RESPONSES OF BRIAN EVANKO
PRESIDENT, U.S. INDIVIDUAL SEGMENT
CIGNA CORPORATION

HEARING BEFORE THE HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
"PPACA ENROLLMENT AND THE INSURANCE INDUSTRY"

Attachment 1:
Additional Requests for the Record

The Honorable Michael C. Burgess

1. While some of the basic problems with the front-end components that individuals face on HeathCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.

1.a. Have any significant improvements been made to these components?

Response: Cigna does not have first-hand knowledge of what improvements CMS has made to the front-end components of HealthCare.gov. With regard to the back-end components, there are still processes that are in interim status or not yet developed. Other back-end systems have experienced improvement. For example, the quality of the 834 enrollment transactions improved over the course of open enrollment. CMS also improved its ability to electronically accept and communicate changes to existing policies (e.g., changes due to life events). Moreover, an interim enrollment reconciliation process completed testing in June and will be used to reconcile enrollment data between insurers and CMS. Cigna believes that these improvements must continue in order for the marketplace to function effectively.

1.b. How will these continued problems affect plan participation and premiums for 2015?

Response: Among other issues, many of the back-end processes, including the interim reconciliation process, remain largely manual, which is more burdensome and slower than a fully automated process. Issues regarding back-end processing were a factor in our assessment of whether to expand our participation on the Exchanges for 2015. These issues, however, have not had a material impact on premiums. Despite the ongoing issues with the back-end systems, Cigna will continue to work with CMS and other regulatory authorities to reduce the burden on Cigna customers and to help ensure access to Cigna's health insurance products.

2. 834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.

2.a. Has this been your experience?

Response: The table below provides the percentage of 834 enrollment transactions sent to Cigna for new enrollees in the Federally Facilitated Marketplace that were defective. A transaction was considered defective if errors were present that prevented the transaction from being received and fully processed by Cigna. The figures in the table below reflect the best information currently available to Cigna from other sources and show that the percentage of defective 834 enrollment transactions has generally decreased over time.

October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014
REDACTED							

2.b. What is your estimation of the failure rate?

Response: Please see our response to Question 2.a.

2.c. Has the failure rate improved over time and by how much?

Response: Please see our response to Question 2.a.

2.d. What problems has this caused for your companies, your enrollees, and contracted providers?

Response: Defective 834 enrollment transactions may cause a number of problems for enrollees. For example, errors in the 834 enrollment transactions may prevent or delay the effectuation of an insurance policy and/or slow the reconciliation of subsidy payments. Additionally, flawed data can create a situation where family members (e.g., spouses and/or dependents) are incorrectly not included on a health insurance policy.

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

3.a. Do you have an estimation of the number of duplicate enrollments in your system?

Response: Cigna has received approximately 3,000 duplicate enrollments.

3.b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

Response: I do not know how the Administration calculated its enrollment figures.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

4.a. If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

Response: In accordance with applicable regulations, Cigna will pay claims for the first 30 days of the grace period. Additional claims may be paid if the customer becomes current on his or her premium payments. Cigna would not be a part of any further payment arrangements between a provider and a patient.

4.b. If you do not pay the claims, who will make providers whole?

Response: Please see our response to Question 4.a.

4.c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

Response: Please see our response to Question 4.a.

4.d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of plans in the second and third month of the grace period.[1]

[1] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

5.a. Do you know how many enrollees are currently covered but behind on paying their premiums?

Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of plans in the second and third month of the grace period.[2]

5.b. The law says that you must provide this information to HHS. Are you doing so?

Response: Cigna provides regular reports to CMS in compliance with applicable laws and regulations. These reports include information to help CMS limit subsidy payments to enrollees who are eligible.

5.c. What is the process for communicating with providers when enrollees enter a grace period?

Response: Cigna has developed telephonic and online enrollment verification systems to make it easy for providers to determine enrollee eligibility. Additionally, Cigna has online resources related to PPACA that are available to everyone, including providers (*see, e.g.*, http://www.cigna.com/health-care-reform/).

6. Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.

6.a. Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?

Response: As an insurer, Cigna receives the amount of the premium subsidy as determined by CMS on the 834 enrollment file and/or pre-audit file. Cigna is not a party to the enrollment process through which income and other data is collected and that is necessary to calculate the premium subsidy for each individual or household. Insurers offering plans on HealthCare.gov are under an

[2] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

obligation as part of the Qualified Health Plan contract with CMS to bill the amount of the tax subsidy communicated to the insurer by CMS. Insurance companies, including Cigna, would be unable to determine if the amount of the premium subsidy communicated via the CMS enrollment file is correct or incorrect. Ultimately, Cigna must rely on the information received from CMS regarding subsidy eligibility and the amount of any subsidy provided to an enrollee.

It is Cigna's understanding that the reconciliation process to determine if an individual or household received too little or too much of a premium subsidy will involve comparing the individual's 2014 reported income information from their tax return with the amount of the premium subsidy from the Exchange as part of the tax filing process. It is also Cigna's understanding that any over- or underpayments of the premium subsidy would be collected or paid via the tax filing process.

6.b. Please describe the process if there is a process in place.

Response: Please see our response to Question 6.a.

6.c. If there is a process, have any miscalculated payments been reconciled?

Response: If any reconciliation has taken place Cigna, as an insurer, would not be informed. Cigna must rely upon the information provided by CMS. If enrollment information (including subsidy information) changes for an enrollee, Cigna would receive an updated enrollment transaction from CMS. However, premium subsidy amounts could be updated for a number of reasons, including individuals reporting updated income information. Accordingly, Cigna would be unable to determine if the cause of premium subsidy change was the updated information from the enrollee or a reconciliation due to "miscalculated payments."

6.d. If miscalculated payments have been reconciled, how many have been processed?

Response: Please see our response to Question 6.c.

6.e. Please provide an estimation for the administrative cost of these miscalculations if possible.

Response: Please see our response to Question 6.c.

6.f. How might the miscalculation or payments affect plans for next year in terms of participation or premiums?

Response: Please see our response to Question 6.c.

7. If a provider calls your company for information on the health care law, what resources or information is your company able to provide?

Response: If a provider is looking for general information on the health care law, we refer to them to our award-winning online resource "Informed on Reform," which is available at www.cigna.com/health-care-reform. Should a provider have specific questions about our plans and benefits, our customer service agents and health care professional experience teams are equipped to discuss plan designs, essential health benefits, and in-network and out-of-network reimbursements.

8. How much has your company been paid to date in premium tax credits?

Response: Cigna received approximately $60 million in Advance Premium Tax Credit payments from January 2014–June 2014.

9. How many plans has your company sold off-exchange in 2014? Provide this information for each state in which you sell.

Response: Please see Cigna's June 23, 2014 production to the Committee, in which it provided data (current as of June 16, 2104) regarding off-exchange enrollments.[3]

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The Honorable Pete Olson

1. In your experience, has CMS built the operation function to pay health plans participating in the federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?

Response: Cigna has received subsidy payments from CMS and, hence, there is a process in place to make subsidy payments to health insurance providers participating in the Federally-Facilitated Marketplace. As to whether the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts are currently working, payments are being made. Cigna must rely on information from the government when reconciling subsidy payments.

[3] Letter from Michael D. Bopp to The Honorable Tim Murphy and The Honorable Diana DeGette (June 23, 2014).

2. Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?

Response: We are not a position to comment on how CMS accounts for the monies collected by the Federally-Facilitated Marketplace user fee.

3. Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?

Response: Based on our interpretation of what is meant by "outstanding 834 transactions," Cigna has observed that some 834 transmissions contain errors (e.g., inaccurate or incomplete information), and Cigna works with CMS and the enrollee to rectify those errors. In other instances, Cigna may receive an 834 transmission for an enrollee who opts not to effectuate his or her policy by paying the first month's premium.

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The Honorable Cory Gardner

1. How many plans offered by your company did you cancel or discontinue in 2013 because of the health care law? Provide this information by the number of plans in each state and the total for your company nationwide.

Response: In 2013, 938 health insurance plans were cancelled for policy holders in Connecticut. To clarify my testimony on this point at the May 7, 2014 hearing, Cigna did not also cancel non-PPACA compliant health insurance plans in South Carolina. Instead, Cigna offered extensions to policy holders in South Carolina following the Administration's announcement regarding the ability to grandfather certain health plans through 2014 that would otherwise not be permitted under PPACA.

Additionally, due to the availability of guaranteed issue individual health insurance coverage through the Exchanges, various states, including Georgia and California, repealed their statutes that required Health Maintenance Organizations to offer conversion coverage for individuals who ceased to be eligible for coverage under a group health plan. As a result of these repeals, and the fact that these states now offer guaranteed issue individual policies, Cigna terminated the 150 conversion policies in California and seven conversion policies in Georgia.

Finally, 158,906 cancellation notices were sent to limited benefit plan policy holders in various states. These policies, which can no longer be sold due to certain provisions in PPACA, offered lower premium and coverage options for individuals.

2. How many plans did your company offer early renewal to in 2013 so they could continue in 2014 that would have otherwise been cancelled, ended, or otherwise modified by the health care law? Provide this information by the number of plans in each state and the total for your company nationwide.

Response: Cigna offered renewals in all states where it offered individual health insurance products, except for Connecticut. The chart below is based upon information currently available to Cigna and details the number of renewals for non-PPACA compliant plans offered in 2013. The total number of renewals offered nationwide was REDACTED

Arizona	California	Colorado	Florida	Georgia	North Carolina	South Carolina	Tennessee	Texas
REDACTED								

3. Last year the President apologized for the plans cancelled by the health care law and offered a delay of the enforcing of the requirements that led to the cancellations. This delay has since been extended. How many plans do you currently offer that do not meet the law's requirements but you are continuing to offer as a result of this policy? Provide this information by the number of plans in each state and the total for your company nationwide.

Response: Cigna no longer sells health insurance plans that are not PPACA compliant to new customers. The chart below is based upon information currently available to Cigna and details the number of non-PPACA compliant plans that were active for existing customers as of May 31, 2014. The total number of such plans nationwide was REDACTED

Arizona	California	Colorado	Florida	Georgia	North Carolina	South Carolina	Tennessee	Texas
REDACTED								

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The Honorable Morgan Griffith

1. One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians—particularly specialists—are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice—give up their specialist or pay the high cost sharing required for out-of-network physicians.

1.a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

Response: Cigna is not offering Exchange plans in Virginia. However, as a general matter, Cigna is constantly evaluating its provider networks to ensure customer affordability and quality. Moreover, Cigna is undertaking an effort to simplify and clarify its online provider directory to make it easier for consumers to find accurate information on which providers are in Cigna's networks.

1.b. What kind of information about provider networks will be available to help them choose a plan?

Response: Please see our response to Question 1.a.

1.c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

Response: Please see our response to Question 1.a.

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Attachment 2:
Member Requests for the Record

The Honorable Tim Murphy

1. Provide information on the number of plans your organization has sold in the Federally-Facilitated Marketplace.

Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of Exchange plans Cigna has sold.[4]

2. Provide any analysis conducted by your organization in 2012, 2013, or 2014 on the impact of the Patient Protection and Affordable Care Act on the premiums paid by consumers. Provide any other analysis conducted on deductibles, out of pocket costs, or the networks your company provides for plans sold on the Federally-Facilitated Marketplace or state exchanges.

Response: Please see Cigna's April 4, 2013 and May 13, 2013 productions to the Committee, in which it provided information related to the potential impact of PPACA on health insurance premiums.[5]

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The Honorable Marsha Blackburn

1. Submit to the Committee any analysis conducted by your organization or by another party for your organization on premiums for plans sold in the Federally-Facilitated Marketplace, state marketplaces, or off the federal or state exchanges in 2015.

Response: Cigna is aware of numerous organizations that have conducted analyses and published informative materials on potential premium changes in 2015 for health insurance plans sold on the Exchanges. For example, the American Academy of Actuaries published a document that details the potential "drivers" of premium changes

[4] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

[5] Letter from Michael D. Bopp to The Honorable Fred Upton (April 4, 2013); Letter from Michael D. Bopp to The Honorable Fred Upton (May 13, 2013).

next year.[6] Similarly, America's Health Insurance Plans ("AHIP"), Avalere Health, and the Urban Institute recently published their analysis and findings related to potential premium changes.[7]

If you are looking for different or other information, please contact us and we will be glad to discuss your questions further.

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The Honorable Michael C. Burgess

1. **Provide a list of individuals from your organization that have met with White House officials, including but not limited to the President, in 2014 to discuss the Patient Protection and Affordable Care Act. Include the date of the meeting, the location, and the individuals present at the meeting. Provide all documentation, including e-mail, relating to these meetings. This would include, but is not limited to, correspondence setting up the meeting, materials prepared in preparation for the meeting, materials distributed or obtained at each meeting, and materials prepared afterwards summarizing or discussing the meeting.**

Response: I am aware of three meetings attended by Cigna personnel and White House officials in 2014 during which topics related to the Patient Protection and Affordable Care Act were discussed. The first meeting, which concerned payment reform, occurred on January 14, 2014 in the White House complex. Cigna was represented by Dr. Alan Muney, Chief Medical Officer; Herbert Fritch, President of Cigna-HealthSpring (Cigna's Medicare Advantage company); and Kristin Julason Damato, Vice President, Public Policy & Federal Affairs. Among the other attendees were Chris Dawe, Health Policy Advisor to the National Economic Council and Timothy Gronniger, Senior Adviser for Health Care Policy, White House Domestic Policy Council.

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[6] American Academy of Actuaries, *Drivers of 2015 Health Insurance Premium Changes* (June 2014) (available at http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf).

[7] America's Health Insurance Plans, *What You Need to Know About 2015 Premiums* (June 25, 2014) (available at http://www.timeforaffordability.com/2015premiums/); Avalere Health, *Exchange Plan Renewals: Many Customers Face Sizeable Premium Increases in 2015 Unless They Switch Plans* (June 26, 2014) (available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1403791423_20140625_silver_market_disruption.pdf); Avalere Health, *Average Exchange Premiums Rise Modestly in 2015 and Variation Increases* (June 18, 2014) (available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1403119552_20140616_2014_Exchange_Rates_FINAL.pdf); Urban Institute, *Will Premiums Skyrocket in 2015?* (May 2014) (available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413410).

The second meeting, which concerned expatriate health plans, occurred on April 25, 2014 in the White House complex. Cigna was represented by David Cordani, President and CEO; Nicole Jones, General Counsel; Kristin Julason Damato, Vice President, Public Policy & Federal Affairs; and Neil Tanner, Chief Counsel. The meeting was also attended by Phil Schiliro, White House Advisor for Health Policy.

The third meeting, which was organized by the Business Roundtable, occurred on July 24, 2014 in the White House complex. Cigna was represented by Kristin Julason Damato, Vice President, Public Policy & Federal Affairs. Among the other attendees were Kristie Canegallo, White House Deputy Chief of Staff; Jeanne Lambrew, Deputy Assistant to the President for Health Policy; Tim Gronniger, Senior Advisor for Health Policy, White House Domestic Policy Council; Mark Iwry, Senior Advisor to the Secretary of the Treasury and Deputy Assistant Secretary, Treasury Department; and Dr. Meena Seshamani, Office of Health Reform, Department of Health and Human Services.

Cigna is reviewing whether it has documents responsive to this request.

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The Honorable Morgan Griffith

1. Provide a list of the states in which you will provide coverage on the federal or state exchange in 2015 and the date on which you will submit your 2015 premium rate filings. List the individuals in the federal or state government to which you will be submitting this information. Provide copies of those submissions to the Committee as they occur.

Response: The table below identifies the states in which Cigna has submitted 2015 premium rates filings for exchange plans and the date on which those filings were made.

State	Date Submitted
AZ	5/1/2014
CO	6/6/2014
FL	6/16/2014
GA	6/13/2014
MD	5/1/2014
MO	6/20/2014
TN	6/9/2014
TX	6/24/2014

Rate filing information is available on some state agency websites, including:

- Arizona Department of Insurance (available at http://www.azinsurance.gov/RateReview/HFAIpage.html#);

- Colorado Department of Regulatory Agencies, Division of Insurance (available at https://www.dora.state.co.us/pls/real/external_forms.serff_link#);

- Florida Office of Insurance Regulation (available at https://apps8.fldfs.com/IFileExternalSearch); and

- Maryland Insurance Administration (available at http://www.healthrates.mdinsurance.state.md.us/).