Cigna Health Insurance

Purpose of This Document

We post a Quality Overview for each Colorado Qualified Health Plan (QHP) on Connect for Health Colorado. It will give you information about company statistics, health plan accreditation, clinical quality measurement (medical care), enrollee experience (member satisfaction) and plan administration (efficiency, affordability and management) so you can compare health plans while you shop for insurance coverage.

Company Statistics

Founded In: 1982

Website: www.Cigna.com

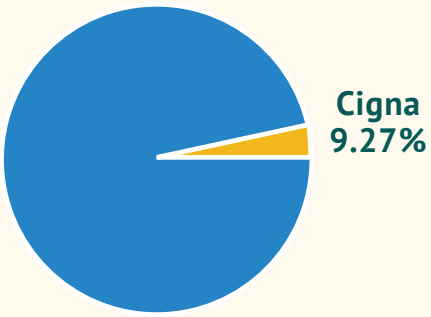
Coverage Area: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, Weld

Coverage area shows the area where a health insurance plan accepts members.

Colorado Membership (2021 Membership):

Individual Members: 27,811

Colorado Market Share



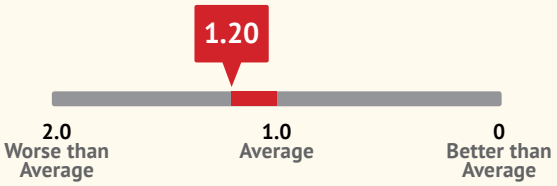
Percentage of total market share is based on all medical and dental carriers.

Confirmed Complaints

Confirmed Complaints: 80

People complain to the Colorado Division of Insurance (DOI) about things like claims handling, cancellation of a policy or a premium refund. In a "confirmed complaint," the DOI decided the insurance company did not follow the state insurance law or regulation, a federal requirement, or the terms and conditions of an insurance policy or certificate they sold. Confirmed complaints come from people in all group sizes, not just individual plans like those available at Connect for Health Colorado.

Consumer Complaint Index



The complaint index shows how often people complain about their health insurance company compared to other companies. These numbers are adjusted for the size of the company and how many policy holders it has in Colorado. A company's total number of complaints divided by its total premium income for a specific insurance product is the complaint index. The average is 1.0. An index greater than 1.0 means more people complained about **Cigna Health Insurance** than other companies.

Source: *2020 Colorado DORA Division of Insurance Online Complaint Report*

Medical Loss Ratio (MLR)

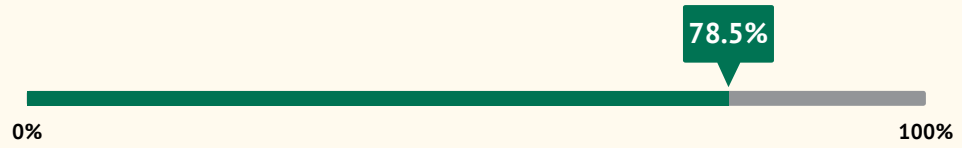
Medical Loss Ratio (MLR) Explained

The Affordable Care Act requires insurers to explain how much of your premium dollars are spent on medical services and quality improvement. This is called the Medical Loss Ratio (MLR). It also requires them to give you a rebate if they don't meet the minimum of 80% MLR for individual and small group plans. This limits the amount insurers spend on things like profits, executive salaries and other overhead.

Medical Loss Ratio for 2020*

Individual

Individual Patient Care Costs:



If a MLR is more than 100%, that company spent more money on medical care than it received in premium dollars.
**2021 MLR data not yet available.*

Accreditation

Accreditation for the Exchange Product

Accreditation is when an impartial organization reviews a company's operations to make sure the company is following national standards.

Accreditation: **NCQA Health Plan Accreditation (Exchange EPO)**

The National Committee for Quality Assurance (NCQA) is an independent not-for-profit organization that looks at and reports on the quality of health-related programs.

Accreditation Status: **Accredited**

Accredited means the organization's programs for service and clinical quality meet basic requirements for consumer protection and quality improvement. "Accredited" is the best possible status for Marketplace plans.

Quality Ratings

Understanding the Differences

Health Insurance Marketplace plans have different premiums and out-of-pocket costs, and the quality of service and benefits they provide may differ too. When choosing a health plan, it is important to understand and consider these differences. To help you decide what plan is right for you, we display "quality ratings" calculated using information provided by health plans each year. These quality ratings are based on enrollee experience and the quality of health care services. All health plan ratings are calculated the same way, using the same information source. This information comes from the federal Centers for Medicare & Medicaid Services (part of the U.S. Department of Health and Human Services) using data provided by health plans in 2022. You can learn more about these ratings on the federal web site. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Rating-System/About-the-QRS.html

Star ratings give you a snapshot of how each health plan's quality compares to that of other plans in Colorado and across the country. Star ratings give objective information on how health plans perform in the Marketplace. Since every plan offered is rated the same way, it is easy to compare their quality.

Quality Ratings System : Global Rating

Each rated health plan has an "overall" quality rating of 1 to 5 stars (5 is the highest rating). This rating is based on three categories: medical care, member experience, and plan administration. Each of these categories also has its own star rating between 1 to 5 stars. A star rating of 3 means that a health plan is considered on average with other Marketplace plans across the country. A star rating higher than 3 means the plan performed better than average compared to other Marketplace plans in a given year. A star rating lower than 3 means that a plan's performance was below average compared to other Marketplace plans in a given year. A star rating isn't a complete picture of the types of services and care a health plan provides. Each year, ratings may change because of information that health plans provide or changes to how the ratings are calculated.

Note: Ratings are calculated on a 5-year scale and may change from year-to-year. In some cases – like when plans are new or have low enrollment – ratings aren't available. This doesn't mean the plans are low quality.

Quality Ratings System : Summary Indicators

Medical Care

How well the plans' doctors, hospitals, and others in the plan's network improve or maintain member health through appropriate screenings, vaccines, and other basic services, and how informed and up-to-date your doctors are about your health care status, blood tests and x-ray results *(details on page 4)*.

Member Experience

How easy it is to get the care you need, when you need it and how other plan members rate their doctors and the care they get *(details on page 5)*.

Plan Administration

If the plan coordinates the care members get from different providers and how well the plan provides access to needed information *(details on page 6)*.

Additional Detail: More detailed measures are used to rate each Qualified Health Plan (QHP). You can find these additional measures in the Appendices. You can also search, compare and choose providers, hospitals and other health care facilities using tools on the federal website: www.healthcare.gov/find-provider-information

Appendix 1 : Clinical Quality Management

Below you will find the detailed measures used to assign the star rating for Medical Care.

Medical Care

How well the plans' doctors, hospitals, and others in the plan's network improve or maintain member health through appropriate screenings, vaccines, and other basic services, and how informed and up-to-date your doctors are about your health care status, blood tests and x-ray results.

Medical Care

- Asthma Medication Ratio
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Controlling High Blood Pressure
- Proportion of Days Covered (RAS Antagonists)
- Proportion of Days Covered (Statins)
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- Proportion of Days Covered (Diabetes All Class)
- Plan All-Cause Readmissions
- International Normalized Ratio Monitoring for Individuals on Warfarin
- Annual Monitoring for Persons on Long-Term Opioid Therapy
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Prenatal and Postpartum Care (Postpartum Care)
- Prenatal and Postpartum Care (Timeliness of Prenatal Care)
- Chlamydia Screening in Women
- Flu Vaccinations for Adults Age 18-64
- Medical Assistance with Smoking and Tobacco Use Cessation
- Annual Dental Visit
- Childhood Immunization Status (Combination 10)
- Immunizations for Adolescents (Combination 2)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits

** Note: Plan quality ratings and enrollee survey results are calculated by the Centers for Medicare & Medicaid Services (CMS) using data provided by health plans in 2022. The ratings are being displayed for health plans for the 2023 plan year. Learn more about these ratings at: www.healthcare.gov/quality-ratings*

Appendix 2 : Enrollee Experience

Below you will find the detailed measures used to assign the star rating for Enrollee Experience.

Member Experience
How easy it is to get the care you need, when you need it and how other plan members rate their doctors and the care they get.

Member Experience

- Access to Care
- Care Coordination
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist

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Appendix 3 : Plan Efficiency, Affordability & Management

Below you will find the detailed measures used to assign the star rating for Plan Efficiency, Affordability & Management or Plan Administration.

Plan Administration
If the plan coordinates the care members get from different providers and how well the plan provides access to needed information.

Plan Administration

- Appropriate Testing for Pharyngitis (sore throat)
- Appropriate Treatment for Upper Respiratory Infection (colds)
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Use of Imaging Studies for Low Back Pain
- Access to Information
- Plan Administration
- Rating of Health Plan

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