

## 1. GENERAL INFORMATION

Insurance Company Name	Cigna Health & Life Insurance Company
NAIC Company Code	67369
HIOS Issuer ID	99248
State	Tennessee
Market Type	Individual
Proposed Effective Date	01/01/2016
Primary Contact Person and Title	Minhe Yu, FSA, MAAA, Actuarial Manager
Primary Contact Telephone Number	(860) 226-0342
Primary Contact Email	Minhe.Yu@Cigna.com

**Scope and Purpose of Filing:** Cigna Health & Life Insurance Company (CHLIC) is filing rates for comprehensive major medical products 99248TN002 and 99248TN006 for individuals & families, to be effective January 1, 2016. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to an existing product that has been submitted under policy form filing TNINDPPO042015, and a new product that has been submitted under policy form TNINDEPO042015. These policy forms are not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

## 2. PROPOSED RATE INCREASE

The proposed weighted average annual rate changes by product, without the impact of aging, are provided below. The rate change reflects the weighted average rate change for all terminating plans being mapped into a new plan. Table 1 in Section 21 provides the detailed mapping of terminating 2015 plans to new 2016 plans that was used for the development of the proposed rate change. Note that due to the introduction of product 99248TN006, some members on 2015 plans will be mapped to different 2016 plans based on geographic location. Specifically, existing members in Rating Area 4 will be mapped to product 99248TN006 since product 99248TN002 will no longer be available in Rating Area 4 beginning in 2016. Additionally, since no products will be offered in Rating Area 3 beginning in 2016, existing members in Rating Area 3 have been excluded from the rate change calculation. This mapping has been taken into consideration in the calculation of the proposed rate changes, and is reflected in Table 1 in Section 21 of this document.

2016 HIOS Product ID	99248TN002	99248TN006
<b>Proposed Rate Change</b>	14.0%	-7.6%

The following factors are the main drivers of the proposed rate change:

- Medical Inflation and unit cost changes of medical services year over year: The underlying claim costs are expected to increase from 2015 to 2016, which is reflective of anticipated changes in the prices of medical services, the frequency with which consumers utilize services, as well as any changes in network contracts or provider payment mechanisms.
- The non-grandfathered individual marketplace is evolving in light of the material segment changes initiated by the Patient Protection and Affordable Care Act (PPACA), such as the introduction of the guaranteed issue requirement, modified community rating, subsidies, the risk adjustment program and many other provisions. After consideration for expected risk adjustment transfers and reinsurance recoveries, the single risk pool experience for CHLIC in Tennessee was more adverse than assumed in the current rates. As a result, CHLIC's best estimate of the average market-wide morbidity of the covered population has increased compared to 2015.
- Transitional Reinsurance Program Changes: The amount of funding available to offset adverse experience is decreasing from \$6B in 2015 to \$4B in 2016. Consequently, the reduction in claim costs due to the program has decreased, driving an increase in premiums compared to 2015.
- Plan design changes and benefit modifications: Changes have been made to certain plans that are resulting in a decrease in expected cost share and therefore a decrease to premium. All plan designs conform to actuarial value and essential health benefit requirements.
- Change in tobacco rating: After an examination of national 2014 individual claims experience, CHLIC has increased the tobacco factor in 2016.

The requested rate change is not the same across all plans. The following factors drive different rate changes by plan:

- Differences in provider network, delivery system, and utilization management across plans
- Plan design changes
- Trend leveraging due to member cost sharing provisions
- CHLIC has made refinements to the manual rating methodology and refreshed the claim probability distribution (CPD) used in the development of the cost sharing for its plans based on its most recent group experience, which leads to different cost share and expected claim cost changes among plans
- CHLIC has updated the data and methodology used to project changes to customer utilization patterns as a result of changes in cost sharing

### 3. EXPERIENCE PERIOD PREMIUM & CLAIMS

- a. **Paid Through Date:** December 31, 2014
- b. **Premiums in Experience Period:** Premiums in experience period represent actual 2014 premiums received through 2/28/2015. [REDACTED]

- c. **Allowed & Incurred Claims:**

All claims are processed through CHLIC’s claim system. Allowed claims shown below represent the sum of payments made under the policy to healthcare providers.

IBNR claims are calculated using completion factors, which represent the known paid claims as a percent of the estimated total accrual as of a particular lag period after a service month. Completion factors for a given reporting period are developed based on historical run-out patterns, adjusted for actuarial judgment regarding deviance from the average (within a reasonable range based on historical deviance). The methodology used to calculate IBNR does not differ for allowed claims versus incurred claims.

[REDACTED]

### 4. BENEFIT CATEGORIES

To determine benefit categories, CHLIC uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- **Inpatient Hospital:** Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- **Outpatient Hospital:** Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital based professionals whose payments are included in facility fees.
- **Other Medical:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- **Prescription Drug:** Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

### 5. PROJECTION FACTORS

The Projection Factors described below are included in Section II, Worksheet 1 of the URRT.

- **Changes in the Morbidity of the Population Insured:** Experience was adjusted to account for expected morbidity differences between the underlying experience population and the projected 2016 population. The morbidity adjustment factor accounts for morbidity drivers specific to CHLIC's single risk pool, including the membership distribution by metal tier, cost-share reduction subsidy status, and network type. The morbidity adjustment factor also accounts for expected market-wide morbidity changes due to stronger individual mandate, increased awareness of Individual health insurance products and pent-up demand which is not expected to continue in 2016.
- **Changes in Benefits:** The adjustment for changes in benefits was derived by comparing the average manual allowed claim cost for the 2016 product portfolio, weighted by projected 2016 membership by plan, to the average manual allowed claim cost for the 2014 product portfolio, weighted by 2014 CHLIC experience membership by plan. This adjustment captures anticipated changes in average utilization of services due to differences between the average member cost-sharing during the experience period and the expected average member cost-sharing in the projection period.
- **Changes in Demographics:** An adjustment was made to account for the change in distribution by age and gender between the 2014 underlying experience and the expected 2016 membership. The adjustment factor was developed as the ratio of the membership-weighted average age factor using CHLIC's best-estimate age slope and 2016 projected membership, and a similar factor computed using the 2014 actual membership. An area adjustment was also made to reflect differences between the distribution of membership across rating areas in our experience population and our 2016 projected population.
- **Trend Factors:** The source data to determine the trend is national group experience adjusted for market-specific differences. Adjustments were made to account for differences in utilization across major service categories and differences in the formulary between group and individual. CHLIC's 2014 single risk pool experience is trended forward two years to 2016. The trend for group is deemed appropriate for use in development of individual rates because the networks constructed for group and individual are similar, and any differences in network are captured by a separate network savings decrement.

## 6. CREDIBILITY MANUAL RATE DEVELOPMENT

### a. Source & Appropriateness of Experience Data used in Developing the Manual Rate

The source data used to generate the Manual Rate is trended national group experience adjusted for state- and market-specific differences. The experience for the national group book of business is deemed appropriate for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are similar to the benefits required to be ACA compliant. The adjustments to the baseline data are addressed below.

### b. Adjustments made to the Data

The following adjustments were made during development of the Manual Rate to account for differences between the source data and characteristics of the anticipated population in the Individual Market for the proposed period:

- **Morbidity Load – A [REDACTED] load** was added to the manual rate to account for the difference in morbidity risk of the population underlying the manual rate and the anticipated Individual population in 2016. [REDACTED] The morbidity load comprehends the following components:
  - Overall health status in the Individual marketplace – Customers seeking coverage through the Individual market tend to have a different average health status than those who receive coverage through their employer. The average morbidity in the Individual market is driven by external factors such as the strength of the individual mandate, overall awareness of Individual health insurance products, and the presence or absence of transitional policies. All such factors are included in the morbidity load.
  - Membership distribution by metal tier and CSR plan – In the Individual market, individuals tend to select plans that best meet their health needs. Riskier individuals tend to choose plans with lower member cost-share. Additionally, individuals receiving CSR subsidies exhibit different utilization patterns due to differences in income and cost-share. The expected membership distribution by metal tier and CSR plan therefore impacts the overall expected morbidity in the single risk pool. This adjustment is applied to the index rate only and no plan-specific adjustments are made to account for anticipated differences in health status of enrollees across plans.
  - Network type – Morbidity is expected to vary by network type as individuals with lower health status are expected to choose broader networks that will meet their health needs. The expected membership distribution by network type therefore impacts the overall expected morbidity for the single risk pool. This adjustment is applied to the

index rate only and no network-specific adjustments are made to account for anticipated differences in health status of enrollees across networks.

- Demographic Adjustment – The experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, an adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2016 individual market than the distribution by age reflected in the data underlying the Manual Rate.
- Impact of EHB – Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a [REDACTED] load.
- Network Savings – CHLIC’s underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. [REDACTED]
- Pharmacy Formulary Savings – Pharmacy claim cost experience used in the development of the Manual Rate is based on national group experience. This group experience is representative of a broader formulary than the formulary associated with CHLIC’s individual product. The narrower formulary results in a savings of [REDACTED] on pharmacy claim costs compared to the Manual Rate.
- Hepatitis C and Tier 2 Specialty – [REDACTED] Also, generic specialty drugs have been moved from the Specialty Drug tier (Tier 5) to the Non-Preferred Generic tier (Tier 2) of the formulary. Together these changes resulted in a [REDACTED] increase to pharmacy claim costs.

**c. Inclusion of Capitation Payments**

There are no services provided under a capitation arrangement for plans included in this filing.

**7. CREDIBILITY OF EXPERIENCE**

Limited fluctuation credibility was used to determine the credibility assigned to the 2014 single risk pool experience. 2014 exposure of 100,000 member months was assigned 100% credibility. Therefore, the credibility assigned to 2014 single risk pool experience was 30.9%.

**8. PAID TO ALLOWED RATIO**

The expected cost-sharing ratio for each benefit plan is calculated by using group experience trended to the proposed filing period to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-sharing estimates. The expected Paid-to-Allowed Ratio for the 2016 single risk pool is [REDACTED].

Some differences exist between the cost-sharing as calculated above and the Metal AVs that are described in Section 18 of this document. These dissimilarities exist as a result of the following differences in methodology:

- The CPD used to calculate member and insurer cost-share is different from the underlying claims distribution in the continuance tables of the AV Calculator. The continuance tables are based on the default standard population developed by HHS using claims and enrollment from a national commercial database. The CPD is based on claims and enrollment data from CHLIC’s national group book of business. This experience-based CPD has a larger volume of its distribution at the tail, which represents higher average costs.
- The underlying cost assumptions for copays are different in the AV Calculator as compared to CHLIC’s experience. Since most of the proposed plans represented in this filing have copay based cost-sharing for Primary Care Physician and Specialist office visits and some plans have copays on additional services, this causes a difference between the Paid-to-Allowed ratio and the Metal AV for most plans.
- The AV Tool only accounts for in-network benefits, whereas the paid-to-allowed ratio incorporates the impact of out-of-network benefits as well for product 99248TN002.
- Cost-sharing for other benefits, such as separate copays for urgent care, is not captured in the AV Tool, whereas CHLIC takes these benefits into account when deriving the paid-to-allowed ratio.

Note that the Paid-to-Allowed ratio as shown above is CHLIC's best-estimate of the total expected paid claims that are the liability of CHLIC, divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in the Projection Period. The URRT does not accurately demonstrate the process used by CHLIC in the development of rates. As a result, in order to accurately reflect CHLIC's Projected Allowed Experience Claims, Single Risk Pool Gross Average Premium, Risk Adjustment, Reinsurance, and Expense assumptions in the URRT, an adjustment factor was applied to the Paid-to-Allowed ratio in Worksheet 1, cell V33 of the URRT.

## 9. RISK ADJUSTMENT & REINSURANCE

### a. Experience Period Risk Adjustment and Reinsurance Adjustments (PMPM)

Reinsurance recoveries for 2014 were estimated by applying the reinsurance parameters as outlined in the 2014 Notice of Benefits & Payment Parameters to 2014 CHLIC member-level experience in Tennessee. Projected reinsurance recoveries on IBNR claims was also estimated based on actual 2014 experience.

The expected member-level risk transfer amounts for 2014 were calculated based on 2014 CHLIC experience in Tennessee [REDACTED]. CHLIC-specific risk scores and other transfer formula components were calculated internally in accordance with the Notice of Benefit and Payment Parameters for 2014 final rule (CMS-9964-F). [REDACTED]

### b. Projected Risk Adjustments (PMPM)

A 2016 risk transfer [REDACTED] of [REDACTED] PMPM on an allowed basis, was assumed in rate development. To model the 2016 risk transfer, 2014 member-level risk transfer amounts were estimated based on 2014 CHLIC experience [REDACTED]. The projection for the 2016 risk transfer further adjusts these 2014 risk transfer amounts for:

- The expected change in market-average morbidity between 2014 and 2016, as outlined in Section 5 of this document
- The expected change in the morbidity of CHLIC's single risk pool between 2014 and 2016, as outlined in Section 5 of this document
- The recalibrated 2016 risk adjustment model, as outlined in the 2016 Notice of Benefits & Payment Parameters
- The average paid-to-allowed ratio as outlined in Section 8 of this document, to provide final estimates on an allowed basis for development of the Market Adjusted Index Rate

The projected average risk adjustment transfer, net of risk adjustment user fees of \$0.15 PMPM resulted in a final risk adjustment PMPM of [REDACTED]. This amount was applied to the Index Rate in the development of the Market Average Index Rate and does not match cell V35 on Worksheet 1 of the URRT, which is on a paid basis.

CHLIC does not anticipate any fees or receipts from the risk corridor program in 2016 and has not included any pricing adjustments for risk corridor payments in rate development.

### c. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance payments have been estimated using one full year of nationwide individual experience claims data in addition to a representative sample of nationwide group claims data. This data consisted of member-level claims data from full year 2014 trended to a 2016 basis and adjusted for the anticipated morbidity level as outlined in Section 6 in this memorandum. We believe that this adjusted claims data is representative of the annual distributions of claims per member we expect in 2016. Based on our claims data and the federal reinsurance parameters, we estimate that the reinsurance will cover [REDACTED] of allowed medical and pharmacy claims.

To estimate reinsurance contributions, an annual contribution of \$27 per covered life is assumed. The net effect on plan costs (contributions minus payments) is expected to be [REDACTED] PMPM. This amount was applied to the Index Rate in the development of the Market Average Index Rate and does not match cell V37 on Worksheet 1 of the URRT, which is on a paid basis.

## 10. NON-BENEFIT EXPENSES, PROFIT, & RISK

The following table illustrates anticipated breakdown of the retention components. [REDACTED] This equates to [REDACTED] and is derived based on the projected expenses as a portion of projected average statewide premium with a target loss ratio of [REDACTED].

Actual expenses on both a PMPM and percentage of premium basis will vary based on the actual size and distribution of membership by age and plan.

[REDACTED]

**a. Administrative expense load**

CHLIC’s non-medical expenses are split out as follows:

- Acquisition administrative expense – this includes, but is not limited to, incentive compensation & salaries for brokers and agents, commissions†, marketing costs (working media & non-working media), and vendor fees.
- Recurring administrative expense – this includes, but is not limited to, costs relating to customer analytics, service operations, account management, and corporate overhead.

The administrative expense load is based on internal estimates from CHLIC’s Financial Analysis team and is deemed appropriate for the plans proposed in this filing. To determine this load, membership for CHLIC’s benefit plans is projected as outlined in Section 20. This membership is then applied to known budgeted amounts for administrative expenses to determine an appropriate administrative load across all plans as a percentage of premium allocation. [REDACTED]

† [REDACTED]

**b. Profit & Risk Margin**

CHLIC has targeted a [REDACTED] profit margin that is built into its premium rates. [REDACTED] In the event that actual membership size and distribution differs from expectations, the actual profit margin may vary. There is no additional risk margin load.

**c. Taxes & Fees**

Please note that this section excludes contributions to Federal transitional reinsurance program and risk adjustment user fees, since these fees are included in the projected risk transfer and reinsurance recoveries, per Section 4.4.8 of the 2016 Unified Rate Review Instructions.

- Premium Tax is applied as 1.75% of premium
- Exchange User Fee is applied as 2.5% of premium‡
- PCORI Fee is applied as \$2.08 PMPY or 0.06% of premium
- Health Insurer’s Fee is applied as 3.0% of premium

‡ Exchange User Fees are applied as an adjustment to the index rate at the market level. Hence, the 3.5% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the 2.5% expected fee stated above.

**11. PROJECTED LOSS RATIO**

The projected 2016 PPACA MLR, without adjustment for credibility, for CHLIC’s individual products is [REDACTED].

[REDACTED]

[REDACTED]

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell X47 in Worksheet 1 URRT.
- Incurred Claims – projections for incurred claims are consistent with Cell X34 in Worksheet 1 of the URRT.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2016 (Final Rule)
- Earned Premium – projections for earned premium are developed by applying the projected average rate PMPM from cell V43 in Worksheet 1 of the URRT to the expected member months projections specified earlier.

- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2016 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

## 12. SINGLE RISK POOL

CHLIC has included all covered lives for every non-grandfathered product/plan combination in the individual market in Tennessee in the single risk pool, as specified in 45 CFR 156.80(d). Please note that CHLIC does not have any transitional policies.

## 13. INDEX RATE

The Index Rate of the Experience Period for this filing is [REDACTED]. The Index Rate of the Experience Period on Worksheet 1, Section 1 of the URRT represents the total combined 2014 allowed claims experience PMPM attributable to Essential Health Benefits in the single risk pool. It is consistent with the Experience Period Allowed Claims PMPM, as shown in Worksheet 1, Section 2 of the URRT, since no benefits in addition to EHBs were offered in the experience period.

The Index Rate for the Projection Period for this filing is \$405.46 and was developed in accordance with 45 CFR Part 156.80(d). The Index Rate for the Projection Period identified in Worksheet 1, Section 3, of the URRT was generated using the same methodology as used in determining the Single Risk Pool Gross Premium Average Rate in Cell V43 of Worksheet 1 in the URRT. Hence, the Projected Index Rate is a representation of the credibility blended Expected Allowed Claims for 2016 attributable to Essential Health Benefits, and incorporates the impact of trend, benefit, morbidity, and demographic adjustments as outlined in Sections 5 and 6 of this document. Refer to Section 7 of this document for additional information regarding the credibility attributed to single risk pool experience in the development of the Index Rate for the Projection Period. There are no benefits in addition to EHBs that are being covered under the proposed plans in 2016. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing.

## 14. MARKET ADJUSTED INDEX RATE

The Market Adjusted Index Rate for this filing is \$345.82. The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156.80 (d)(1). The following market-wide adjustments have been made to the Index Rate, as allowed under these rules:

- Federal Reinsurance Recoveries - The Index Rate has been adjusted for the net recovery from the reinsurance program. This adjustment equates to an impact of [REDACTED] PMPM.
- Risk Transfer - The Index Rate has been adjusted for the net transfer from the risk adjustment program. This adjustment equates to an impact of [REDACTED] PMPM on the Index Rate.
- Exchange User Fees - Exchange User Fees are applied as an adjustment to the Index Rate at the market level. The 3.5% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the 2.5% expected fee.

Please refer to Risk Adjustment and Reinsurance Section (section 9) for detailed explanation of how the Reinsurance adjustments and Risk adjustment were developed.

The Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

## 15. PLAN ADJUSTED INDEX RATE

### a. Plan Adjusted Index Rate for the Projection Period

Only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the Market Adjusted Index Rate to arrive at the Plan Adjusted Index Rates:

- Plan-specific actuarial value and cost sharing adjustments
- Adjustment factor to remove the portion of the cost that is expected to be recouped through the premium charged for tobacco
- Administrative costs, excluding the Risk Adjustment User Fee, Transitional Reinsurance Program fee, and Exchange user fees
- Impact of Provider Network, Delivery System and UM changes

The adjustment impact of specific eligibility categories for the catastrophic plan is not applicable since CHLIC does not plan to offer catastrophic plans in 2016.

Note that the AV and cost-sharing adjustment encompasses expected cost-sharing differences, utilization differences due to differences in cost-sharing, and an adjustment for non-tobacco user status.

The expected cost-sharing ratio for each benefit plan is calculated by using group experience over the experience period (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan.

In addition to cost sharing differences, this adjustment also includes utilization differences due to differences in cost sharing. In evaluating adjustment for utilization changes, CHLIC has relied on internal studies that used regression analysis at the major service category level, to develop a relationship between historical utilization and corresponding expected cost-sharing. This adjustment is consistent with the description on page 59 of the 2016 Unified Rate Review Instructions. There are no explicit and/or additional adjustments used in our rate development process that reflect expected differences in utilization due to health status.

The adjustment for non-tobacco user status was developed by a weighted average of the expected claim cost between tobacco-user and non-tobacco-user by an assumed distribution.

**b. Plan Adjusted Index Rate for the Experience Period**

The Plan Adjusted Index Rate for the Experience Period has been included in row 58 on Worksheet 2 of the URRT. This represents the expected non-calibrated statewide average premium for a non-tobacco user based on expected membership at time of 2014 Pricing. The Plan Adjusted Index Rate for the Experience Period differs from the average premium rate in Section 1 of Worksheet 1 due to the following items:

- Differences between projected and actual 2014 membership by age and geography
- The Plan Adjusted Index Rate represents the average projected 2014 premium for a non-tobacco user, while the average premium rate in Section 1 of Worksheet 1 includes non-tobacco users and tobacco users

**16. CALIBRATION**

CHLIC calibrates the Plan Adjusted Index Rates to apply the allowable rating factors (age and geography) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below.

**a. Age Curve Calibration**

The weighted average age factor for the projected membership was calculated using the Default Federal Standard Age Curve. The average age associated with this projected membership (rounded to the nearest whole number) is [REDACTED]. This single risk pool average age was determined using a blend of the current 2015 age distribution in the single risk pool and 2015 industry-wide enrollment data released by CMS. The Plan Adjusted Index Rate was divided by the weighted average age factor mentioned above, to arrive at the calibrated Plan Adjusted Index Rate for a 21 year old. A demonstration of how the Plan Adjusted Index Rate and the age curve were used to generate the calibrated Plan Adjusted Index Rate for each plan is provided below.

**b. Geographic Factors**

Rate variations among geographical areas vary only by the geographic rating regions defined by the federal government. Area factors reflect only differences in the cost of the delivery of medical services among rating areas for a standard population and fixed market basket of covered services. The following table shows the geographic factors for each defined area in Tennessee:



An average geographic factor is developed based on the projected distribution of membership across all areas. Then the calibrated Plan Adjusted Index Rate is calculated as Plan Adjusted Index Rate divided by this weighted average geographic factor.

A demonstration of calibration for the Plan Adjusted Index Rate is provided in the table below.



\* The Plan Adjusted Index Rate represents average premium for the projected single risk pool at the unrounded average age, weighted using the best-estimate Default Federal Standard Age Curve factors. Linear interpolation between integer Default Federal Standard Age Curve factors was used in the development of the Demographic Calibration factor.

**17. CONSUMER ADJUSTED PREMIUM RATE**

Consumer Adjusted Premium Rate is developed by applying the following allowable adjustments to the calibrated Plan Adjusted Index Rate.

- Individual and family tier – applied by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account
- Rating area factor – applied by multiplying the area factors to the calibrated Plan Adjusted Index Rate
- Age factor – applied by multiplying the age factor to the calibrated Plan Adjusted Index Rate
- Tobacco status – applied by multiplying the tobacco factor calibrated to the Plan Adjusted Index Rate

**18. AV METAL VALUES**

The AV Metal Values shown in Worksheet 2 of the URRT for the following plans were based entirely on the AV Calculator. Therefore, CHLIC has not submitted a Unique Plan Design justification for these plans.

HIOS Plan ID
99248TN0020001
99248TN0020003
99248TN0060001
99248TN0060003

The AV Metal Values shown in Worksheet 2 of the URRT for the plans listed below were based on the AV Calculator, with the exception of the following unique benefits for select plan designs:

- Cost Sharing for Pharmacy Generic Drugs
- Cost-Sharing for Pharmacy Retail vs. Home-Delivery Service
- Copays for Outpatient Mental Health and Substance Abuse Services

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). The impacted plans, alternate methodologies, and the reason for their use is explained in the accompanying actuarial certification titled “Unique Plan Design Supporting Documentation & Justification”.

HIOS Plan ID	
99248TN0020002	99248TN0060002
99248TN0020004	99248TN0060004
99248TN0020005	99248TN0060005
99248TN0020007	99248TN0060006

**19. AV PRICING VALUES**



CHLIC is not incorporating any impact due to the different morbidity or health status of individuals who select certain plans in the derivation of the Pricing AV. See Section 15 in this document for an explanation of the factors used in the development of the Pricing AV.

**20. MEMBERSHIP PROJECTIONS**

The membership projections for CHLIC’s benefit plans are developed internally as best estimates. They were derived from CHLIC 2015 open enrollment experience and assumed channel growth in Tennessee. Active membership splits were used to develop projections by exchange indicator and metal tiers, together with growth assumptions by channel. The projected distribution of member months represents our expectation of the industry average distribution of enrollment by age for the Individual Market for 2016. For Silver metal plans, the projected enrollment subject to cost-sharing reduction subsidies at each level is developed based on CHLIC’s most recent actual enrollment data.

Distribution by Plan by CSR-Level				
Plan ID	100% - 150% FPL	150% - 200% FPL	200% - 250% FPL	>250% FPL
99248TN0020003	27%	13%	6%	54%
99248TN0020004	27%	13%	6%	54%
99248TN0020005	27%	13%	6%	54%
99248TN0060003	27%	13%	6%	54%
99248TN0060004	27%	13%	6%	54%
99248TN0060005	27%	13%	6%	54%

**21. TERMINATED PRODUCTS**

Table 1 below provides a summary of the actual plan mapping for 2014 through to 2016. For purposes of completing Sections III and IV on Worksheet 2 of the URRT, plans having the highest membership in the Experience Period were mapped to plans offered in the Projection Period. Table 2 below provides a summary of this mapping. Further, “terminated” plans that were offered in the Experience Period but were not mapped to plans offered in the Projection Period for the purposes of completing these sections in the URRT are shown in Table 3.

**Table 1: Actual Plan Mapping**



**Table 2: URRT Mapping – Mapped Plans from the Experience Period**



**Table 3: URRT Mapping - Terminated Plans from the Experience Period**



**22. PLAN TYPE**

The plan types as inputted in Worksheet 2, Section 1 of the URRT accurately describe the plans in this filing.

**23. WARNING ALERTS**

Rows 54 & 56 – The Plan Adjusted Index Rate and Total Premium for the Experience Period differs from the average premium rate in Section 1 of Worksheet 1 due to differences in projected versus actual distribution of membership by age and geography. Additionally, the Plan Adjusted Index Rate for the Experience Period reflects the expected premium for non-tobacco users only. See Section 15 in this document for additional information regarding the Plan Adjusted Index Rate for the Experience Period.

Row 67 & 72 – Per Worksheet 2 of the URRT, the Total Incurred claims payable with issuer funds equals allowed claims less all allowed claims which are not the issuer’s obligation, including member cost-sharing, reinsurance and risk adjustment receivables or payables, and cost-sharing paid by HHS on behalf of low-income members. However, page 13 of the Universal Rate Review Instructions indicates that the Incurred Claims in Experience Period, as shown on Worksheet 1 of the URRT, is allowed claims less member cost-sharing and cost-sharing paid by HHS on behalf of low-income members. Therefore, cell F15 on Worksheet 1 of the URRT does not exclude expected receipts or payments to the reinsurance or reinsurance programs for 2014, while row 71 on Worksheet 2 does exclude these payments.

**24. EFFECTIVE RATE REVIEW INFORMATION**

**a. Financial Information**

Cigna Health & Life Insurance Company (CHLIC)					
(\$ Millions)	2011	2012	2013	2014	2015 (Proj)
Stat Capital & Surplus	543	1,018	1,714	2,800	3,123
Authorized Control Level RBC	44	172	355	480	591

CHLIC is in strong financial condition. The YE 2014 ACL RBC ratio was 603%. In prior years when the company was significantly smaller, the RBC ratio was much higher. For the next few years, CHLIC is expected to maintain an ACL RBC ratio around 540%. The proposed plans and rates will have an immaterial impact on the company’s financial condition, even with significant membership growth.

**b. Rating Information**

To see the proposed rate manual by age, area and smoking status please reference the accompanying QHP Rate Data Template. For additional rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying Plans Benefits Template.

Please note that CHLIC shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit, and a standalone exchange-certified pediatric dental policy.

**c. Other**

CHLIC’s anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is [REDACTED].

**25. RELIANCE**

In preparing the Part 1 Unified Rate Review Template submission, I have relied on data and analysis provided by Allyssa Ward, Actuarial Specialist. In addition, I have relied on external sources in order to develop the underlying assumptions for the development of the proposed premium rates.

**26. ACTUARIAL CERTIFICATION**

I, Minhe Yu, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify, to the best of my knowledge and judgment, that:

- a) The rates proposed in the above noted rate filing are
  - In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
  - Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
    - ASOP #5, Incurred Health & Disability Claims
    - ASOP #8, Regulatory Filings for Health Plan Entities
    - ASOP #12, Risk Classification
    - ASOP #23, Data Quality

- ASOP #25, Credibility Procedures Applicable to Accident & Health, Group Term Life, and Property & Casualty Coverages
  - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - ASOP #41, Actuarial Communications
  - Reasonable in relation to the benefits provided and the population anticipated to be covered
- b) The Projected Index Rate presented in this filing is:
- a. In compliance with all applicable state and Federal statutes and regulations in 45 CFR 156.80(d)(1)
  - b. Developed in compliance with the applicable Actuarial Standards of Practice
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
  - d. Neither excessive nor deficient
- c) Plan level rates were generated using only the index rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)
- d) The geographic rating factors reflect only differences in the costs of delivery, including unit cost and provider practice pattern differences, and do not include differences for population morbidity by geographic area.
- e) The percent of total premium that represents Essential Health Benefits included in Worksheet 2, Section IV, of the Part 1 URRT was calculated in accordance with applicable Actuarial Standards of Practice
- f) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans, save the exceptions shown in Section 18, which are further explained in the accompanying actuarial certification “Unique Plan Design Supporting Documentation & Justification”.

The URRT does not demonstrate the process used to develop the rates presented in this filing. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Marketplaces, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



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