

Chair Black and Members of the House Health Care Committee:

Thank you again for the opportunity to testify on S.197 last week. During the meeting you had questions that I was able to track down answer for—I hope I captured them accurately. Please do not hesitate to contact me or my local counsel, Becky Lewandoski, if you have any questions or need more information. I look forward to continuing to work with you!

Q: What percentage of premium does Cigna spend on primary care in Vermont?

We don't have any data around Primary Care Spend as a percentage of *premium*. I am able to get primary care spend as a percentage of **total medical expenses** for state residents regardless of plan situs or funding. Primary care spend as a percentage of total medical expenses range between 4% and 6.5%.

Q: How are Cigna's value-based contracts structured? If we reward providers for prevention, chronic disease management and care coordination, what does that look like?

- Cigna's value-based care arrangements build on traditional fee-for-service payments with tiered, performance-based incentives tied to quality and total cost of care. Providers are paid through standard claims processing and may earn additional payments through pay-for-performance, shared savings, or advanced shared-risk arrangements depending on their level of readiness and accountability. Participation is voluntary, quality-gated, and designed to allow providers to progress along the value continuum over time.
 - **1. Base Payment: Fee-for-Service Remains the Foundation**
 - Providers continue to submit and be paid claims under standard FFS methodology (e.g., Medicare-based rates, commercial negotiated rates). This preserves cash-flow stability and limits disruption to practice operations. VBC payments are typically retrospective reconciliations, not replacements for claims payment. Value-based payments are additive or reconciliatory, not a wholesale replacement of FFS.
 - **2. Performance Incentive Payments (Upside)**
 - Providers can earn supplemental payments based on performance against predefined metrics, such as: Quality measures (e.g., preventive care, chronic condition management), Total cost of care benchmarks, Utilization efficiency (e.g., avoidable admissions, ED use), Patient experience and access measures.
 - Payments are typically:
 - **Annual or semi-annual**
 - Based on **risk-adjusted, attribution-based populations**
 - Benchmarked against **historical spend, peer performance, or regional norms**
 - **3. Care Management or Infrastructure Support (Selected Models)**
 - In some arrangements, Cigna may provide:
 - Care coordination payments
 - Per-member-per-month (PMPM) support

- Data analytics and clinical insights in lieu of direct subsidy
 - These payments are modest and targeted, intended to support:
 - Care management staffing
 - Data reporting and quality improvement
 - Practice transformation
- **Quality performance is non-negotiable.** Poor quality performance can: Reduce incentive payments, Eliminate shared savings eligibility, and Trigger contract remediation

Q: As a follow-up, do the value-based contracts differ between large-group fully insured v. self-insured?

- Yes; Cigna's value-based care (VBC) contracts *do* differ between fully-insured and self-insured plans, but the differences are structural and financial, not philosophical. The core VBC framework is the same, while authority, funding, and risk allocation differ based on who bears insurance risk.
- **Fully-insured:** Cigna has direct authority to implement and fund value-based payment arrangements because Cigna bears the insurance risk.
- **Self-insured:** Value-based arrangements are offered through employer opt-in; savings and payments ultimately belong to the employer, with Cigna acting as administrator.
- In both markets, providers are paid the same way operationally, but who funds incentives and how savings are distributed differs.

Q: What does Cigna contribute to the Blueprint? What plans (large group v self-insured) and how much?

- Under Vermont law (8 V.S.A. § 4025 and 18 V.S.A. § 706), commercial health insurers doing business in Vermont are required to participate in the Blueprint for Health as a condition of operating in the state. Cigna's participation is therefore statutory, not voluntary. Cigna contributes \$3.00 PMPM for fully-insured plans for each attributed member enrolled with a Blueprint-recognized PCMH. Cigna also contributes \$2.77 PMPM toward Community Health Teams. These dollars are pooled across payers and administered regionally through Blueprint Administrative Entities.

Q: What percentage of our plans in VT are in a value-based arrangement v. FFS?

- Cigna does not publicly report a Vermont-specific percentage of plans or members in value-based arrangements versus fee-for-service. In Vermont, the majority of Cigna's plans continue to pay providers through fee-for-service claims, with value-based components layered on top through programs like value-based arrangements and the Blueprint for Health. As in other states, a portion of Cigna's Vermont membership is attributed to value-based arrangements, but full replacement of fee-for-service is not the predominant model.

Thanks again for the dialogue,

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