Large Group Aggregate Rates and Prescription Drug Costs Report

Measurement Year 2020

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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 the vast majority of 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) 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 plans must include a statement comparing its proposed rate change to the average rate increases negotiated by 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.

In 2017, SB 17 (Hernandez, 2017) additionally required 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 2020, including comparisons over the course of five reported years. For measurement year 2020, 23 health plans submitted large group aggregate rate and prescription drug cost information.

Key Findings[1,2]

Large Group Aggregate Rates

- In 2020, over 8.1 million enrollees in roughly 14,000 renewing groups were affected by the rate changes. The overall average premium per member per month (PMPM) was about $515.
- Overall, the weighted average rate increase for the large group health plans was 4.3% in 2020.

[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 70,730 enrollees as of December 31, 2020. 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.

- From 2016 to 2020, 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 have ranged from 3.5% to 5.5%, compared to Covered California which ranged from 0.5% to 21.1% and CalPERS ranged from 1.1% to 7.7%.

- About 78% of covered enrollees were in benefit plans that had an actuarial value[3] of 90% or higher, which is the category with the most benefits. Over 91% of covered enrollees were in plans with an actuarial value of 80% or higher.

- While only 11.5% of groups are experience rated, the experience rated groups account for over 71% of total covered enrollees. In contrast, there were 88.5% of groups that were either blended and community rated and accounted for approximately 29% of the total covered enrollees.

Large Group Prescription Drug Costs[4]

- Prescription drug expenses, net of manufacturer rebates, accounted for $67.72, or 13.3%, of health plan premiums on a PMPM basis in 2020.

- Prescription drug costs for large group health plans increased by 1.7% in 2020, whereas medical expenses increased by 1.2%. Overall, health plan premiums increased by 3% from 2019 to 2020.

- The percentage of premium spent by large group health plans on prescription drugs ranged from 9.0% to 19.0%.

- Manufacturer drug rebates totaled approximately $703 million, up from $650 million in 2019. These rebates helped mitigate some of the overall impact of rising prescription drug prices by reducing total health plan premiums by 1.5% in 2020.

- All 23 health plans, including IHSS plans, utilized pharmacy benefit managers[5] (PBMs): 22 health plans used PBMs for claims processing; 14 health plans used PBMs for utilization management and provider disputes resolution; and 4 health plans used PBMs for enrollee grievances.

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[3] 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.

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

[5] 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

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

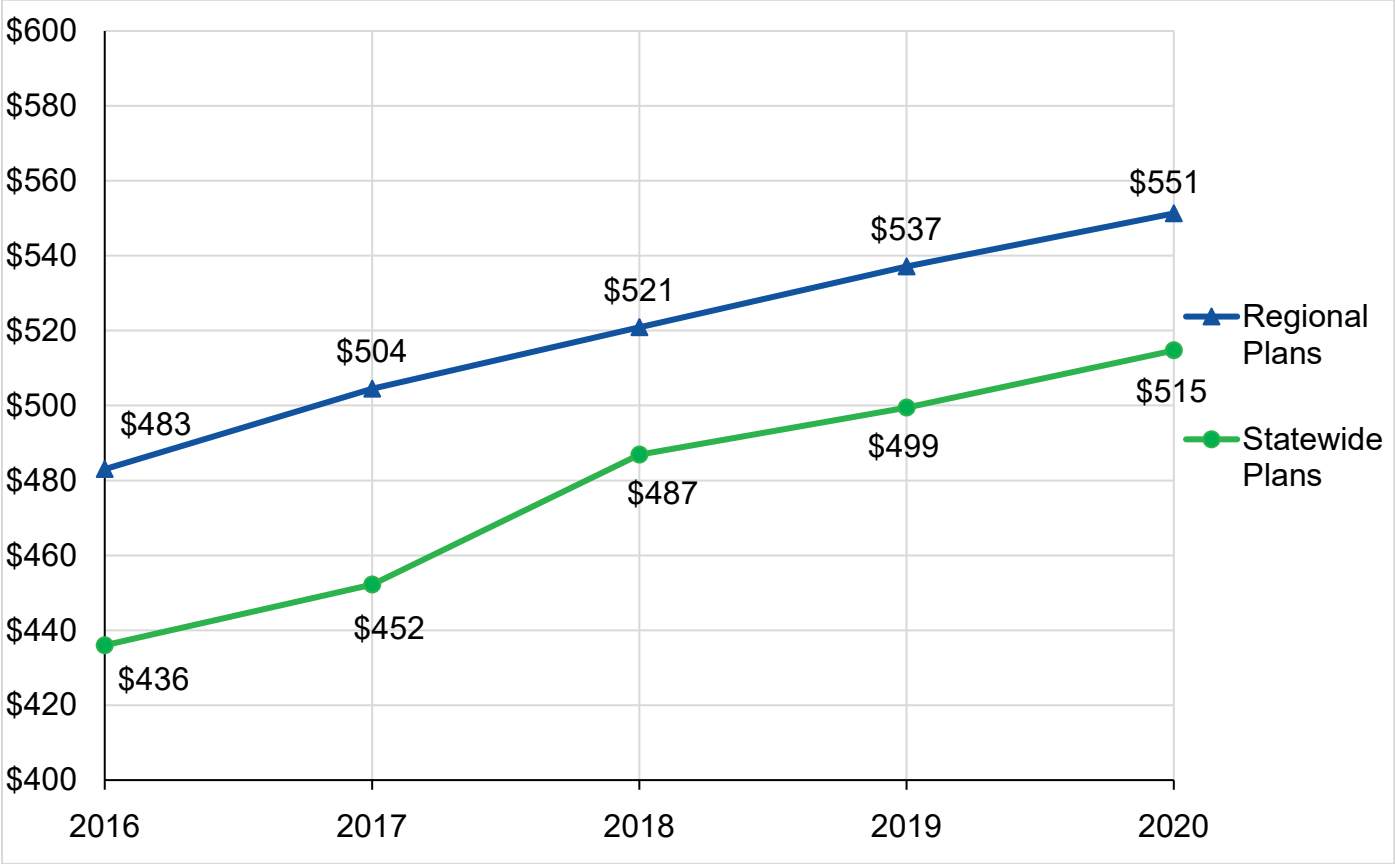


Chart 1 illustrates the average premium[6] per member per month[7] (PMPM) for regional[8] and statewide[9] plans from 2016 to 2020. From 2016 to 2020, the average premium PMPM increased by 14% for regional plans and 18% for statewide plans. On an annualized basis over this period, the average rate increase for the regional plans was 3.3% and the average rate increase for the statewide plans was 4.2%.

[6] 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).
[7] 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.
[8] Regional plans are health plans that primarily operate and offer health care products to enrollees in specific regions.
[9] Statewide plans, as its name implies, operate and offer health care products to enrollees in multiple regions throughout the state.

Chart 2

Weighted Average Rate Increase Trend

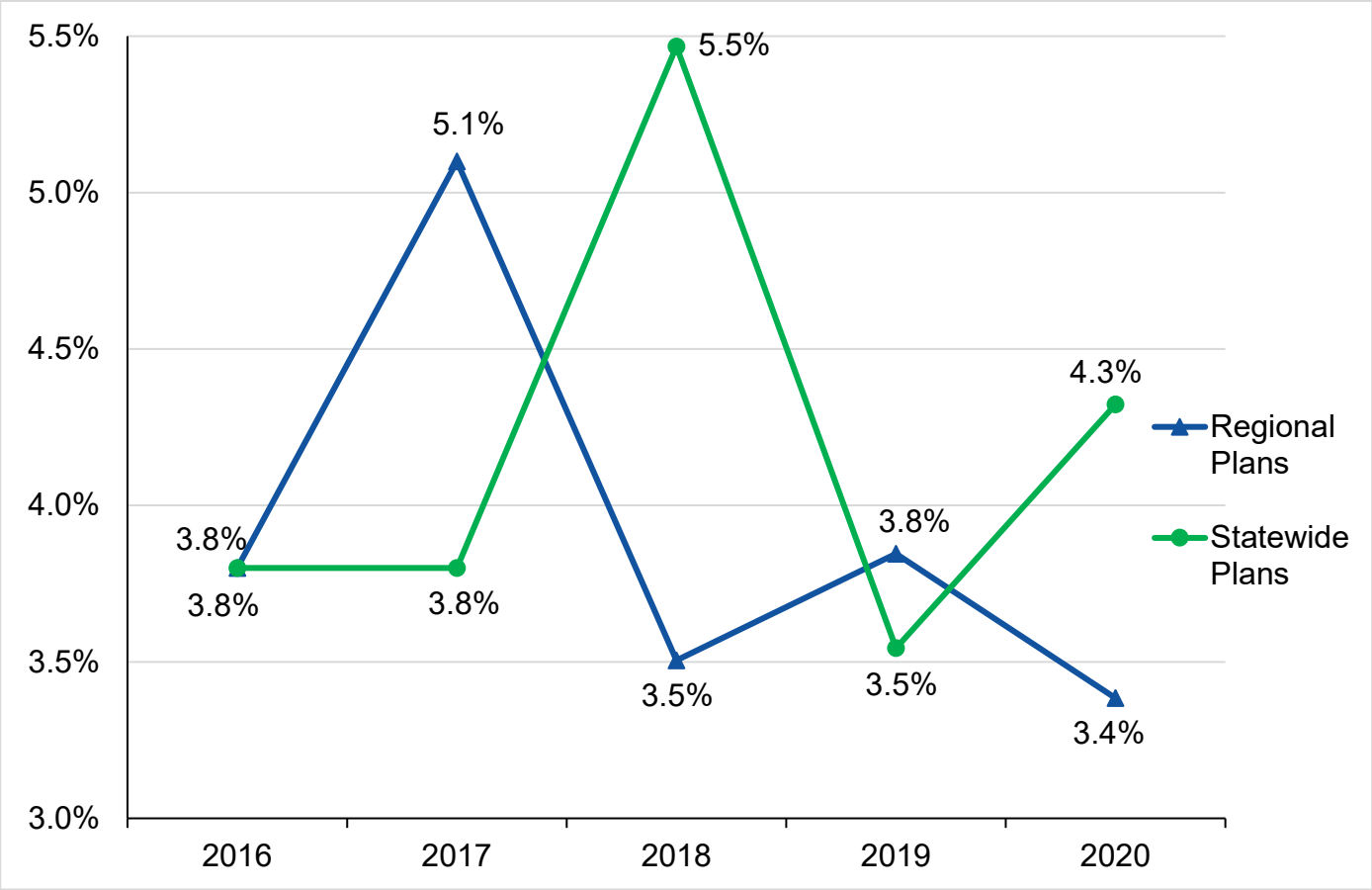


Chart 2 shows the weighted average rate increase trend[10] from 2016 to 2020. The rate increases on average have fluctuated from 2016 to 2020 but have remained below 6% each year.

[10] 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 Statewide Plans, with the exception being the 2018 measurement year, have remained in the vicinity of 4% for each measurement year in this 5-year period.

Table 1
Rate Increases for Covered California, CalPERS and Large Group Statewide Plans

Year	Covered California[11]	CalPERS	Large Group Statewide Plans
2016	4.0%	7.7%	3.8%
2017	13.2%	3.9%	3.8%
2018	21.1%	2.5%	5.5%
2019	8.7%	1.1%	3.5%
2020	0.8%	5.1%	4.3%
2021	0.5%	5.3%	Not Available

[11] 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[12] (Karla, 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 2020, 23 large group health plans submitted data which includes eight statewide plans, ten regional plans and five IHSS plans. Over 8.1 million enrollees in roughly 14,000 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 the functions performed by the PBMs.

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.

[12] The filings submitted by health plans pursuant to AB 731 is available on the DMHC's website and is 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 2020, 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 reasoning for excluding the IHSS rate information from the analysis is because 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. The five IHSS plans had 70,730 enrollees as of December 31, 2020, which is less than 1% of the large group enrollment. The remaining 18 health plans served 8.1 million enrollees. Kaiser Foundation Health Plan, Inc.'s (Kaiser Permanente) enrollment represents 65% of the large group market or 5.3 million of the 8.1 million enrollees. Because Kaiser's data has a significant impact on the overall state averages, the data for Kaiser is often shown on a stand-alone basis throughout this report.

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. As shown below, when Kaiser's rate increase is included along with the other plans, the overall average is reduced by a full 1%.

Table 2
Average Rate Increase in the Large Group Market in 2020

	Unadjusted Average Rate Increase	Adjusted[13] Average Rate Increase	Number of Enrollees	Average Premium Per Member Per Month (PMPM)
All Plans	4.3%	5.0%	8,104,561	$515.85
Kaiser	3.7%	4.3%	5,257,666	$498.88
All Plans Excluding Kaiser	5.3%	6.1%	2,846,895	$547.20

[13] "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.

Statewide plans represent almost 97% of large group membership. The eight statewide plans had 7.85 million covered enrollees in 13,380 renewing groups in the large group market. Overall, the average rate increases in 2020 were generally in the mid-single digits. The only exception being UnitedHealthcare Benefits Plan of California, which is appearing for the first time in this report. Kaiser, which has the lowest overall premium of all statewide plans, makes up a significant percentage of the statewide market.

Table 3
Average Rate Increase in the Large Group Market in 2020 – 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	8,104	5,257,666	65.0%	3.7%	4.3%	$498.88
Anthem Blue Cross	1,715	1,082,720	13.4%	4.5%	5.7%	$535.97
Blue Shield of California	1,046	540,920	6.7%	6.1%	6.0%	$542.56
Health Net of California	379	291,017	3.6%	4.0%	4.1%	$558.95
UnitedHealthcare of California	523	210,882	2.6%	5.8%	7.5%	$568.01
UnitedHealthcare Benefits Plan of California	761	224,266	2.8%	10.3%	13.2%	$575.28
Aetna Health of California	571	135,236	1.7%	6.3%	6.6%	$518.20
Cigna Healthcare of California	281	104,553	1.3%	3.9%	2.6%	$580.07
Total	**13,380**	**7,847,260**	**96.8%**	**4.3%**	**5.0%**	**$514.69**

Regional health plans have very small market share compared to the statewide plans. The ten regional plans had 257,000 covered enrollees in 641 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 remained in the low-single digits in 2020.

Table 4
Average Rate Increase in the Large Group Market in 2020 – 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	199	65,852	0.8%	4.8%	5.0%	$563.92
Sharp Health Plan	132	65,689	0.8%	0.9%	0.6%	$502.33
Sutter Health Plus	263	53,571	0.7%	3.2%	3.6%	$536.70
Valley Health Plan	2	23,663	0.3%	2.9%	2.9%	$766.56
Scripps Health Plan Services	1	14,696	0.2%	2.9%	2.9%	$474.27
Ventura County Health	1	12,080	0.1%	6.0%	6.0%	$508.03
Community Care Health Plan	15	11,230	0.1%	2.5%	2.5%	$461.63
Contra Costa Health Plan	4	8,033	0.1%	9.8%	9.8%	$659.43
Chinese Community Health Plan	23	2,265	0.0%	6.2%	6.2%	$491.70
MemorialCare Select Health Plan[14]	1	222	0.0%	0.0%	0.0%	$544.08
Total	641	257,301	3.2%	3.4%	3.5%	$551.29

[14] Formerly known as Seaside Health Plan.

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. In 2020, PPO plans had the highest premium, with an average premium of over $600 PMPM. Overall, HMO plans experienced the lowest average rate increases with a 4.1% increase, and had the second lowest average premium, or $509 PMPM.

Table 5
Average Rate Increase and Premium by Product Type

Product Type	Average Rate Increase	Minimum	Maximum	Average Premium PMPM
Health Maintenance Organization (HMO)	4.1%	0.0%	9.8%	$509.14
Preferred Provider Organization (PPO)	5.9%	0.0%	9.4%	$613.34
Exclusive Provider Organization (EPO)	8.9%	0.0%	15.0%	$561.38
Point of Service (POS)	6.2%	-6.0%	9.1%	$570.65
High Deductible Health Plan (HDHP)	4.4%	-2.1%	15.4%	$472.75

Table 6 shows large group market enrollment by product type and actuarial value. The majority of members are in HMO plans with higher actuarial values, which have the richest benefits overall. In contrast, HDHP plans tend to give members a lower premium option with higher out of pocket costs.

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)	5,899,465	726,048	163,860	26,898	108	6,816,379
Preferred Provider Organization (PPO)	248,164	241,280	97,301	20,833	10,846	618,424
High Deductible Health Plan (HDHP)	22,396	189,835	214,402	102,793	49,005	578,431
Point of Service (POS)	79,327	138	1,806	-	-	81,271
Exclusive Provider Organization (EPO)	25,533	11,965	6,059	2,033	5,388	50,978
Total	**6,274,885**	**1,169,266**	**483,428**	**152,557**	**65,347**	**8,145,483**

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 top bracket or the 0.9 -1.00 range. When compared to statewide plans, benefits in the regional plans tend 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	86.7%	87.1%	74.8%
0.8 – 0.89	10.4%	10.2%	21.1%
0.7 – 0.79	2.3%	2.4%	2.4%
0.6 – 0.69	0.6%	0.3%	1.7%
<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 determines rates for that particular employer group. Finally, Blended Rates are calculated using a combination, or blend, of rates determined via Community Rating and Experience Rating.

Table 8 shows the percentage of renewing groups, number of enrollees, 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 group, 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	63.4%	1,055,158	5.2%	$519.40
Blended	25.1%	1,211,942	5.1%	$512.95
Experience Rated	11.5%	5,728,242	4.0%	$515.83

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 the data is less credible. Only 3.1% of Regional groups are Experience Rated. In comparison, groups contracting with Kaiser tend to be much larger, and therefore more credible. Accordingly, Kaiser has a much higher percentage of Experience Rated groups.

Chart 3
Percentage of Renewing Groups by Rating Methodology

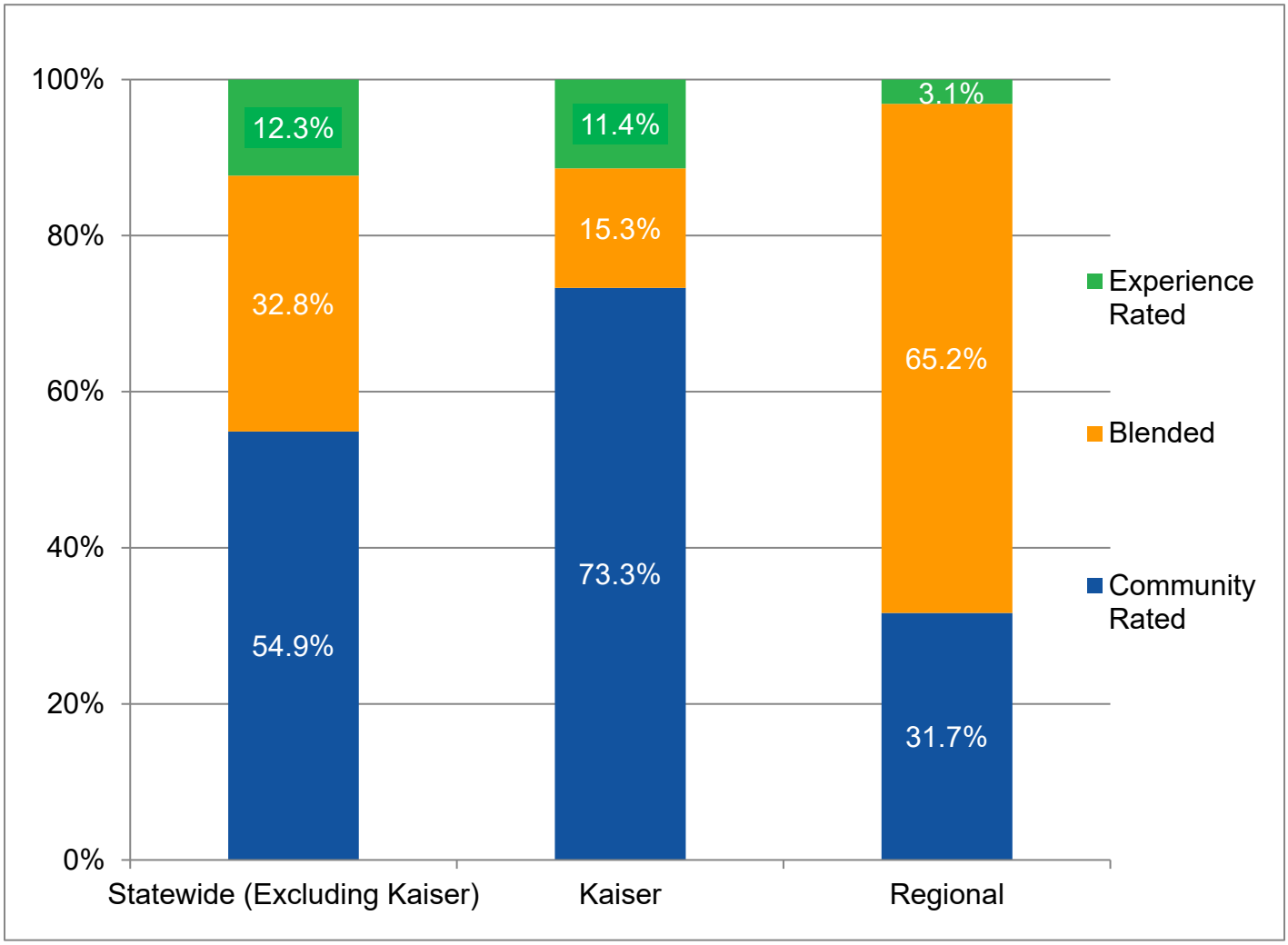


Chart 4 shows average unadjusted rate increases for Statewide (excluding Kaiser), Kaiser, and Regional groups. If you rank the increases by methodology, Community Rated had the highest increase, followed by Blended, then Experience Rated. Community Rated groups have little or no data on which to base their rates, and in fact, the risk of costly catastrophic events is larger. As a result, their rates and average rate increases tend to be higher. Experience Rated groups, on the other hand, have more credible data to be used for rate development.

Chart 4
Average Rate Increases by Rating Methodology

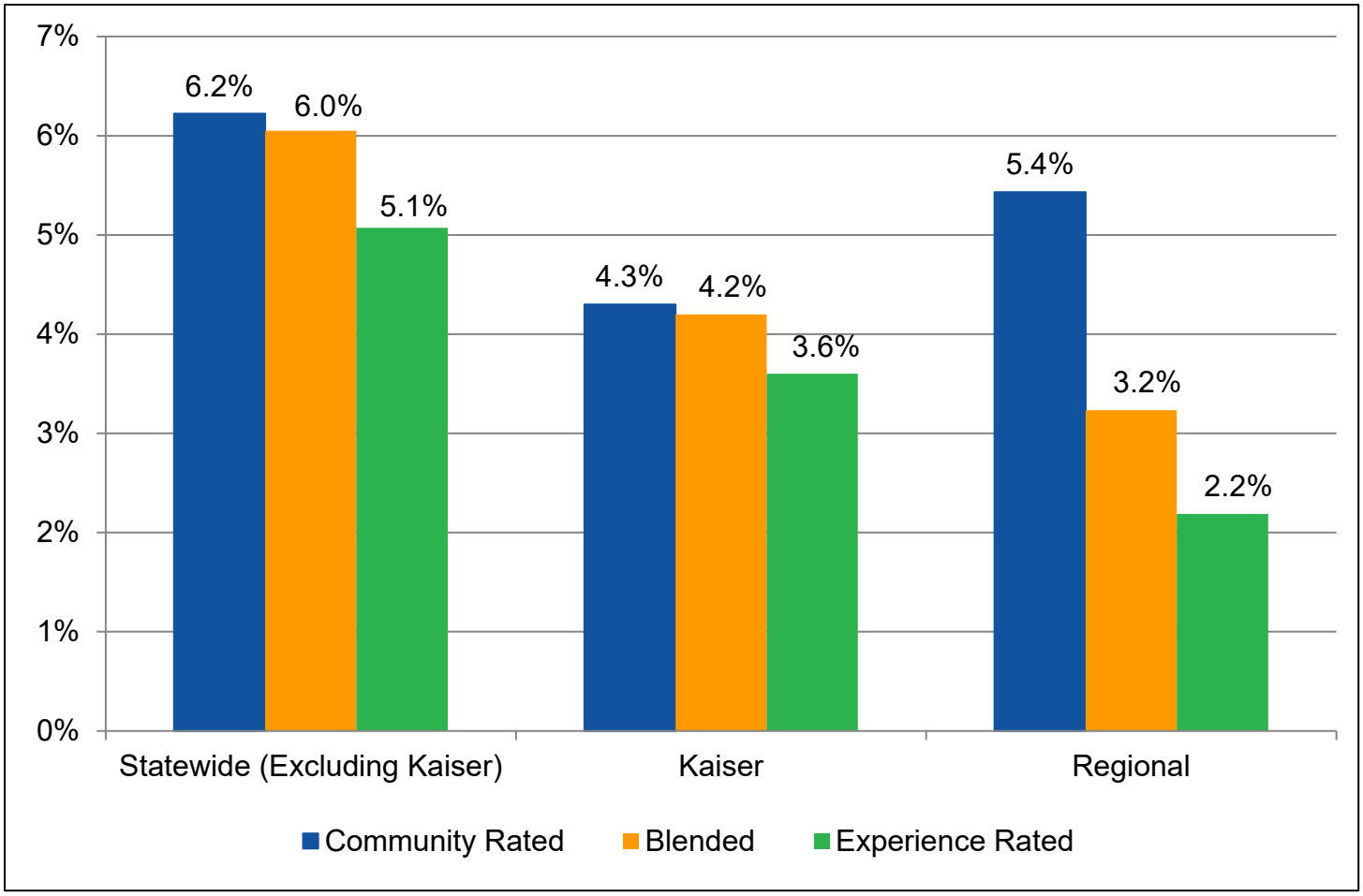
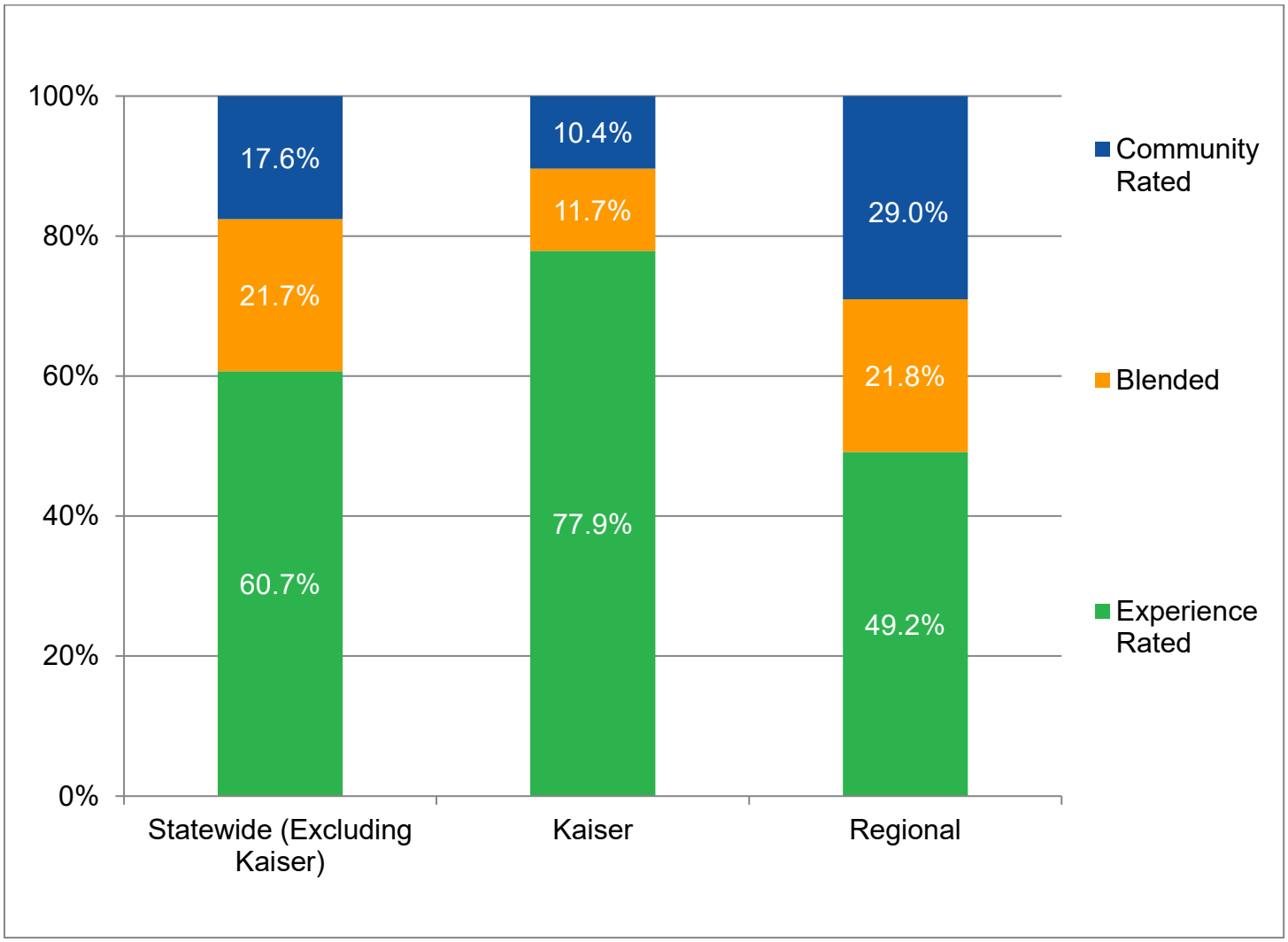


Chart 5 shows the percentage of renewing enrollees by rating methodology for Statewide Plans (excluding Kaiser), Kaiser, and Regional groups. Because regional groups tend to be smaller in size, it is less common for them to be experience rated, as the data is less credible. Less than 50% of regional members are experience rated. Groups contracted with Kaiser tend to be much larger, and therefore they provide more credible data for experience rating. As such, Kaiser has much a higher percentage of experience rated members, or almost 80%.

Chart 5
Percentage of Renewing Enrollees by Rating Methodology



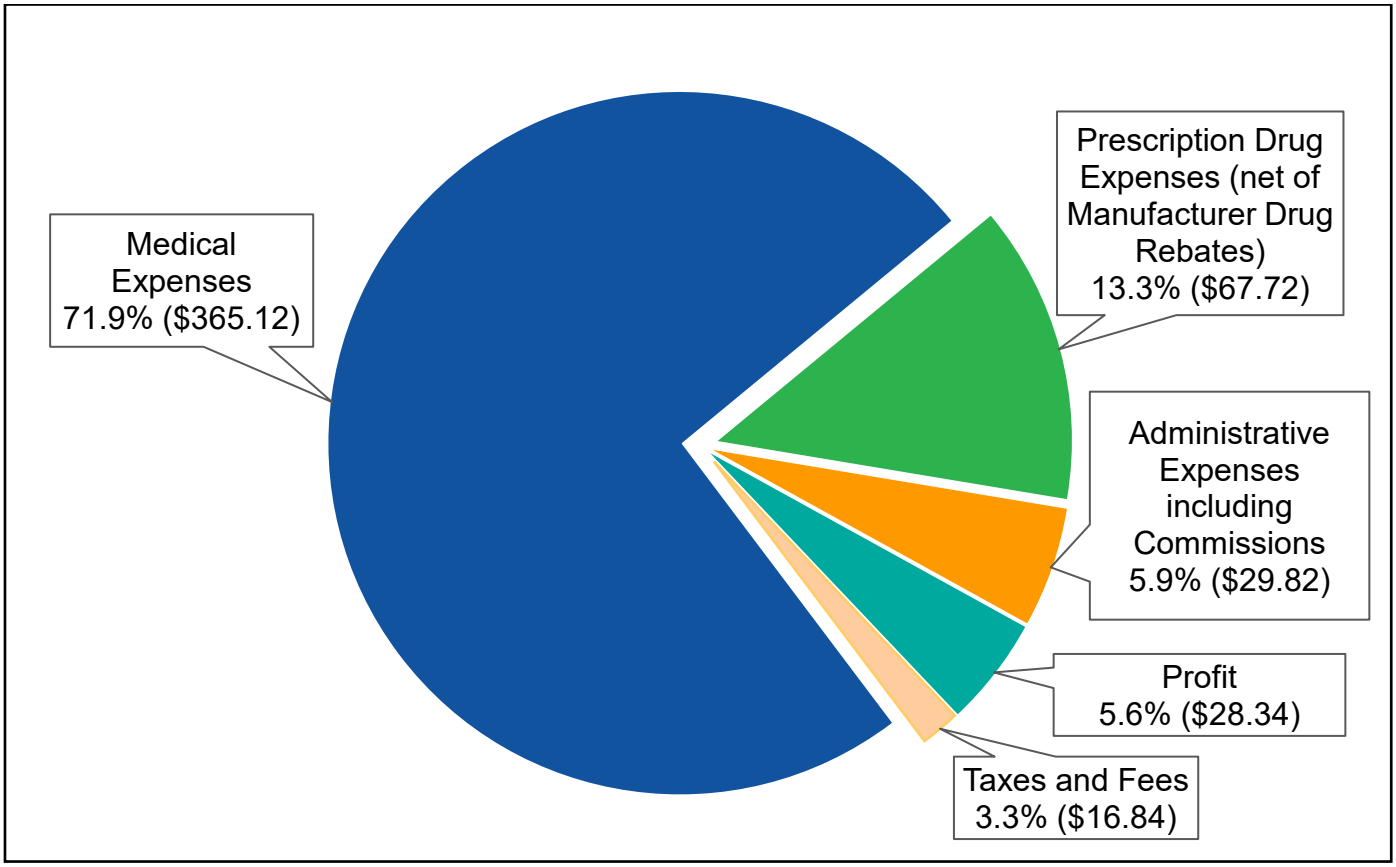
IV. Impact of Prescription Drug Costs on Large Group Rates

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 per member per month 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 2020, the total health plan premium on a PMPM basis was $507.83. Medical expenses accounted for $365.12, or 71.9%, of the health plan premium. Prescription drug expenses, net of manufacturer rebates, accounted for $67.72, or 13.3%, of total health plan premium on a PMPM basis. Profit accounted for $28.34, or 5.6%, of the total health plan premium on a PMPM basis. Administrative expenses[15] including commissions accounted for $29.82, or 5.9%, and taxes and fees made up the remaining $16.84 or 3.3% of total health plan premiums on a PMPM basis.

Chart 6

Breakdown of Large Group Health Plan Premium Per Member Per Month



[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 per member per month basis in 2020 in comparison to 2019. Medical expenses increased by 1.2% since 2019, while prescription drug expenses increased by 1.7%. Health plan profit increased by 13.8%. Administrative expenses, including commissions increased by 3.5%. Manufacturer drug rebates increased by 10.8% in 2020 and totaled approximately $703 million in 2020 compared to $650 million in 2019. These rebates helped mitigate some of the overall impact of rising prescription drug prices by reducing total health plan premiums by 1.5% in 2020. Taxes and fees increased by 45% as a result of the health plans being subject to the federal Health Insurance Tax[16] in 2020.

Table 9

Components of Large Group Health Plan Premium on a PMPM Basis

Category of Premium Payment	2020	Percentage of Premium	2019	Percentage of Premium	Year-over-Year Percentage Change
Medical Expenses	$365.12	71.9%	$360.74	73.1%	1.2%
Prescription Drug Expenses	$75.21	14.8%	$73.98	15.0%	1.7%
Manufacturer Drug Rebates	($7.49)	(1.5%)	($6.76)	(1.4%)	10.8%
Administrative Expenses including Commissions	$29.82	5.9%	$28.82	5.8%	3.5%
Taxes and Fees	$16.84	3.3%	$11.59	2.3%	45.3%
Profit	$28.34	5.6%	$24.91	5.1%	13.8%
Total Health Plan Premium	$507.83	100.0%	$493.27	100.0%	3.0%
Member Months (in millions)	93.8		88.9		5.5%

[16] Health Insurance Tax (HIT) is a federal annual fee charged to insurance companies providing health policy premiums established by the Patient Protection and Affordable Care Act. The fee took effect in 2014 and was suspended for 2017 and 2019.

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 statewide and regional plans.

Table 10

Large Group Prescription Drug and Medical Expenses as a Percent of Premium 2020

Health Plan Name	Average Premium	Percentage of Premium Spent on Prescription Drugs	Percentage of Premium Spent on Medical Expenses[17]
Aetna Health of California	$498	12.3%	66.0%
Anthem Blue Cross	$508	19.0%	63.8%
Blue Shield of California	$535	14.0%	68.4%
Cigna Healthcare of California	$510	15.1%	74.2%
Health Net of California	$551	9.1%	71.1%
UnitedHealthcare of California	$534	9.0%	69.9%
UnitedHealthcare Benefits Plan of California	$527	12.5%	63.7%
Statewide Plans (Excluding Kaiser)	$521	15.3%	66.6%
Kaiser	$501	12.5%	74.1%
Regional Plans	$552	13.6%	74.6%

[17] Does not include prescription drug expenses.

Five health plans reported information related to the costs associated with administering drugs in a doctor's office.[18] Table 11 shows the range of costs for these services on a PMPM basis. The maximum cost reported by health plans was $25.71 PMPM, and the minimum reported was $1.91 PMPM. The median cost reported for all plans was $18.97 PMPM.

Table 11

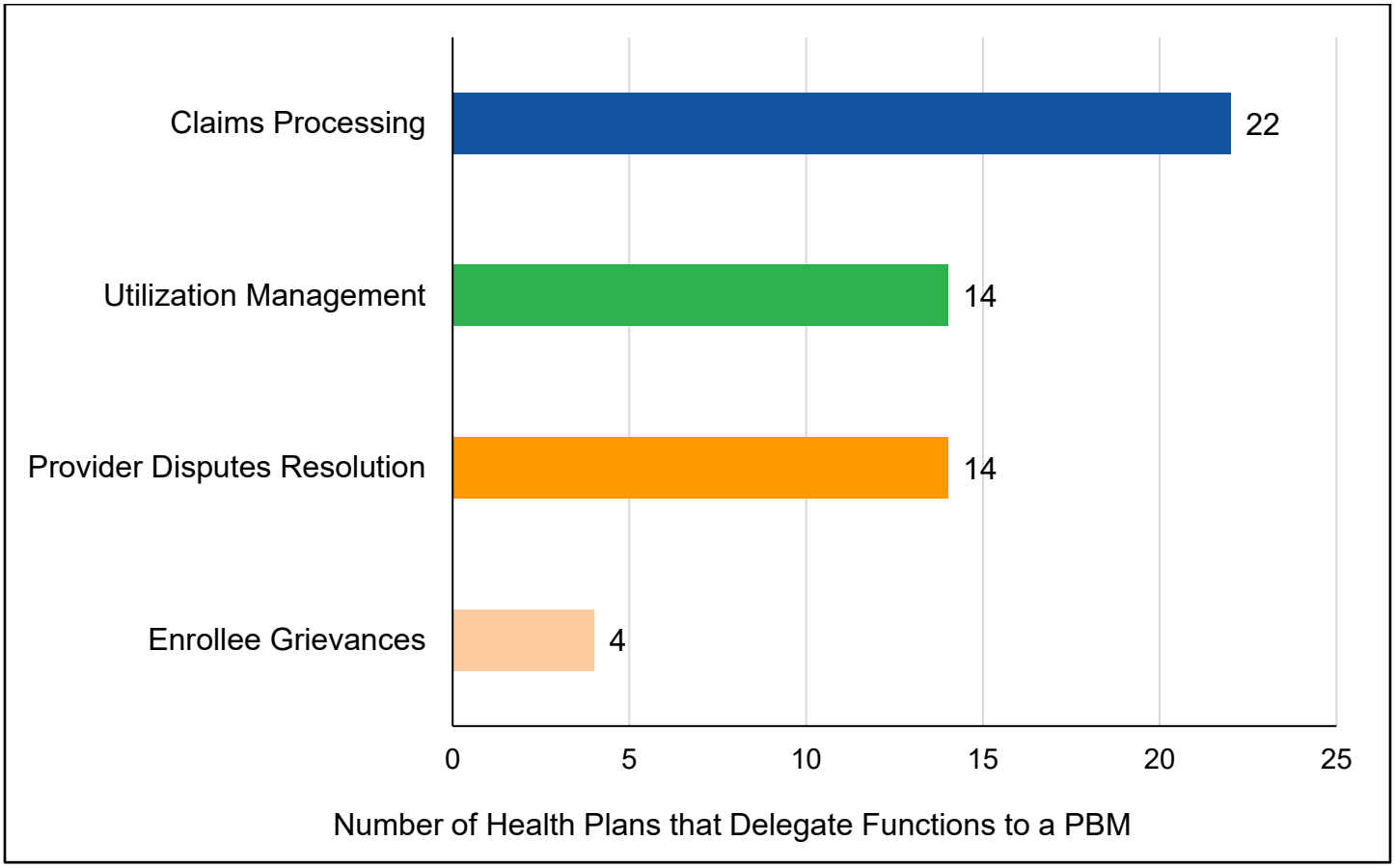
Costs for Drugs Administered in a Doctor's Office on a PMPM Basis

Category	Number of Plans	Minimum (Reported)	Maximum (Reported)	Median (Reported)
All Plans	5	$1.91	$25.71	$18.97
Statewide Plans (Excluding Kaiser)	1	$22.23	$22.23	$22.23
Kaiser	1	$18.97	$18.97	$18.97
Regional Plans	3	$1.91	$25.71	$2.82

[18] 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, 14 health plans used PBMs for utilization management and 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 2020, the annual average rate increases for the large group market have remained relatively consistent averaging around 4% each year. 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 have ranged from 3.5% to 5.5%, compared to Covered California which ranged from 0.5% to 21.1% and CalPERS ranged from 1.1% to 7.7%.

Prescription drug costs, net of manufacturer rebates, accounted for 13.3% of total health care premiums in 2020, a slight decrease from 13.6% in 2019. Medical expenses made up 71.9%, or $365.12, of total health plan premiums on a PMPM basis. Medical expenses increased by 1.2% since 2019, a lower rate increase than prescription drug expenses, which increased by 1.7%.

This is the fifth annual report prepared on health plan's large group annual aggregate rate information. 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. 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	No	Yes	Yes	No
Blue Shield of California	SS&C Health	No	Yes	No	No
Blue Shield of California	CVS Health	No	No	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	Express Scripts	No	Yes	Yes	No
Cigna Healthcare of California	Argus	No	Yes	No	No
Community Care Health Plan	MEDIMPACT	Yes	Yes	Yes	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	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
MemorialCare 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
Ventura County Health	Express Scripts	No	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
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	
Ventura County Health	Ventura County Health Care Plan
Western Health Advantage	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