Large Group Aggregate Rates and Prescription Drug Costs Report

Measurement Year 2021

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I. Executive Summary

The California Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates most commercial health plans and products in the large group, small group, and individual markets, including most of the health plans that participate in Covered California. The DMHC also regulates Medi-Cal managed care plans, Medicare Advantage plans, and specialized health plans, including dental and vision plans.

Senate Bill (SB) 546 (Leno, 2015), Health and Safety Code section 1385.045, requires health plans that offer commercial large group products to annually submit aggregate rate information and the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. Additionally, large group renewal notices delivered by health plans must include a statement comparing its proposed rate change to the average rate increases negotiated by the California Public Employees' Retirement System (CalPERS) and by Covered California. The DMHC is also required to conduct a public meeting regarding large group rate changes.

Health plans first submitted their large group aggregate rate information in October 2016. The DMHC held its first public meeting on large group aggregate rates in February 2017. Starting in 2022, the public meetings will be held in even-numbered years only.

In 2017, SB 17 (Hernandez, 2017), Health and Safety Code section 1367.243, additionally requires health plans that file annual large group rate information with the DMHC to file specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs. Since measurement year 2018, large group health plans have submitted prescription drug cost information as required by SB 17, in addition to, aggregate rate information.

This report summarizes the large group aggregate rate information and analyzes the impact of the cost of prescription drugs on health plan premiums in the large group market for measurement year 2021, including comparisons over the course of the five reported years. For measurement year 2021, 23 health plans submitted large group aggregate rate and prescription drug cost information.

Key Findings[1,2]

Large Group Aggregate Rates

- In 2021, over 7.9 million enrollees in roughly 14,350 renewing groups were affected by the rate changes. The overall average premium per member per month (PMPM) was nearly $534.
- Overall, the weighted average rate increase for the large group health plans was 4.2% in 2021.
- From 2017 to 2021, average annual rate increases remained below 6%.
- A comparison of these average rate increases to those of Covered California and CalPERS shows that the annual average rate increases for the large group market ranged from 3.5% to 5.5%, compared to Covered California which ranged from 0.5% to 21.1%[3] and CalPERS which ranged from 1.1% to 7.7%.
- About 76% of covered enrollees were in benefit plans that had an actuarial value[4] of 90% or higher, which is the category with the richest benefits. Almost 93% of covered enrollees were in plans with an actuarial value of 80% or higher. Less than 1% of enrollees in the large group market were in the leanest benefit range (i.e., less than 70% and greater than 60%).
- While only 10.6% of groups were experience rated, the experience rated groups account for roughly 71% of total covered enrollees. In contrast, 89.4% of groups were either blended and community rated, accounting for approximately 29% of the total covered enrollees.

[1] The information in this report relies on the data submitted by the health plans.
[2] The analysis in this report does not include the information for the five In-Home Supportive Services (IHSS plans). The five IHSS plans had 71,304 enrollees as of December 31, 2021. The rate development process for IHSS plans differs from traditional large group health plans, which utilizes community rated, experience rated or blended rate development methodologies. For IHSS products, the county and the IHSS plans determine the rates which are based on the anticipated costs for providing services to the IHSS enrollees.
[3] Covered California saw double digits rate increases for the individual market products in 2017 and 2018 due to changes at the federal level. In 2017, the Affordable Care Act's Reinsurance and Risk Corridor programs ended. In 2018, rate charges were considerably larger than usual due to the uncertainty regarding cost sharing reduction funding from the federal government. Additionally, in 2019, the federal individual mandate ended which resulted in slightly higher premium increases.
[4] The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 80%, on average, the enrollee/member would be responsible for 20% of the costs of all covered benefits.

Large Group Prescription Drug Costs[5]

- Prescription drug expenses, net of manufacturer rebates, accounted for $70.87, or 13.4%, of health plan premiums on a PMPM basis in 2021.
- Prescription drug costs for large group health plans increased by 5.5% in 2021, whereas medical expenses increased by 12.0%. Overall, health plan premiums increased by 4.0% from 2020 to 2021.
- The percentage of premiums spent by large group health plans on prescription drugs ranged from 9.9% to 19.0%.
- Manufacturer drug rebates totaled approximately $800 million, up from $703 million in 2020. These rebates helped mitigate some of the overall impact of rising prescription drug prices by reducing total health plan premiums by 1.6% in 2021.
- All 23 health plans, including IHSS plans, utilized pharmacy benefit managers[6] (PBMs): 22 health plans used PBMs for claims processing; 15 health plans used PBMs for utilization management, 14 health plans used PBMs for provider disputes resolution; and 4 health plans used PBMs for enrollee grievances.

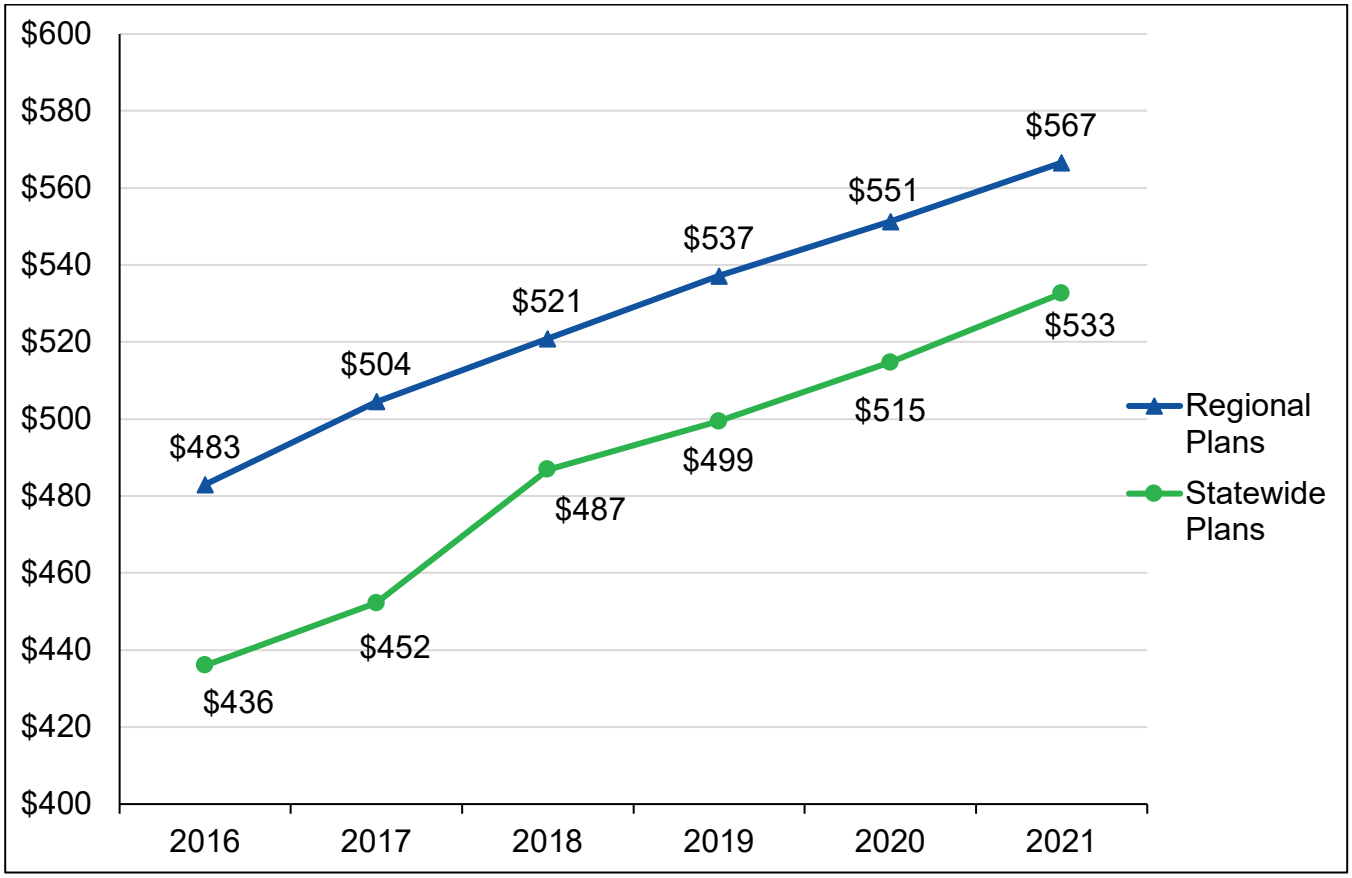
[5] Includes premium, medical expenses and prescription cost information for only large group products with prescription drug benefits.

[6] A pharmacy benefit manager is an organization dedicated to administering prescription benefit management services to employers, health plans, third-party administrators, union groups, and other plan sponsors. A full-service PBM maintains eligibility, adjudicates prescription claims, provides clinical services and customer support, contracts and manages pharmacy networks, and provides management reports.

Chart 1 illustrates the average premium[7] PMPM[8] for regional[9] and statewide[10] plans from 2016 to 2021. From 2016 to 2021, the average premium PMPM increased by 17% for regional plans and 22% for statewide plans. On an annualized basis over this period, the average rate increase for the regional plans was 3.3% and the average rate increase for the statewide plans was 4.1%.

Chart 1

Six-Year Trend Analysis: Average Large Group Premium Per Member Per Month

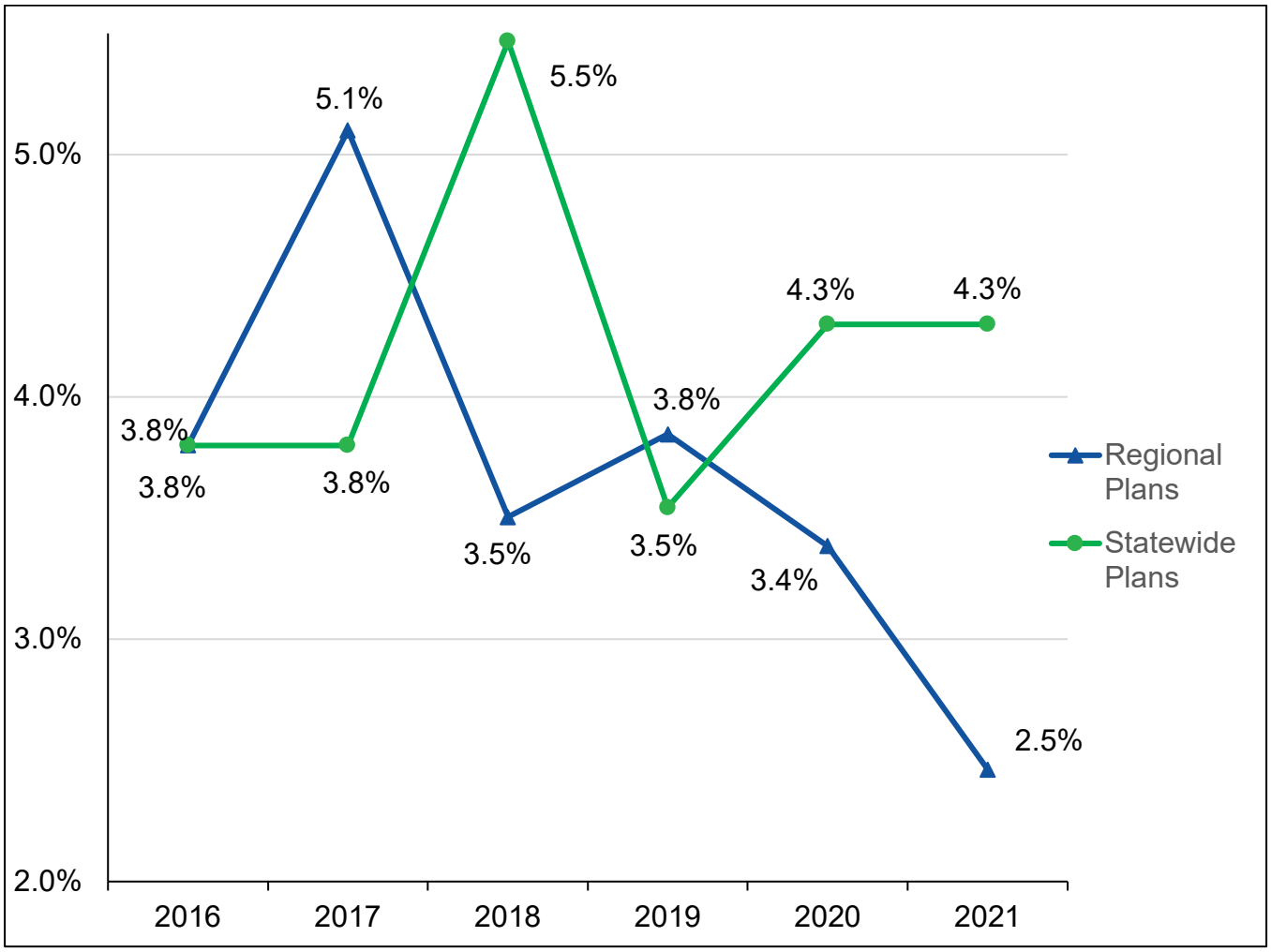


[7] Premium is the monthly payment the enrollee and/or enrollee's employer pays for health coverage. Factors that impact large group premium rates include age, geography/location, family size, occupation/industry and health status (historical experience and utilization of medical services).
[8] Per member per month is a measure used to assess population-based metrics such as cost or utilization, computed by dividing the total monthly cost/utilization/other measure by the total number of member months for the population over a specific time period.
[9] Regional plans are health plans that primarily operate and offer health care products to enrollees in specific regions.
[10] Statewide plans, as their name implies, operate and offer health care products to enrollees in multiple regions throughout the state.

Chart 2 shows the weighted average rate increase trend[11] from 2016 to 2021. The rate increases on average have fluctuated from 2016 to 2021 but have remained below 6% each year.

Chart 2

Weighted Average Rate Increase Trend



[11] Not adjusted for changes in such things as benefits, cost sharing, provider network, geographic rating area, and average age.

Health plans are required to include information in their notice of premium rate change indicating whether the rate change is greater than the average increase for CalPERS and Covered California. Table 1 shows the side-by-side comparison of the rate increases for CalPERS, Covered California individual market products, and the large group statewide health plans since 2016. While the Covered California increases have fluctuated widely, the average unadjusted rate increases for large group plans, with the exception being the 2018 measurement year, have remained in the vicinity of 4% for each measurement year.

Table 1

Rate Increases for Covered California, CalPERS and Large Group Plans

Year	Covered California[12]	CalPERS	Large Group Plans
2016	4.0%	7.7%	3.9%
2017	13.2%	3.9%	3.9%
2018	21.1%	2.5%	5.4%
2019	8.7%	1.1%	3.6%
2020	0.8%	5.1%	4.3%
2021	0.5%	5.3%	4.2%
2022	1.8%	5.5%	Not Available

[12] Covered California saw double digits rate increases for the individual market products in 2017 and 2018 due to changes at the federal level. In 2017, the Affordable Care Act's Reinsurance and Risk Corridor programs ended. In 2018, rate charges were considerably larger than usual due to the uncertainty regarding cost sharing reduction funding from the federal government. Additionally, in 2019, the federal individual mandate ended which resulted in slightly higher premium increases.

II. Introduction/Background

In 2015, California enacted SB 546 for the purpose of increasing transparency of rates in the large group market. SB 546 requires health plans and health insurers that offer commercial large group products to submit aggregate rate information and the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year to the DMHC or the California Department of Insurance (CDI) by October 1, 2016, and annually thereafter. In addition, SB 546 requires health plans to comply with disclosure requirements relating to large group renewal notices. Specifically, no change in premium rates or changes in coverage stated in a group health plan contract can become effective unless the plan has delivered a notice in writing indicating the change or changes at least 60 days prior to the contract renewal effective date including a statement comparing the proposed rate change to the average rate increases negotiated by CalPERS and by Covered California.

The DMHC is required to conduct a public meeting regarding large group rate changes. Additionally, to further increase transparency of large group rates, Assembly Bill (AB) 731[13] (Kalra, 2019) established a rate review process for the large group market. Effective July 1, 2020, health plans with large group products must file specified information at least annually and 120 days before any change in methodology, factors or assumptions that would affect the rate paid by a large group employer or contract holder.

For measurement year 2021, 23 large group health plans submitted data which includes eight statewide plans, ten regional plans and five IHSS plans. Almost 7.9 million enrollees in roughly 14,350 renewing groups were affected by the rate changes.

In addition, SB 17 requires health plans that file annual large group rate information with the DMHC and CDI to also file specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs. SB 17 also required large group health plans to provide the names of the PBMs they utilize and their functions.

Under a separate statutory requirement, health plans and health insurers that offer commercial products and file rate information with the DMHC or the CDI are required to annually report specific information related to the costs of covered prescription drugs, including:

- The 25 prescription drugs most frequently prescribed to health plan enrollees;
- The 25 most costly prescription drugs by total annual health plan spending;
- The 25 prescription drugs with the highest year-over-year increase in total annual health plan spending; and
- The overall impact of drug costs on healthcare premiums.

This information is reported in the Prescription Drug Cost Transparency Report required by SB 17 which can be found on the DMHC website.

[13] The filings submitted by health plans pursuant to AB 731 are available on the DMHC website and are not discussed in this report.

III. Large Group Aggregate Rate Summary

The DMHC received the aggregate rate filings from 23 health plans for measurement year 2021, including eight statewide plans, ten regional plans and five IHSS plans. The analysis in this report excludes the rate information for the IHSS plans. The IHSS rate information was excluded from the analysis because the rate development process for IHSS plans differs from traditional large group health plans, which utilize community rated, experience rated or blended rate development methodologies. For IHSS products, the county and the IHSS plans determine the rates which are based on the anticipated costs for providing services to the IHSS enrollees. The five IHSS plans had roughly 71,300 enrollees (with only about 13,500 enrollees affected by a rate change) as of December 31, 2021; this represents less than 1% of the large group enrollment. The remaining 18 health plans served 7.9 million enrollees. Kaiser Foundation Health Plan, Inc.'s (Kaiser Permanente) enrollment represented 66% of the large group market or 5.2 million of the 7.9 million enrollees. Since Kaiser's data had such a significant impact on the overall state averages, the data for Kaiser is often shown on a stand-alone basis throughout this report.

The observations from the 2021 health plan data related to the large group aggregate rates include:

- In 2021, over 7.9 million enrollees were covered by the large group health plans. The overall average premium per member per month (PMPM) was nearly $534. Overall, the weighted average rate increase for the large group health plans was 4.2% in 2021. (Table 2)

- Statewide plans represent almost 97% of large group membership. The eight statewide plans had 7.7 million covered enrollees in 13,700 renewing groups in the large group market. Overall, the average unadjusted rate increases in 2021 were generally in the low or mid-single digits. Kaiser, which had the lowest overall premium of all statewide plans, made up a significant percentage of the statewide market and therefore heavily impacted the overall average. (Table 3)

- Regional health plans have very small market share compared to the statewide plans. The ten regional plans had 250,585 covered enrollees in 644 renewing groups, accounting for about 3.2% of large group market enrollment. Western Health Advantage, Sharp Health Plan, and Sutter Health Plan (Sutter Health Plus) represent the largest of these plans in terms of membership. The overall average rate increases for health plans in this category generally remained in the low-single digits in 2021, with Ventura County Health's 12% increase and Chinese Community Health Plan's 11.5% increase being notable exceptions. (Table 4)

- In 2021, Preferred Provider Organization (PPO) and Point of Service (POS) plans had the highest premium, with an average premium of just over $600 PMPM. Overall, Health Maintenance Organization (HMO) plans experienced the second lowest average rate increases with a 4.2% increase, and had the second lowest average premium, or $528 PMPM. (Table 5)

- Most members (6.7 million or 85% of large group enrollees) were in HMO plans with higher actuarial values and therefore, the richest benefits overall. In contrast, High Deductible Health Plans (HDHP) tend to give members a lower premium option with higher out of pocket costs. (Table 6)

Table 2 shows the unadjusted and adjusted average rate increases for all large group health plans (including Kaiser), Kaiser and all large group health plans excluding Kaiser.

Table 2

Average Rate Increase in the Large Group Market in 2021

	Unadjusted Average Rate Increase	Adjusted[14] Average Rate Increase	Number of Enrollees	Average Premium Per Member Per Month (PMPM)
All Plans	4.2%	4.5%	7,947,015	$533.70
Kaiser	4.2%	4.3%	5,232,593	$522.10
All Plans Excluding Kaiser	4.3%	5.0%	2,714,422	$556.07

[14] "Adjusted average rate increase" means the unadjusted average rate increases are adjusted or normalized to reflect aggregate changes in benefit designs, cost sharing, provider network, geographic rating region, and average age. In general, changes in benefit designs, cost sharing, provider network, geographic rating region, and average age may result in higher adjusted average rates than unadjusted rates.

Tables 3 and 4 show the average rate increases for the statewide and regional health plans in the large group market.

Table 3

Average Rate Increase in the Large Group Market in 2021 – Statewide Health Plans

Health Plan Name	Number of Renewing Groups	Number of Enrollees	Percentage of Large Group Total	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
Kaiser Permanente	8,699	5,232,593	65.8%	4.2%	4.3%	$522.10
Anthem Blue Cross	1,574	1,096,492	13.8%	3.3%	4.5%	$521.41
Blue Shield of California	1,006	506,598	6.4%	3.9%	3.3%	$571.97
Health Net of California	356	275,551	3.5%	6.6%	6.6%	$631.59
UnitedHealthcare Benefits Plan of California	727	191,346	2.4%	8.6%	10.6%	$578.84
UnitedHealthcare of California	519	185,580	2.3%	5.4%	6.3%	$577.84
Aetna Health of California	617	130,791	1.6%	3.9%	4.7%	$524.81
Cigna Healthcare of California	210	77,479	1.0%	3.0%	4.0%	$584.26
Total	**13,708**	**7,696,430**	**96.8%**	**4.3%**	**4.6%**	**$532.63**

Table 4

Average Rate Increase in the Large Group Market in 2021 – Regional Health Plans

Health Plan Name	Number of Renewing Groups	Number of Enrollees	Percentage of Large Group Total	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
Western Health Advantage	172	60,984	0.8%	2.0%	5.0%	$566.82
Sutter Health Plus	299	59,093	0.7%	2.0%	1.2%	$539.47
Sharp Health Plan	122	58,243	0.7%	2.5%	4.0%	$521.09
Valley Health Plan	2	23,942	0.3%	0.0%	0.0%	$784.00
Scripps Health Plan Services	1	15.598	0.2%	0.8%	0.8%	$479.42
Ventura County Health	1	11,442	0.1%	12.0%	12.0%	$584.81
Community Care Health Plan	16	11,357	0.1%	2.1%	2.1%	$470.39
Contra Costa Health Plan	4	7,777	0.1%	5.4%	5.4%	$729.56
Chinese Community Health Plan	26	1,933	0.0%	11.5%	11.5%	$572.21
MemorialCare Select Health Plan	1	216	0.0%	0.0%	0.0%	$553.47
Total	**644**	**250,585**	**3.2%**	**2.5%**	**33%**	**$566.58**

Average Rate Increase and Actuarial Value by Product Type

Health plans also reported the average rate increase and actuarial value information by product type. Table 5 shows the average rate increases and the average premium PMPM across these product types.

Table 5

Average Rate Increase and Premium by Product Type

Product Type	Average Rate Increase	Minimum	Maximum	Average Premium PMPM
Preferred Provider Organization (PPO)	4.1%	0.0%	9.6%	$608.77
Point of Service (POS)	4.7%	-3.5%	8.7%	$608.73
Exclusive Provider Organization (EPO)	8.9%	0.0%	10.2%	$565.56
Health Maintenance Organization (HMO)	4.2%	0.0%	12.0%	$527.69
High Deductible Health Plan (HDHP)	4.6%	-0.8%	7.2%	$503.60

Table 6 shows large group market enrollment by product type and actuarial value.

Table 6

Number of Covered Lives by Actuarial Value by Product in the Large Group Market

Product Type	Number of Covered Lives by Actuarial Value					
	0.9 – 1.00	0.8 – 0.89	0.7 – 0.79	0.6 – 0.69	< 0.60	All
Health Maintenance Organization (HMO)	5,754,094	804,379	152,905	36,103	104	6,747,585
Preferred Provider Organization (PPO)	229,215	301,299	67,887	10,625	3,997	613,023
High Deductible Health Plan (HDHP)	-	170,379	187,375	80,961	31,579	470,294
Point of Service (POS)	81,729	548	14	1	-	82,292
Exclusive Provider Organization (EPO)	13,791	24,778	6,717	1,242	522	47,050
Total	**6,078,829**	**1,301,383**	**414,898**	**128,932**	**36,202**	**7,960,244**

Table 7 groups HMO membership into actuarial value ranges for the following categories: statewide plans (excluding Kaiser), Kaiser, and regional plans. As the table demonstrates, a sizable majority of members have benefits in the 0.9 -1.00 range, the richest benefit bracket. When compared to statewide plans, benefits in the regional plans tended to be a little less generous overall.

Table 7

Actuarial Value for HMO Members

Actuarial Value	Statewide Plans (Excluding Kaiser)	Kaiser	Regional Plans
0.9 – 1.00	83.6%	85.9%	75.4%
0.8 – 0.89	14.0%	11.2%	20.8%
0.7 – 0.79	1.7%	2.5%	2.4%
0.6 – 0.69	0.7%	0.5%	1.4%
<0.60	0.0%	0.0%	0.0%

Large Group Rating Methodology

Large group health plans use one of the following three rating methodologies to set premium rates: community rated, experience rated or blended. Community rating uses a standard base rate for a pool of large employer groups and additional factors specific to that employer group, such as geographic region or industry, to determine rates. Experience rating uses the actual claims experience of an employer group to determine rates for a given employer group. Finally, a blended approach calculates rates using a blend of rates determined via community rating and experience rating.

Table 8 shows the percentage of renewing groups, number of enrollees, unadjusted average rate increases, and average premium PMPM by rating methodology. Although the percentage of experience rated groups is lower compared to blended and community rated groups, the number of enrollees in experience rated groups is significantly larger.

Table 8

Percentage of Renewing Groups and Enrollment by Rating Methodology

Category	Percentage of Renewing Groups	Number of Enrollees	Unadjusted Average Rate Increase	Average Premium PMPM
Community Rated	64.4%	1,065,954	4.4%	$534.85
Blended	24.9%	1,224,857	4.9%	$523.73
Experience Rated	10.6%	5,656,203	4.0%	$535.64

Chart 3 shows the percentage of renewing groups by rating methodology for statewide plans (excluding Kaiser), Kaiser, and regional groups. Because regional groups tend to be smaller in size, it is less common for them to be experience rated, as their data may be less credible for projecting expected medical trend. Only 3.1% of regional groups are experience rated. In comparison, groups contracting with Kaiser tend to be much larger, and therefore, their underlying rate data is more credible for projecting expected medical trend. Accordingly, Kaiser has a much higher percentage of experience rated groups than those of smaller carriers.

Chart 3

Percentage of Renewing Groups by Rating Methodology

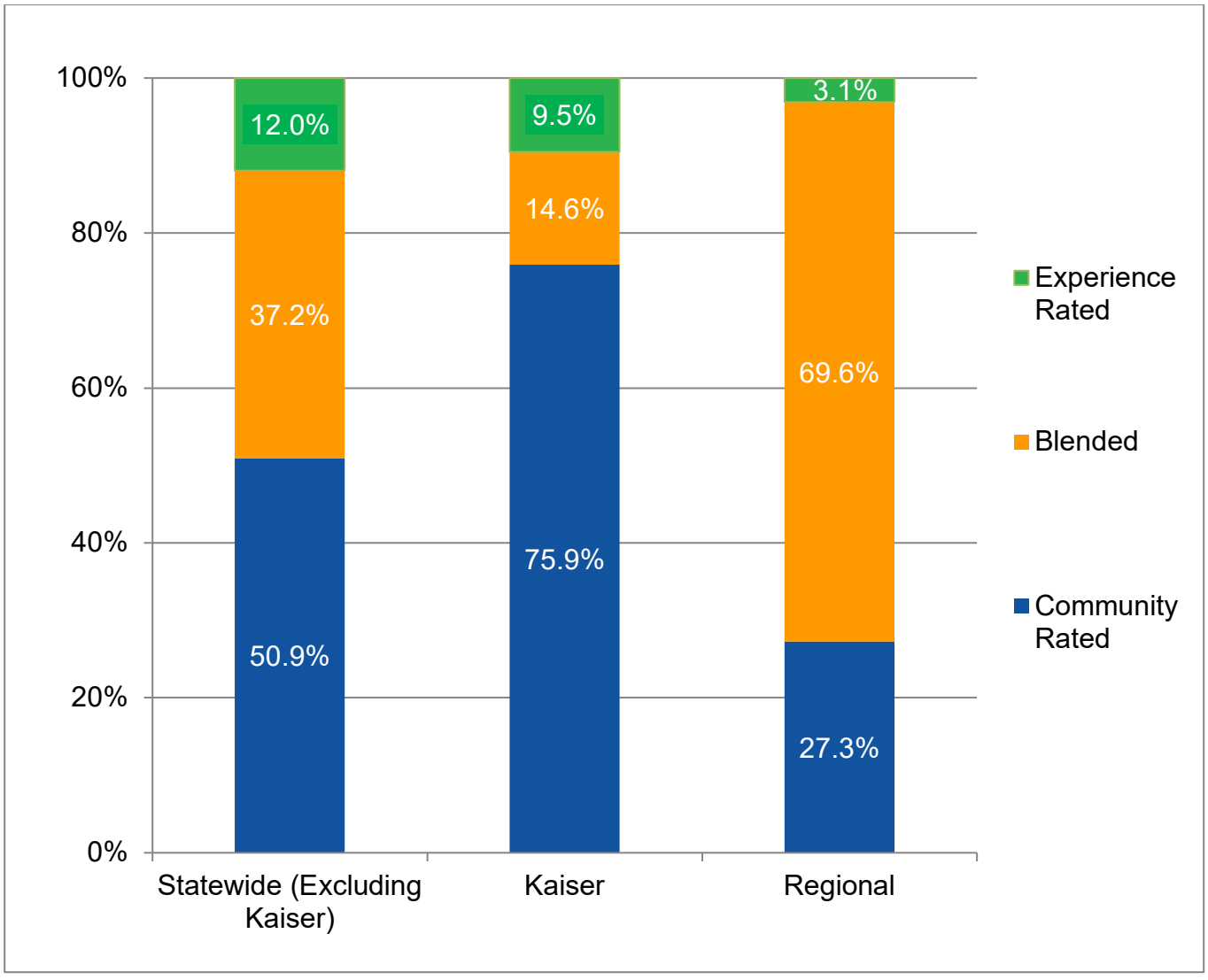


Chart 4 shows average unadjusted rate increases for statewide (excluding Kaiser), Kaiser, and regional groups. Ranked by methodology, blended groups had the highest increase, followed by community rated, then experience rated. Community rated groups have less credible data on which to base their rates. Experience rated groups, on the other hand, are typically larger and have more credible data to be used for rate development.

Chart 4

Average Rate Increases by Rating Methodology

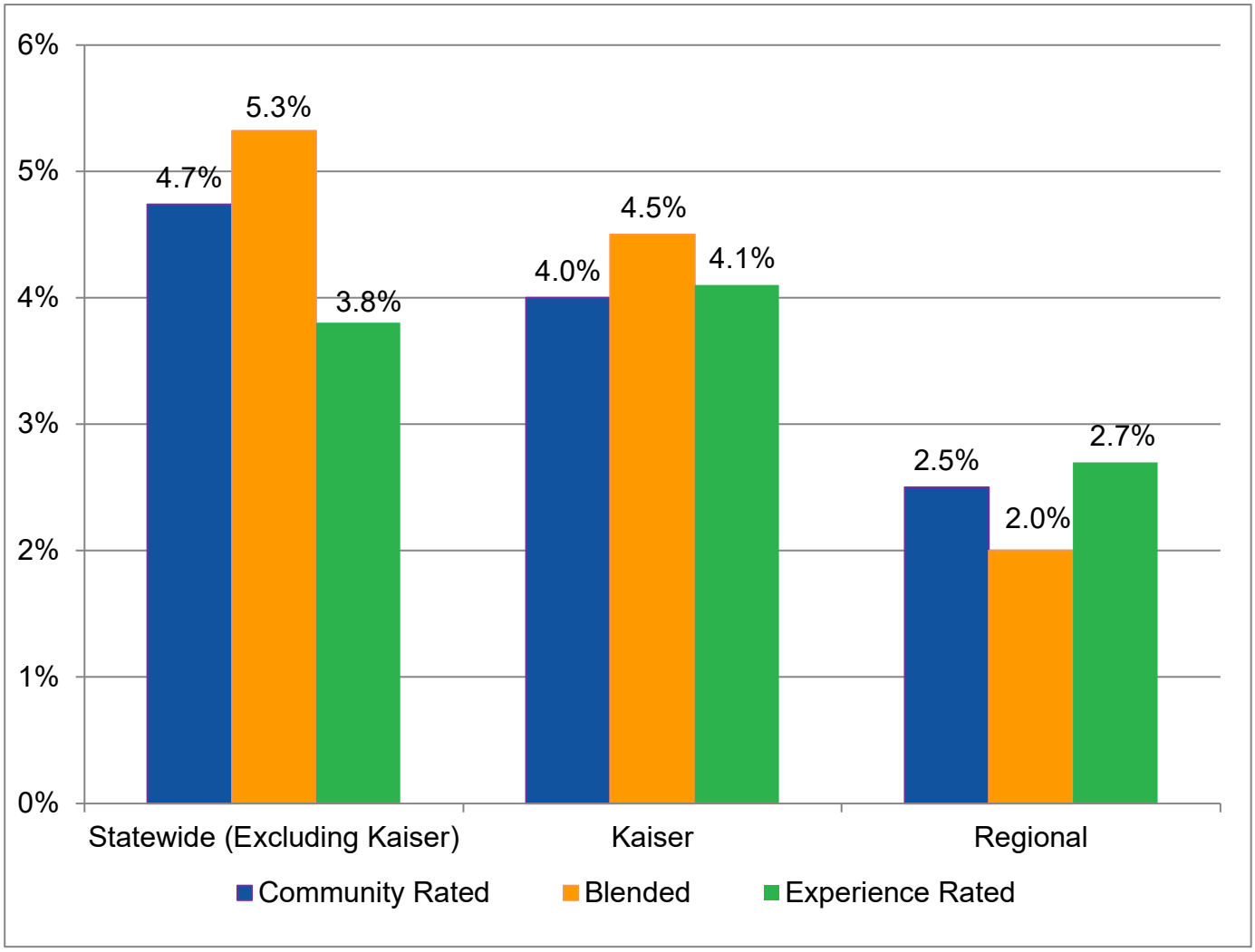
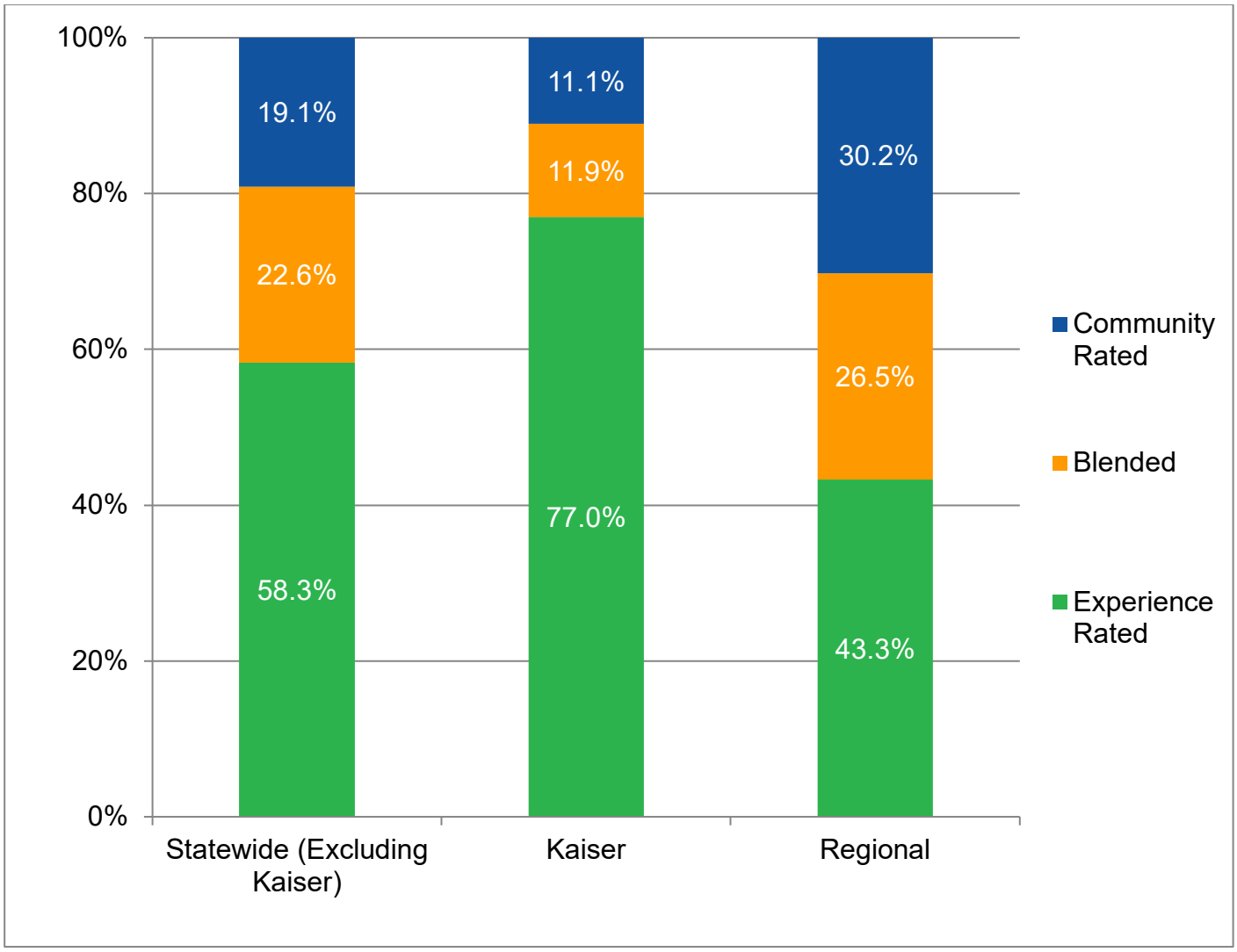


Chart 5 shows the percentage of renewing enrollees by rating methodology for statewide plans (excluding Kaiser), Kaiser, and regional groups. Because regional groups tend to be considerably smaller in size, it is less common for them to be experience rated, as their underlying data is less credible for projecting expected medical trend. In 2021, less than 45% of members in regional plans were experience rated. Groups that contracted with Kaiser tended to be much larger, and therefore provided more credible data for experience rating. As such, Kaiser had a much higher percentage of experience rated, accounting for almost 80% of members.

Chart 5

Percentage of Renewing Enrollees by Rating Methodology



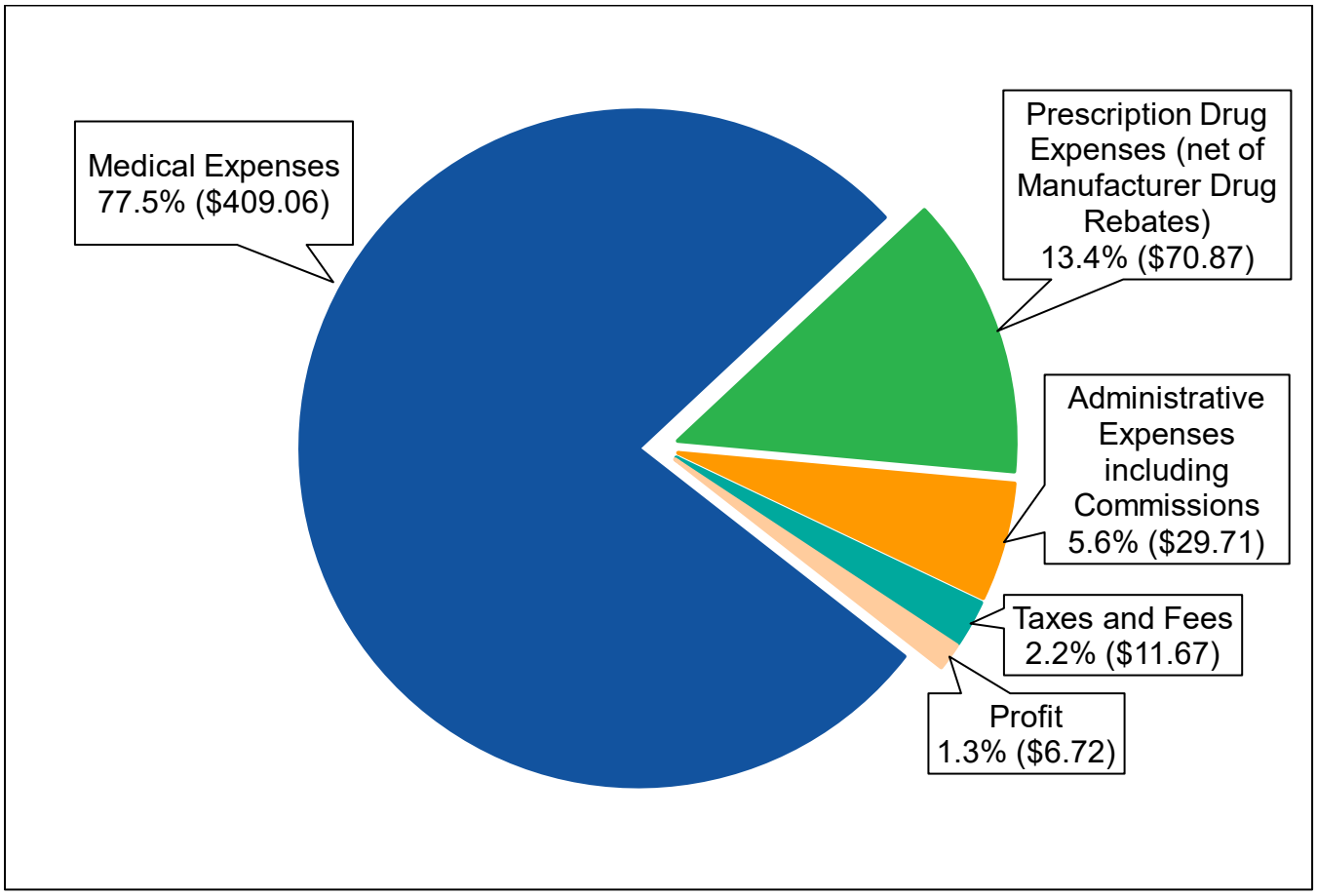
IV. Impact of Prescription Drug Costs on Large Group Rates

The DMHC also analyzed the impact of the cost of prescription drugs on large group health care premiums, on an aggregate level and on a PMPM basis. For this section of the report, health plans reported only on the large group products that included prescription drug benefits.

Chart 6 shows the breakdown of total health plan premiums on a PMPM basis. For measurement year 2021, the total health plan premium on a PMPM basis was $528.03. Medical expenses accounted for $409.06, or 77.5% of the health plan premium. Prescription drug expenses, net of manufacturer rebates, accounted for $70.87, or 13.4% of total health plan premium on a PMPM basis. Administrative expenses[15] including commissions accounted for $29.71, or 5.6% and taxes and fees made up $11.67, or 2.2% of total health plan premiums on a PMPM basis. Profit accounted for the remaining $6.72, or 1.3% of the total health plan premium on a PMPM basis.

Chart 6

Breakdown of Large Group Health Plan Premium PMPM



[15] Administrative expenses are business expenses associated with general administration, agent/broker fees and commissions, direct sales salaries, workforce salaries and benefits, loss adjustment expenses, cost containment expenses, and community benefit expenditures.

Table 9 shows the components of large group health care premiums on a PMPM basis in 2021 in comparison to 2020. Medical expenses increased by 12.0% since 2020, while prescription drug expenses increased by 5.5%. Manufacturer drug rebates increased by 13.0% in 2021 and totaled approximately $800 million in 2021 compared to $703 million in 2020. These rebates helped mitigate some of the overall impact of rising prescription drug prices by reducing total health plan premiums by 1.6% in 2021. Administrative expenses, including commissions decreased by 0.3% and taxes and fees decreased by 30.7% as a result of the repeal of health insurance tax in 2021. Compared to 2020, health plan profit decreased by 76.3% in 2021 as utilization and costs increased after an unprecedented drop related to the COVID-19 pandemic.

Table 9

Components of Large Group Health Plan Premium on a PMPM Basis

Category of Premium Payment	2021	Percentage of Premium	2020	Percentage of Premium	Year-over-Year Percentage Change
Medical Expenses	$409.06	77.5%	$365.12	71.9%	12.0%
Prescription Drug Expenses	$79.33	15.0%	$75.21	14.8%	5.5%
Manufacturer Drug Rebates	($8.46)	(1.6%)	($7.49)	(1.5%)	13.0%
Administrative Expenses including Commissions	$29.71	5.6%	$29.82	5.9%	(0.3%)
Taxes and Fees	$11.67	2.2%	$16.84	3.3%	(30.7%)
Profit	$6.72	1.3%	$28.34	5.6%	(76.3%)
Total Health Plan Premium	$528.03	100.0%	$507.83	100.0%	4.0%
Member Months (in millions)	94.47		93.82		0.7%

Health plans also reported their average health care premium, medical expenses, and prescription drug costs, including costs associated with administering prescription drugs in a doctor's office. Table 10 shows the average premium, and the percentage of premium spent on prescription drugs and medical expenses for each of the statewide plans, averages for all statewide plans (excluding Kaiser), Kaiser and averages for all regional plans.

Table 10

Large Group Prescription Drug and Medical Expenses as a Percent of Premium 2021

Health Plan Name	Average Premium	Percentage of Premium Spent on Prescription Drugs	Percentage of Premium Spent on Medical Expenses[16]
Aetna Health of California	$502	12.5%	74.4%
Anthem Blue Cross	$530	19.0%	65.9%
Blue Shield of California	$561	12.5%	78.5%
Cigna Healthcare of California	$557	16.4%	73.3%
Health Net of California	$566	10.7%	78.8%
UnitedHealthcare of California	$567	9.9%	75.8%
UnitedHealthcare Benefits Plan of California	$557	13.0%	71.2%
Statewide Plans (Excluding Kaiser)	$545	15.2%	71.8%
Kaiser	$519	12.6%	80.1%
Regional Plans	$562	13.9%	74.2%

[16] Does not include prescription drug expenses.

Five health plans reported information related to the costs associated with administering drugs in a doctor's office.[17] Table 11 shows the range of costs for these services on a PMPM basis. The maximum cost reported by health plans was $31.23 PMPM, and the minimum reported was $1.38 PMPM. The median cost reported for all plans was $19.40 PMPM.

Table 11

Costs for Drugs Administered in a Doctor's Office on a PMPM Basis

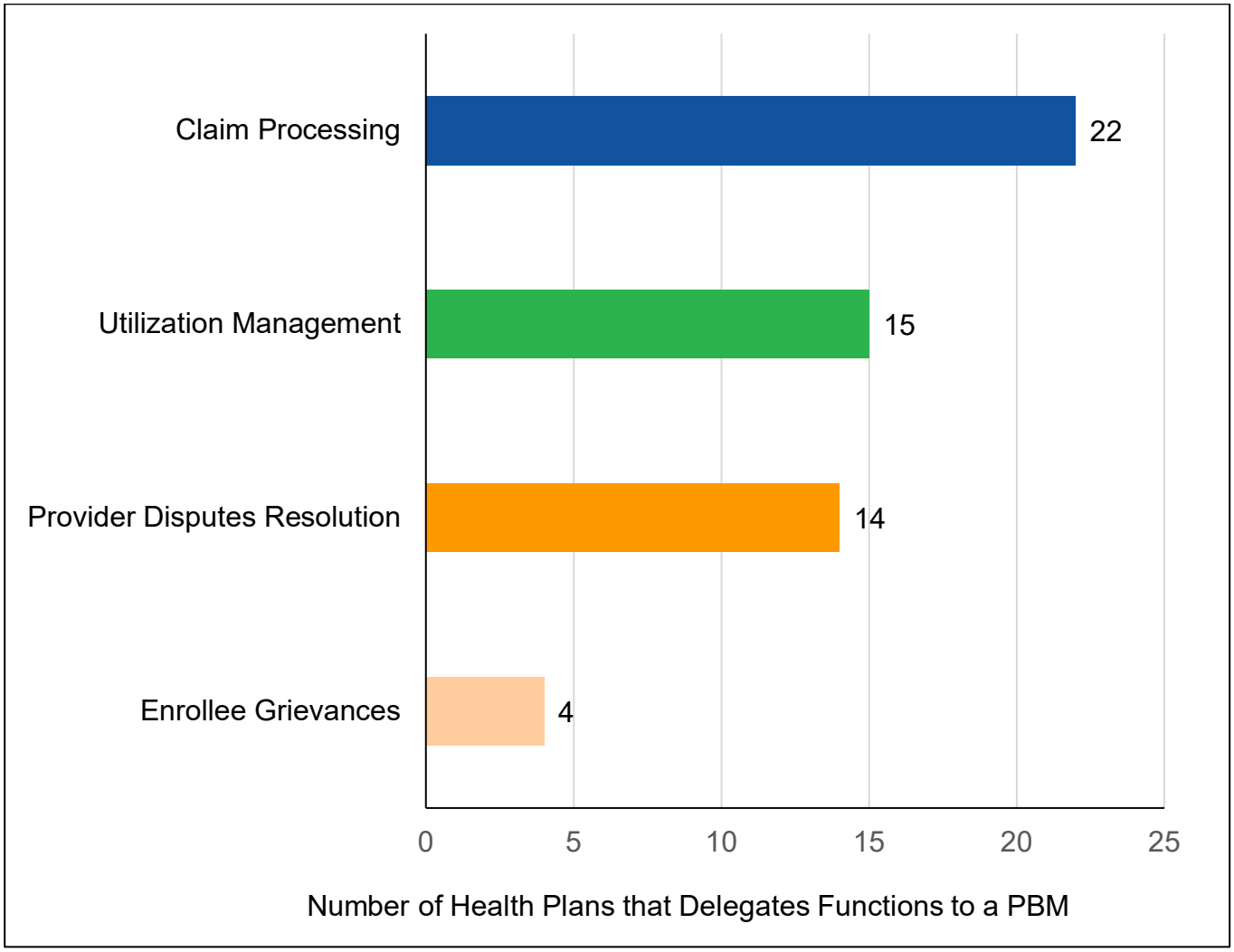
Category	Number of Plans	Minimum (Reported)	Maximum (Reported)	Maximum (Reported)
All Plans	5	$1.38	$31.23	$19.40
Statewide Plans (Excluding Kaiser)	1	$23.01	$23.01	$23.01
Kaiser	1	$19.40	$19.40	$19.40
Regional Plans	3	$1.38	$31.23	$1.68

[17] Health plans were required to report this information if it was available.

Chart 7 shows PBM functions for large group plans. All 23 health plans, including IHSS plans, utilized PBMs. As shown below, the majority of health plans (22) use PBMs for claims processing, 15 health plans used PBMs for utilization management, 14 health plans used PBMs for provider disputes resolution, and 4 health plans used PBMs for enrollee grievances. A detailed listing of the PBMs utilized by health plans is included in Appendix A.

Chart 7

Pharmacy Benefit Manager (PBM) Functions for Large Group Plans



V. Conclusion

Generally, from 2016 to 2021, the annual average rate increases for the large group market have remained relatively consistent, averaging around 4% each year, with 2018 being an outlier. A comparison of these average rate increases to those of Covered California and CalPERS showed that the annual average rate increases for the large group market have ranged from 3.5% to 5.5%, compared to Covered California which has ranged from 0.5% to 21.1%, and CalPERS, which has ranged from 1.1% to 7.7%.

Prescription drug costs, the net of manufacturer rebates, accounted for 13.4% of total health care premiums in 2021, a slight increase from 13.3% in 2020. Medical expenses made up 77.5%, or $409.06, of total health plan premiums on a PMPM basis.

Due to COVID-19, in 2020, the utilization experience was low during shelter-in-place. However, in 2021, there have been COVID-19 surges as well as the return of deferred care. Medical expenses increased by 12.0%, and prescription drug expenses increased by 5.5% since 2020.

The report provides transparency into the large group market by providing insight into a health plan's average rate increases for the reporting year along with historical and anticipated claims trends, actuarial values, and rating methodologies utilized. The DMHC will continue to collect and report this data, which will provide the public access to aggregate rate and data information pertaining to the large group market. Starting in 2022, the DMHC will hold a public meeting every other year in even-numbered years regarding large group rate changes and prescription drug costs.

Appendix A:
Pharmacy Benefit Managers Utilized by Large Group Health Plans

Health Plan Name	Functions Delegated to PBM				
	PBM Name	Utilization Management	Claims Processing	Provider Dispute Resolutions	Enrollee Grievances
Aetna Health of California	CVS	Yes	Yes	Yes	No
Alameda Alliance For Health	PerformRX	Yes	Yes	Yes	No
Anthem Blue Cross	IngenioRx	Yes	Yes	Yes	No
Blue Shield of California	CVS Health	No	Yes	No	No
Chinese Community Health Plan	MEDIMPACT	Yes	Yes	Yes	No
Cigna Healthcare of California	Cigna Pharmacy Management	Yes	No	No	Yes
Cigna Healthcare of California	ESI	No	Yes	Yes	No
Cigna Healthcare of California	DST/SS&C	No	Yes	No	No
Community Care Health Plan	MEDIMPACT	Yes	Yes	Yes	No
County of Ventura	Express Scripts	No	Yes	No	No
Contra Costa Health Plan	PerformRX	No	Yes	No	No
Health Net of California	Envolve Pharmacy Solutions	Yes	No	No	No
Kaiser Permanente	MEDIMPACT	Yes	Yes	Yes	No
L.A. Care Health Plan	Navitus Health Solutions	No	Yes	Yes	No
San Francisco Health Authority	PerformRX (1/2021-6/2021) Magellan Rx (7/2021)	Yes	Yes	No	No
San Mateo Health Commission	SS&C Health (DST Pharmacy Solutions)	No	Yes	No	No

Health Plan Name	Functions Delegated to PBM				
	PBM Name	Utilization Management	Claims Processing	Provider Dispute Resolutions	Enrollee Grievances
Central California Alliance for Health	MEDIMPACT	No	Yes	Yes	No
Memorial Care Select Health Plan	MEDIMPACT	No	Yes	No	No
Scripps Health Plan Services	MEDIMPACT	Yes	Yes	No	No
Sharp Health Plan	CVS Caremark	Yes	Yes	Yes	Yes
Sutter Health Plan	Express Scripts	Yes	Yes	Yes	No
UnitedHealthcare of California	OptumRx	Yes	Yes	Yes	Yes
UnitedHealthcare Benefits Plan of California	OptumRx	Yes	Yes	Yes	Yes
Valley Health Plan	Navitus Health Solutions	Yes	Yes	No	No
Western Health Advantage	OptumRX	No	Yes	Yes	No

Appendix B:
Health Plan Names (Legal & Doing Business As)

Health Plan Name	Doing Business As (DBA)
Aetna Health of California Inc.	
Alameda Alliance For Health	
Blue Cross of California	Anthem Blue Cross
California Physicians' Service	Blue Shield of California
Chinese Community Health Plan	
Cigna Healthcare of California, Inc.	
Community Care Health Plan, Inc.	
Contra Costa County Medical Services	Contra Costa Health Plan
County of Ventura	Ventura County Health Care Plan
Health Net of California, Inc.	
Kaiser Foundation Health Plan, Inc.	Kaiser Permanente
Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan
San Francisco Health Authority	San Francisco Health Plan
San Mateo Health Commission	Health Plan of San Mateo
Santa Cruz-Monterey-Merced Managed Medical Care Commission	Central California Alliance for Health
MemorialCare Select Health Plan	
Santa Clara County	Valley Health Plan
Scripps Health Plan Services, Inc.	
Sharp Health Plan	
Sutter Health Plan	Sutter Health Plus
UHC of California	UnitedHealthcare of California
UnitedHealthcare Benefits Plan of California	
Western Health Advantage	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