quality data that includes both outcome and cost comparisons for specific procedures via our online directory. Furthermore, there is a cost estimator tool for the most common 200 procedures so a

member can see their projected costs based on the facility they choose. Each medical member has access to the Centers of Excellence program.

For additional information on the Cigna Care Designation and the Centers of Excellence program, please see Appendix 3.

6. **Please describe the impact of your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.**

Delivery system consolidation in Massachusetts has created an environment whereby large delivery systems can dictate rate and trend requirements. Although this is not a new dynamic, it continues to accelerate and put additional significant pressure on employers. Additionally, this lack of a competitive environment limits our ability to create tiered and narrow network strategies which would mitigate total medical cost exposure and for which Massachusetts employers strongly desire.

7. **Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance, or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.**

To demonstrate compliance with the provisions in Section 206 of Chapter 224 of the Acts of 2012, Cigna filed for approval our Comprehensive Price Transparency Plan. Cigna fully embraces the empowerment of our consumers and health care providers to make informed and cost-effective health care decisions and has many such practices currently in place that customers can access via the secure Cigna portal or by calling the number on the back of their Cigna ID card to have customer service assist them with obtaining the information.

Cigna provides real time price information to our customers and incorporates procedure-level cost information into the health care professional directory on www.myCigna.com for over 200 procedures including labs, immunizations, office visits, radiology, outpatient procedures, and inpatient procedures.

For additional information, please see Appendix 4.

8. **After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.**

Cigna supports the recommendation by the Massachusetts Attorney General in April 2013 to measure and monitor the market implications of provider consolidation and alignments, particularly where consolidation may reduce access to lower-cost services for consumers and undermine efforts to promote value-based decisions by purchasers. Experience in the marketplace demonstrates that consolidation strengthens provider negotiating power, which can limit competition and result in higher prices for services without improvement in the quality of care delivered.

As required by statute, Cigna submitted data to the Massachusetts Center for Health Information and Analysis for its August 2013 annual report. Cigna's own analysis generally supports the findings outlined in the report regarding provider payments, particularly with respect to the ability of dominant providers in Massachusetts to obtain significantly higher payments relative to the market.

Exhibit C – Responses to the Questions from the Office of the Attorney General

1. **Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to CY 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed allowed claims trends is due to (a) demographic of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trend, payer mix trend).**

Please see the attachment labeled, "AGO Exhibit C1."

2. **Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:**
    a. **Market segment**
    b. **Membership whose care is reimbursed through a risk contract, by market segment**
    c. **Within your commercial large group, commercial small group, and commercial individual membership, by product line**
    d. **Membership in a tiered network product by market segment**
    e. **Membership in a limited network product by market segment**
    f. **Membership in a high deductible health plan by market segment.**

Please see the attachment labeled, "AGO Exhibit C2, for responses to a, c and f

C 2 b- N/A
C 2 d- N/A
C 2 e- N/A

3. **To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.**

Since 1/1/2011, Connecticut General Life Insurance Company (CGLIC) has realigned approximately 8 million members, predominately ASO, from CGLIC to Cigna Health and Life Insurance Company (CHLIC) which drive the changes reflected in the membership numbers listed in Question 2 above.

4. **Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors, or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit**

price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully insured).

Cigna has not shifted downside risk to the health care delivery systems or provider communities. Rather, it has been Cigna's strategy to partner with care providers through information exchange and total medical cost and quality performance improvement initiatives, and encourage delivery of such results through financial incentives.

5. **Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate transfer of insurance risk to providers.**

Not applicable.

6. **Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.**

As noted above, we have not shifted risk to the health care provider community. Our incentive approach is limited to provider partnerships with organizations that can demonstrate governance, appropriate care improvement infrastructure, and an expected capability to effectuate behavioral change.

7. **Please explain and submit supporting documents that show for each year from 2009 to 2013 the average prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited products. Include an explanation of assumptions around these price differences, such as (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products; and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.**

Not applicable.

8. **Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that**

promote health and wellness. Include in your response any analyses you have performed regarding the cost and benefit of such wellness programs.

Cigna's primary goal is to help improve our members' health, well-being, and sense of security, and we consider our wellness programs of primary importance in helping us achieve that goal. Many of our wellness programs and services are included at no charge to our clients and members. Clients who self-fund their health benefits program may also purchase additional telephonic and online wellness programs. Additionally, as part of the Health Promotion and Awareness Program, client engagement managers will willingly visit client locations and present complimentary, introductory health seminars, upon request. Other options include onsite wellness services and a health awareness day event.

For a detailed description of our wellness programs and services, please see Attachment 5.

Exhibit D – Responses to the Questions from the Center for Health Information and Analysis

1. **Do you analyze information or spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?**
    a. **If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with and identified and comparative providers.**

Not applicable.

APPENDIX 1: Additional response to Exhibit B, Questions 1a and 1b

Cigna's Collaborative Accountable Care (CAC) programs increase patient access to health care, improve care coordination, and achieve better health care quality, affordability, and patient satisfaction. Our CAC programs focus on high-risk individuals, including people with chronic health conditions such as diabetes or heart disease. CAC's help identify individuals who may have missed an important medical test, or health screening, or may be overdue for a prescription refill; help reduce unnecessary use of hospital emergency rooms; help increase preventive health visits; and help improve follow-up care for those leaving the hospital.

On July 1, 2013, Cigna established its first CAC in western Massachusetts by partnering with Baycare. The partnership will serve more than 17,000 individuals covered by a Cigna health plan who receive care from Baycare's 413 primary care physicians.

Consistent with our other CAC's, the principles of the patient-centered medical home are the foundation of Cigna's collaborative with Baycare. Cigna builds on that foundation with a strong focus on collaboration and communication with physician practices.

Under the program, Baycare Health Partners monitors and coordinates all aspects of an individual's medical care. Patients continue to go to their current physician and automatically receive the benefits of the program. Individuals who are enrolled in a Cigna health plan and later choose to seek care from a doctor in the medical group will also have access to the benefits of the program. There are no changes in any plan requirements regarding referrals to specialists. Patients most likely to see the immediate benefits of the program are those who need help managing chronic conditions, such as diabetes or heart disease.

Critical to the program's benefits are registered nurses, employed by Baycare Health Partners, who serve as clinical care coordinators and help patients with chronic conditions or other health challenges navigate the health care system The care coordinators are aligned with a team of Cigna case managers to ensure a high degree of collaboration between the medical group and Cigna that ultimately results in a better experience for the individual.

The care coordinators enhance care by using patient-specific data from Cigna to help identify patients being discharged from the hospital who might be at risk for readmission, as well as patients who may be overdue for important health screenings or who may have skipped a prescription refill. The care coordinators are part of the physician-led care team that helps patients get the follow-up care or screenings they need, identifies potential complications related to medications and helps prevent chronic conditions from worsening.

Care coordinators can also help patients schedule appointments, provide health education and refer patients to Cigna's clinical support programs, such as disease management programs for diabetes, heart disease and other conditions; and lifestyle management

programs, such as programs for tobacco cessation, weight management and stress management.

Cigna will compensate Baycare Health Partners for the medical and care coordination services it provides. Additionally, the medical group may be rewarded through a "pay for value" structure if it meets targets for improving quality and lowering medical costs.

APPENDIX 2: Additional Response to Exhibit B, Question 4

Alignment:

- Uses 24 months of retrospective medical claim data.
- Is run nationally (customer/patient is only aligned to 1 health care professional)
- Uses 29 Evaluation & Management (E & M) procedure codes:
  Office Visit E&M New & Established (99201 – 99205; 99211 – 99215)
  Office Visit Preventive New & Established (99381 – 99387; 99391 – 99397)
  Office Consult (99241 – 99245)

Step 1 - Alignment to Primary Care Physician
Uses Servicing Provider Specialty for Primary Care (See Table 1)

- **Current 12 months**
  - For the most recent 12 months of claims, select services for the 29 E & M codes and sum by customer and PCP (sort by customer ID, # of visits).
  - Customer is assigned to the PCP with the most visits.
  - If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most visits and the most recent visit.
- **Prior 12 months**
  - For customers NOT aligned for the most recent 12 months (no PCP visit), select services for the 29 E & M codes for the prior 12 months (sort by service date).
  - Customer is assigned to the PCP with the most recent visit.

Step 2 – Alignment to a Nurse Practitioner, Physician Assistant or Ob/Gyn Health Care Professional (if customer is not aligned to a PCP in Step 1)

Uses Servicing Provider Specialty for Nurse Practitioners, Physician Assistants and Ob/Gyns. Nurse Practitioners and Physician Assistants must have a Cigna role code of Primary Care in order to have customers aligned (See Table 2)

- **Current 12 months**
  - For the most recent 12 months of claims, select services for the 29 E & M codes and sum by customer and health care professional with a Nurse Practitioner, Physician Assistant or Ob/Gyn specialty (sort by customer ID, # of visits).
  - Customer is assigned to the health care professional with the most visits.
  - If there is a tie for the number of visits (to multiple health care professionals), assignment is to the one with the most visits and the most recent visit.
- **Prior 12 months**
  - For customers NOT aligned for the most recent 12 months (no Nurse Practitioner, Physician or Ob/Gyn visit), select services for the 29 E & M codes for the prior 12 months (sort by service date).

- Customer is assigned to the health care professional with the most recent visit.

Additional checks:

Distance radius check to compare customer zip code to aligned health care professional zip code
If alignment is to a health care professional with a distance greater than100 miles, customer is aligned using the 'next best' alignment from Step 1 and 2 above. If there is no other service to a health care professional with an appropriate specialty within 100 miles, customer is not aligned.

Customer eligibility in the most recent 12 months
If customer was not active in the most recent 12 months (e.g., customer did not have at least 1 month of eligibility), exclude from alignment.

Changes affecting market/peer group alignment:
Collaborative Accountable Care (CAC) aligned patients/customers and associated utilization and costs will be excluded from market peer group. For historical reports, the CAC aligned patients, utilization and costs are included in the market peer group.

Table 1: Cigna PCP Specialty Codes

Provider Category	Cigna CPF Specialty Code	Specialty
PCP	FP	Family Practice
PCP	XI	Family Practice Staff
PCP	GP	General Practice
PCP	IM	Internal Medicine
PCP	XM	Internal Medicine Staff
PCP	GE	Geriatric Medicine
PCP	GM	Geriatric Medicine Staff
PCP	PD	Pediatrics
PCP	XU	Pediatrics Staff
PCP	AM	Adolescent Medicine

Table 2: Cigna Specialty and Role Codes

Provider Category	Cigna CPF Specialty Code	Specialty	Role Code
Nurse Practitioner	NF	Family Nurse Practitioner	
Nurse Practitioner	NG	Family Nurse Practitioner Primary Care	
Nurse Practitioner	NH	Adult Nurse Practitioner Primary Care	

Nurse Practitioner	NK	Gerontological Nurse Practitioner	
Nurse Practitioner	NS	Nurse Practitioner	P
Nurse Practitioner	NI	Pediatric Nurse Practitioner Primary Care	
Nurse Practitioner	NL	Pediatric Nurse Practitioner	P
Nurse Practitioner	NO	Women's Health Nurse Practitioner	
Physician Assistant	FA	Physician Assistant	P
Ob/Gyn	GY	Gynecology (no OB)	
Ob/Gyn	OB	Obstetrics	
Ob/Gyn	OG	Obstetrics/Gynecology	
Ob/Gyn	XO	Obstetrics/Gynecology Staff	
Ob/Gyn	MI	Midwifery	
Ob/Gyn	MW	Midwifery	

APPENDIX 3: Additional Response to Exhibit B, Question 5

Cigna Care Designation doctors are clearly identified in our health care professional directories and provide additional cost ratings and quality designations. By using this helpful information, customers make their own informed decisions about the doctors they choose.

We select doctors based on a combination of their quality and efficiency. We use state-of-the-art tools and input from third-party organizations to analyze the specialists' overall performance. The following criteria are used to determine network inclusion:

- **Cigna network participation** - Doctor meets Cigna credentialing standards
- **Board certification** is required
- **Performance index** - must have managed episodes of care for a minimum of 30 Cigna members over a two-year period for statistical validity
- **NCQA recognition** - for diabetes care, cardiac, stroke care, and low back pain, or Physician Practice Connections - Patient-Centered Medical Home (PCMH), effective use of technology in practice management, are automatically included
- **Evidence-based guidelines** - applies to specialties where evidence-based guidelines are provided by the Ambulatory Quality Alliance: allergy and immunology, cardiology, cardiothoracic surgery, colon and rectal surgery, endocrinology, family practice, gastroenterology, general surgery, hematology/oncology, internal medicine, nephrology, neurology, neurosurgery, OB/GYN, ophthalmology, orthopedics, otolaryngology, pediatrics, rheumatology, pulmonology, and urology.
- **Efficiency** - specialist's relative cost efficiency using the ETGs methodology, which compares medical costs for a given episode of care to other doctors

Factors impacting the projected savings are plan design, market location, and utilization of Cigna Care Designation doctors.

The doctor specialty types included in the Cigna Care Designation are those that represent a large portion of the medical costs in a given location, and that show a significant variation in treatment patterns among the specialists. These specialties are:

- allergy/immunology
- cardiology
- cardiovascular surgery
- colon and rectal surgery
- dermatology
- ear, nose, and throat
- endocrinology
- family practice
- gastroenterology
- general surgery
- hematology/oncology
- internal medicine

- nephrology
- neurology
- neurosurgery
- obstetrics/gynecology
- ophthalmology
- orthopedics and surgery
- pediatrics
- pulmonary
- rheumatology
- urology

The following are not currently assessed as part of the Cigna Care Network:

- participating general practitioners and pediatric sub-specialty doctors
- hospital-based doctors
- participating hospitals
- participating ancillary providers
- participating doctors whose specialty is not listed above

Doctors outside of the 22 listed specialties will be accessible to Cigna Care Network members at the standard level of in-network coverage.

Cigna Care Designation doctors are identified in the standard directories available to Cigna members in print and online at myCigna.com. We encourage members to refer to the online directory for the current Cigna Care Designation status. This information is also available by calling customer service.

Doctor profiles related to the 22 Cigna Care specialties and three PCP categories are available on myCigna.com. The cost efficiency data used to profile these specialists is converted into a ranking of two or three stars to assist members in comparing doctors on cost.

Our formal communication plan includes health care professional outreach, letters, and medical society communications. Internally, health care professional service areas receive training on Cigna Care Designation details, including how to respond to questions from health care professionals and members. Another aspect of the plan is an escalation process to address health care professional concerns.

Approximately 40 percent of every potentially allowed specialist in a health care professional network will receive the Cigna Care Designation.

Non-emergency services obtained from a Cigna Care designated doctor are covered at the highest in-network level (tier one level). A second level of in-network coverage applies to non-emergency services/items received from non-Cigna Care designated but Cigna contracted health care professional (tier two levels).

By giving members a better understanding of medical expenses, we help them take a more active role in their health and health care spending. Members receive covered services from Cigna Care Designation specialists and PCPs at the in-network level, and copays or coinsurance are more favorable than the standard in-network level. Members receiving covered services in-network from a non-Cigna Care Designation doctor are paid at the in-network level, and copays or coinsurance are at the standard level.

Members receiving covered out-of-network services are paid at the out-of-network level, and copays or coinsurance are at the least favorable level.

Health care professionals with these designations are identified in our health care professional directory in markets where we have transparency displays, and are given the Cigna Care Designation.

Centers of Excellence

Using publicly available external hospital data along with external patient safety standards from Leapfrog and the CMS to evaluate the quality of care, Cigna's Centers of Excellence program provides members with quality and outcome scores in the form of star ratings for 31 common procedures/conditions at participating hospitals. Hospitals that achieve the highest rating are identified as Centers of Excellence. The information is located on our website, www.Cigna.com and our personalized member website, myCigna.com.

As an extension of our Centers of Excellence strategy, we have developed an innovative program that allows members to view a hospital's rating via the online directory. The data is composed of measurements that assess patient outcomes and cost efficiency for performance in a select number of clinical categories. It is available on www.Cigna.com and our member website, myCigna.com, and is included with the plans.

The surgical procedures and medical conditions are determined by volume, variability of outcome, and member interest:

acute bronchitis - pediatric	Infant - premature
angioplasty, with and without stent	irregular heartbeat
bariatric surgery	laparoscopic gall bladder removal
cardiac catheterization	mastectomy/lumpectomy for breast cancer
cardiac defibrillator implant	pediatric asthma
cardiac pacemaker implant	pneumonia - adult
cesarean section	radical prostatectomy
COPD	removal of kidney/ureter
colon surgery	spinal fusion
coronary artery bypass surgery	stroke
disc surgery	surgery for female reproductive cancer
head and neck endarterectomy	total abdominal hysterectomy
heart attack	total hip replacement
heart failure	total knee replacement
heart valve replacement	vaginal delivery

Category-level Assessment:

orthopedic back - surgery	disc surgery spinal fusion
general cardiac - medical	heart attack heart failure irregular heart beat
elective cardiac - medical	cardiac catheterization angioplasty – with and without stent
pulmonary - medical	COPD pneumonia - adult

Ratings are represented by a scale of one to three stars, three being the best. Searches produce a listing of hospitals in the member's area and results are displayed in order of an overall rating for each facility, by procedure. The overall rating is a combination of quality and cost. Hospitals that achieve five or more out of a possible six stars, three stars for quality and three stars for cost, are identified as Centers of Excellence.

Patient outcome ratings are derived from a weighted average of the following measures: 1) complication rates; 2) mortality rates; 3) the CMS overall hospital quality measure; 4) and the CMS hospital condition-specific quality measures for heart attack, heart failure, and pneumonia care

Leapfrog Group Patient Safety Index

The data used to compare hospitals on patient outcomes is public. Hospitals in every state are required to submit detailed information to the federal government about Medicare patients they treat (generally over 65 and/or disabled), for what condition, and how successfully.

Additionally, many states also require hospitals to report data on patients, not just Medicare patients. WebMD Quality Services, a WebMD division, provides Cigna with the most currently available data for 50 states from state and federal governments and agencies.

Some hospitals treat more seriously ill people than others. To minimize the impact of this, we use an industry-standard methodology to severity adjust the included measures for each hospital relative to the others in the area.

Cost efficiency represents a measure of the hospital's cost (not including doctor fees and outpatient services) relative to the national average cost for a particular procedure or condition. This data is derived from a combination of Cigna contracted per diem rates and payers' average-length-of-stay total episode costs.

APPENDIX 4: Additional Response to Exhibit B, Question 7

For inpatient procedures, we calculate cost based on severity adjusted average length of stay data for the procedure as well as the hospital-specific average cost per day for the procedure. For outpatient procedures, the methodology ties together the doctor's professional charges, the hospital, lab, skilled nursing etc. charges (specifically for the places where the doctor performs that procedure based on claims history), as well as other charges such as anesthesia costs.

Estimates are created based on 12 months of Cigna claims data, with the key data elements being allowed charge amount (after discount and claim processing rules) by procedure. Estimates are created by Truven for other types of procedures and are also based on 12 months of Cigna claims data.

Before the claim methodology is applied, claim data is reviewed to remove claims with a place of service of emergency room, exclude ineligible charges, ensure that claim adjustments are reflected in the final claim amount, and group claims into plan coverage lines (PPO, HMO, Open Access Plus). The claim data is refreshed monthly.

Cigna's www.mycigna.com offers customers real time side-by-side medication pricing from 57,000 pharmacies nationwide, each according to the members' health plan. Cigna provides customers with a web tool that allows them to view individual provider prices. While the price of the physician service does not vary by product, customers may have different cost sharing benefits. A link is provided to allow customers to see their own cost sharing benefit requirements, including deductibles, OOP expenses and account balances of HSAs, HRAs or FSAs to assist them in calculating their cost-sharing expenses.

Our cost estimates are based on estimates created from our claim experience. We do not use fee schedules for transparency as we believe that it is of utmost importance to show the consumer all of the services associated with an "event or procedure". So for example, we would want to show all services associated with a knee arthroscopy, including Physician's changes, facility charges, and anesthesia and other ancillary charges. This helps the consumer to plan and budget for that service or procedure. Fee schedules cannot illustrate this example as it would require the customer to know exactly which CPT services they are receiving and add them all up. The consumer's provider has a tool that does allow for such exact selection by CPT codes as described in the Health Care Provider Cost of Care Estimator online tool.

As required by Massachusetts statute we provide the following disclosure with our Cost of Care Estimator:

"This cost estimate is intended to help you and your family better understand how much you may potentially need to pay for the specific health care service(s) indicated. Great effort has gone into ensuring that only the most meaningful information is made available through this estimate. However, Cigna does not guarantee or warrant the accuracy, reliability or thoroughness of any information contained in the estimate due to risk of

error or intervening factor that alters the actual costs. This is only an estimate; it is not a guarantee of coverage or payment. The final amount you will owe may be different from this estimate for a variety of reasons including, but not limited to: (1) your plan or the health care professional/facilities' contract with Cigna has specific inclusions, exclusions or unique variations, (2) the coverage ends, (3) there are other claims processed before these services are received, (4) fewer, more or different services are received, (5) you may have paid additional amounts toward your deductible, (6) your out-of-pocket maximum has been met (when the plan starts to pay 100% for covered services), (7) the available amount in your fund accounts (if applicable), or (8) the site of service chosen to receive the service."

As noted above, Cigna has a Health Care Provider Cost of Care Estimator online tool that allows Cigna contracted health care professionals to create an estimate of a customer's payment responsibility specific to that health care professional and the treatment or service, based on a real-time snapshot of the customer's Cigna administered medical benefits. Health care professionals in the Cigna Network can access the tool by going to the Cigna for Health Care Professionals website (www.Cignaforhcp.com) and clicking Estimate Patient Liability or from the Eligibility and Benefits page by clicking: Estimate Costs.

The Health Care Provider Cost of Care Estimator is available for patients in the following Cigna administered medical plans:

- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- Open Access Plus (OAP) and Open Access Plus In-Network (OAPIN)
- Managed Care plans (HMO, Network-EPP, HMO Open Access, Network Open Access, HMO POS-Flex, Network POS-DPP, HMO POS Open Access, Network POS Open Access)
- Patients with Cigna administered Choice Fund plans

This is a downloadable course that instructs the provider in the tool's use.
https://cigna-all.custhelp.com/ci/fattach/get/111704/1301080660/redirect/1/filename/Final_Estimator_Sales_%20eCourse%20updated%2003%2023%2011.ppt

Prior to rolling out the estimator on the customer portal, we piloted the program with five National Accounts for 12 months. During that time we did surveys and held user focus groups to determine the effectiveness of the estimator in meeting the consumer's needs. Most of the feedback supplied by the users was incorporated in the development of the tools. Additionally, we worked with a number of large physician groups to pilot the provider tool five years ago, as well as large physician data clearing management groups such as NaviNet, and Availability.

Overview of the
Cigna Customer Cost

APPENDIX 5: Additional Response to Exhibit C, Question 8

Complimentary Wellness Services

Many of our wellness programs and services are included at no charge to our clients and members. These include:

- **Health Assessments** - Cigna's online health assessments help members identify potential health risks and steps to leading a healthier life. Powered by analytics from the University of Michigan Health Management Research Center (UM-HMRC), Cigna uses health assessment responses to help identify members who could be helped by our health advocacy programs and services.
- **Health Information Line and Audio Library** - Cigna's health information line provides convenient, toll-free access to medical information at any time of the day or night. Members can speak with nurses (licensed as registered nurses in at least one state) to obtain general health information, level-of-care information, and information about doctors, hospitals, and other health care professionals.
- **Healthy Rewards® Discount Program** - Cigna offers discounts for a variety of health and wellness products and services related to weight management and nutrition, fitness, vision and hearing care, tobacco cessation, alternative medicine, mind/body care, and vitamins.
- **Cigna's Health Promotion and Awareness Program** - This program offers employers tools and resources to design, implement, and communicate a health improvement strategy. The year-long program targets national health observances and other important health themes, as outlined in the included yearly wellness calendar. The calendar may be used as-is, or customized to reflect client-specific health promotion and wellness strategies. Through the "VitaMin" communication series, clients receive several items for distribution to their employees. Items include a monthly newsletter, monthly Cooking Light recipes, an informational postcard, and a "myth of the month" eCard. Turnkey health awareness campaigns and introductory worksite wellness "lunch and learns" are also available on site.
- **Client Wellness Website, the Well** – This site allows clients to access an assortment of free health and wellness resources, including how best to promote internal wellness initiatives/events. It is easy to extract information from the Well and post it on internal bulletin boards to promote awareness and program participation among internal groups.
- **Healthy Babies® Maternity Education** - This voluntary prenatal service program offers expectant parents educational materials from the March of Dimes and toll-free access to information and nurse support.
- **Targeted Wellness Communications** - We send targeted reminders annually to members in some markets who appear noncompliant with certain HEDIS effectiveness-of-care screenings and care standards (e.g., newborn/childhood immunizations, breast cancer screenings, cervical cancer screenings, colorectal cancer screenings, cholesterol management after a heart attack, and diabetic

health screenings). Our Plain Talk Library® includes brochures on a variety of wellness and preventive care topics.

- **myCigna.com** - This personalized, confidential website grants members access to interactive health tools based on the current recommendations of the U.S. Preventive Services Task Force. Members also have access to industry-leading decision-support tools, including our health care professional locator/quality assessment tools and our online health library. We also provide personalized Health Trackers—graphic tools for tracking important health measurements over time.

Telephonic and Online Wellness Programs Available for Purchase

Clients who self-fund their health benefits program may also purchase additional wellness programs and services, including:

- **Cigna Health Advisor®** - We provide healthy and at-risk members with one-on-one coaching from a health advocate (nurse, health educator, behavioral clinician, or nutritionist) for six health topics/conditions, including hypertension, hyperlipidemia, healthy eating, physical activity, prevention, and pre-diabetes. Predictive modeling and other identification sources also allow health advocates to coach members coping with one of several preference-sensitive care conditions. Outreach for identified potential gaps in care related to hypertension and hyperlipidemia is also part of this program. Please note that Cigna Health Advisor is included at no additional charge when clients elect a Choice Fund program (health reimbursement account or health savings account).
- **Lifestyle Management Programs** – Health advocates deliver phone-based coaching. Members can choose to participate through online coaching if that is their preference. Onsite lifestyle management coaching for a variety of topics is also available. Together, coaches and members develop and maintain a personalized, goal-oriented behavior modification plan.
- **Your Health First® Chronic Condition Coaching** - The innovative Your Health First chronic condition coaching model takes a broad approach to helping members manage chronic health conditions. In addition to coaching for identified chronic conditions, and in support of working with the whole person, Your Health First coaching includes health and wellness coaching, treatment decision support, gaps-in-care coaching, and lifestyle management coaching.
- **Incentive Programs** - Cigna's incentive plans accommodate a wide array of applicable programs, providing employees with many incentive-earning opportunities. Award types include HRA/HSA contributions, premium reductions, and other client-specified discounts. Clients can determine award values to align with each company's culture, budget, and goals.

Complimentary Onsite Introductory Health Seminars

As part of the Health Promotion and Awareness Program, client engagement managers will willingly visit client locations and present complimentary, introductory health seminars, upon request. Programs typically occur during a "lunch and learn" or health awareness day at key client locations. The calendar included with the Health Promotion and Awareness Program includes a list of optional monthly seminars, providing clients the flexibility to present/schedule presentations on topics appropriate for the health and wellness challenges most relevant to the employee population.

Available introductory wellness seminar topics include: blood pressure, breast cancer, cholesterol, healthy babies, healthy eating, healthy meal planning, men's health, physical activity, skin cancer, sleep, stress management, weight management, and women's health

Introductory seminars include an onsite speaker and related educational materials. Topics for the wellness seminars are linked to the theme of the month. Printed materials and giveaways or raffles intended to increase onsite wellness seminar participation may incur additional costs.

Our Health Promotion and Awareness Program delivers health information consistently, and can serve as an important foundation to your wellness initiatives.

Onsite Wellness Services Available for Purchase

Cigna can also provide the following onsite wellness services at client locations:

- **Onsite Biometric Screening Events** - The highly effective health screening packages help identify prevalent conditions including hypertension, elevated glucose levels, and elevated cholesterol levels. Participants receive results and staff members deliver recommendations for healthy behavior change. Clients receive an aggregate report that provides direction for condition-specific health and wellness program referrals and actions based on the report findings. These screenings are presented directly by Summit Health. They are available to adults, age 18 and older. We charge on a per participant basis.
- **Onsite Flu Clinics** - This seasonal immunization positively impacts the overall health and wellness of the employee population. Immunizations are administered at worksites by onsite staff, with or without additional support as determined by the volume and timing of delivery. Worksite flu clinics increase the number of employees who are vaccinated against the flu, helping to reduce future health and disability claims and increase employee productivity. These immunizations are presented directly by Summit Health. They are available to adults, age 18 and older, who are not pregnant or nursing. We charge on a per participant basis.
- **Onsite In-depth Wellness Seminars** - We closely analyze the workforce and biometric screening results to determine which of the over 65 available seminar topics are most suitable for certain populations at various locations. We leverage and apply our knowledge of a client's population to recommend seminar topics to address risks and complement other worksite activities. While these clinical seminars are typically delivered on site, a separate webinar format is also

available. Cigna provides these services directly for adults aged 18 and older. We charge on an hourly basis.

- **Onsite Coaching** - Cigna provides full-time, part-time, or hourly worksite health coaching. Onsite coaching sessions provide a trusted, convenient resource for employees interested in face-to-face coaching. These worksite interventions strive to increase active participation in health and/or disease management programs. The industry's most knowledgeable health coaches help employees understand their health status, inform employees of potential risks, and teach people how to achieve and maintain personal health goals. Cigna provides these services directly for adults aged 18 and older. We charge on an hourly basis (minimum of four hours on site).
- **Onsite Lifestyle Management Programs** - The Metabolic Syndrome Improvement Program is a multi-modal lifestyle improvement program that offers education and tools to incorporate healthier nutritional and physical activity habits into their lives, and to sustain these changes as life-long commitments. This program combines proven lifestyle improvement strategies, specifically targeting employees with or at risk for metabolic syndrome through an intense 90-day program. These classes/webinars/self-directed modules are provided for adults aged 18 and older, and are charged on a per participant basis.

Health Awareness Days

A health awareness day event (sometimes called a health fair) gives clients the opportunity to provide their employees and their family members the following services: disseminate health information, raise awareness of targeted health issues. provide demonstrations of healthy practices, provide preventive health screenings and immunizations, and inform participants about available wellness program resources.

A health awareness day successfully accomplishes these goals efficiently for a large number of people in an engaging event that people will be eager to attend. The event can serve as a health promotion and wellness program launch, with activities and objectives tied to your organization's health risks and cost drivers.

Cigna provides a health awareness day planning guide to assist with the execution and evaluation of a health awareness day. We may be able to offer the following activities during health awareness day events: skin safety/DermaScan screening, step test, body composition, grip strength, flu shots, biometric screenings, health seminars, and health literature.

Total	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY2010	4.8%	0.3%	*	-1.4%	3.6%
CY2011	8.5%	-3.1%	*	-2.4%	2.7%
CY2012	4.0%	-12.9%	*	0.5%	-8.9%
YE Q1 2012	[redacted]				-1.4%
YE Q1 2013	[redacted]				-4.9%

*Given the growth of business on CHLIC we did not think we could accurately normalize the impact of provider mix and report a distinct trend figure. The impact of provider mix is captured in unit cost and to a lesser extent service mix.

1. Actual Observed Medical Expenditure Trend
    a. For 2010 through 2012, demographics of the population increased observed trend for MA residents by 1.6% in 2010, 0.8% in 2011, and 0.6% in 2012. Nationally, these figures are 1.8%, 0.4%, and 0.2% respectively.
    b. Benefit buy downs decreased observed trend for MA residents by 1%, 5%, and 1.4% for the years 2010-2012. Nationally these figures are 1.6%, 1.7%, and 2.1%.
    c. The health status of this population had a range of estimated costs associated with the identified health risk. The range of impact on trend is estimated to be between -0.3% and 15.7% in 2010, between -4.0% and -22.3% in 2011, and between -8.5% and 23.1% in 2012.

Period	FUNDING	PRODUCT	Total Member Months
200912	ASO	CARVEOUT Pharmacy	2
200912	ASO	HMO	181
200912	ASO	HMO POS	2
200912	ASO	INDEMNITY	20
200912	ASO	PPO	8836
200912	Fully Insured	CARVEOUT Pharmacy	2
200912	Fully Insured	HMO	69
200912	Fully Insured	HMO POS	40
200912	Fully Insured	INDEMNITY	20
200912	Fully Insured	PPO	3148
	Total		12,320
201012	ASO	HMO	109
201012	ASO	HMO POS	1
201012	ASO	INDEMNITY	76
201012	ASO	PPO	8,810
201012	Fully Insured	Medicare	1
201012	Fully Insured	CARVEOUT Pharmacy	2
201012	Fully Insured	HMO	36
201012	Fully Insured	HMO POS	41
201012	Fully Insured	INDEMNITY	17
201012	Fully Insured	PPO	7,574
	Total		16,667
201112	ASO	HMO	28
201112	ASO	HMO POS	2
201112	ASO	INDEMNITY	79
201112	ASO	PPO	18,780
201112	Fully Insured	CARVEOUT Pharmacy	2
201112	Fully Insured	HMO	44
201112	Fully Insured	HMO POS	50
201112	Fully Insured	INDEMNITY	17
201112	Fully Insured	PPO	10,316
	Total		29,318
201212	ASO	CARVEOUT Pharmacy	209
201212	ASO	HMO	502
201212	ASO	HMO POS	143
201212	ASO	INDEMNITY	439
201212	ASO	PPO	65,062
201212	Fully Insured	CARVEOUT Pharmacy	1
201212	Fully Insured	HMO	160
201212	Fully Insured	HMO POS	76
201212	Fully Insured	INDEMNITY	27
201212	Fully Insured	PPO	19,839
	Total		86,458

Note: HMO & HMO POS products are network insurance products. CHLIC is no longer offering HMO prod

2. MA Residence Membership
    f. Massachusetts residents enrolled in a high deductible plan
        2009: Large Group 3,839
        2010: Large Group 3,589
        2011: Large Group 3,765
        2012: Large Group 12,000