From: DMHC Licensing eFiling

To: "andersonmv@aetna.com"; "terry.german@wellpoint.com"; "kathleen.lynaugh@blueshieldca.com"; "cdobry@CCHPHMO.COM"; "william.jameson@cigna.com"; "JLorge@communitymedical.org"; "ptanguary@hsd.co.contra-costa.ca.us"; "Dee.Pupa@ventura.org"; douglas.a.schur@healthnet.com; "deborah.espinal@kp.org"; "JA91913@gmail.com"; "georgette.cook@vhp.sccgov.org"; "Pantovic.Linda@scrippshealth.org"; "DThompson2@memorialcare.org"; melissa.cook@sharp.com; "christina.suggett@simnsa.com"; "LachanG@sutterhealth.org"; "elizabeth.hays@uhc.com"; "r.downing@westernhealth.com"

Cc: Wong, Nancy@DMHC

Subject: SB Director"s Letter No. 8-K Revised

Date: Friday, September 02, 2016 4:07:00 PM

Attachments: DMHC_CA_LARGE_GROUP_ANNUAL_AGGREGATE_RATE_DATA_REPORT_FORM_Fillable_pdf_AUGUST_31__2016.pdf
DMHC_CA_CALIFORNIA_LARGE_GROUP_ANNUAL_AGGREGATE_RATE_DATA_REPORT_FORM_SB_546_August_31_2016.docx
DMHC Director"s Letter 8-K_8-31-16.pdf
DMHC_CA_LARGE_GROUP_HISTORICAL_DATA_SPREADSHEET_August 31_2016.xlsx

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Dear Health Plan Reviewer:

This email regarding compliance with SB 546 is being sent to all applicable plans which arrange for Commercial Full-Service Large Group plans.

Attached you will find correspondence dated August 31, 2016, including Director's Letter 8-K Revised, the large group reporting form in Word and fillable PDF format and the historical data spreadsheet.

For any questions, please contact the Office of Legal Services at (916) 322-6727.

Thank you for your attention to this matter.

Regards,

Nancy Wong
Deputy Director
Office of Plan Licensing
916-323-1228
Nancy.Wong@dmhc.ca.gov

California Large Group Annual Aggregate Rate Data Report Form
Version 2, August 31, 2016

(File through SERFF as a PDF or excel. If you enter data on a Word version of this document, convert to PDF before submitting the form. SERFF will not accept Word documents.
Note "SB 546 Large Group Annual Aggregate Rate Data Report" in the SERFF "Filing Description" field)

The aggregate rate information submission form should include the following:

1) Company Name (Health Plan)
2) Rate Activity 12-month ending date
3) Weighted Average Rate Increase, and Number Enrollees subject to rate change
4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month
5) Segment Type
6) Product Type
7) Products Sold with materially different benefits, cost share
8) Factors affecting the base rate
9) Overall Medical Trend
10) Projected Medical Trend
11) Per Member per Month Costs and Rate of Changes over last five years
    -submit CA Large Group Historical Data Reporting Spreadsheet (Excel)
12) Changes in Enrollee Cost Sharing
13) Changes in Enrollee Benefits
14) Cost Containment and Quality Improvement Efforts
15) Number of products that incurred excise tax paid by the health plan
16) Other Comments

1) Company Name:

2) This report summarizes rate activity for the 12 months ending reporting year _____.[1]

3) Weighted average annual rate increase (unadjusted)[2]:
   - All large group benefit designs: _____%
   - Most commonly sold large group benefit design: _____%

   Weighted average annual rate increase (adjusted)[3]:
   - All large group benefit designs: _____%
   - Most commonly sold large group benefit design[4] _____%

[1] Provide information for January 1-December 31 of the reporting year.
[2] Average percent increase means the weighted average of the annual rate increases that were implemented (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives.
[3] "Adjusted" means normalized for aggregate changes in benefits, cost sharing, provider network, geographic rating area, and average age.
[4] Most commonly sold large group benefit design is determined at the product level. The most common large group benefit design, determined by number of enrollees should not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month

1	2	3	4	5	6	7
Month rate change effective	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected by Rate Change[5]	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted[6]
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
Overall		***100%***				

See Health and Safety Code section 1385.045(a) and Insurance Code section 10181.45(a)

[5] The total number of enrollees/covered lives (employee plus dependents) affected by, or subject to, the rate change.

[6] Average percent increase means the weighted average of the annual rate increases that were offered (final rate quoted, including any underwriting adjustment) (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives in columns 4 & 5.

Place comments below:

(*Include (1) a description (such as product name or benefit/cost-sharing description, and product type) of the most commonly sold benefit design, and (2) methodology used to determine any reasonable approximations used).*

5) Segment type: Including whether the rate is community rated, in whole or in part
See Health and Safety Code section 1385.045(c)(1)(B) and Insurance Code section 10181.45(c)(1)(B)

1	**2**	**3**	**4**	**5**	**6**	**7**
Rating Method	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)						
Blended (in part)						
100% Experience Rated						
Overall		***100%***				

Comments: Describe differences between the products in each of the segment types listed in the above table, including which product types (PPO, EPO, HMO, POS, HDHP) are 100% community rated, which are 100% experience rated, and which are blended. Also include the distribution of covered lives among each product type and rating method.

6) Product Type:

See Health and Safety Code section 1385.045(c)(1)(C) and Insurance Code section 10181.45(c)(1)(C)

1	**2**	**3**	**4**	**5**	**6**	**7**
Product Type	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
HMO						
PPO						
EPO						
POS						
HDHP						
Other (describe)						
Overall		***100%***				

HMO – Health Maintenance Organization PPO – Preferred Provider Organization
EPO – Exclusive Provider Organization POS – Point-of-Service
HDHP – High Deductible Health Plan with or without Savings Options (HRA, HSA)

Describe "Other" Product Types, and any needed comments here.

7) The number of plans sold during the 12-months that have materially different benefits, cost sharing, or other elements of benefit design.

See Health and Safety Code section 1385.045(c)(1)(E) and Insurance Code section 10181.45(c)(1)(E)

Please complete the following tables. In completing these tables, please see definition of "Actuarial Value" in the document "SB546 – Additional Information":

HMO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

PPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

EPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

POS

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

HDHP

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

In the comment section below, provide the following:

- Number and description of standard plans (non-custom) offered, if any. Include a description of the type of benefits and cost sharing levels.
- Number of large groups with (i) custom plans and (ii) standard plans.

Place comments here:

8) Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:
See Health and Safety Code section 1385.045(c)(2) and Insurance Code section 10181.45(c)(2)

Factor	Provide actuarial basis, change in factors, and member months during 12-month period.
Geographic Region (describe regions)	
Age, including age rating factors (describe definition, such as age bands)	
Occupation	
Industry	
Health Status Factors, including but not limited to experience and utilization	
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	
Enrollees' share of premiums	
Enrollees' cost sharing	
Covered benefits in addition to basic health care services and any other benefits mandated under this article	
Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated	
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	

[7] i.e. premium tier ratios

9) Overall large group medical allowed trend factor and trend factors by aggregate benefit category:

Overall Medical Allowed Trend Factor

"Overall" means the weighted average of trend factors used to determine rate increases included in this filing, weighting the factor for each aggregate benefit category by the amount of projected medical costs attributable to that category.

Allowed Trend: (Current Year) / (Current Year – 1)

Medical Allowed Trend Factor by Aggregate Benefit Category

The aggregate benefit categories are each of the following – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(A) and Insurance Code section 10181.45(c)(3)(A)

Hospital Inpatient[8]	
Hospital Outpatient (including ER)	
Physician/other professional services[9]	
Prescription Drug[10]	
Laboratory (other than inpatient) [11]	
Radiology (other than inpatient)	
Capitation (professional)	
Capitation (institutional)	
Capitation (other)	
Other (describe)	

[8] Measured as inpatient days, not by number of inpatient admissions.
[9] Measured as visits.
[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

10) Projected medical trend:

Use the same aggregate benefit categories used in item 9 – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). Furthermore, within each aggregate category quantify the sources of trend, i.e. use of service, price inflation, and fees and risk.

See Health and Safety Code section 1385.045(c)(3)(B) and Insurance Code section 10181.45(c)(3)(B)

Projected Medical Allowed Trend by Aggregate Benefit Category

Pricing Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]					
Hospital Outpatient (including ER)					
Physician/other professional services[13]					
Prescription Drug[14]					
Laboratory (other than inpatient)[15]					
Radiology (other than inpatient)					
Capitation (professional)					
Capitation (institutional)					
Capitation (other)					
Other (describe)					
Overall					

[12] Measured as inpatient days, not by number of inpatient admissions.
[13] Measured as visits.
[14] Per prescription.
[15] Laboratory and Radiology measured on a per-service basis.

11) Complete the CA Large Group Historical Data Spreadsheet to provide a comparison of the aggregate per enrollee per month costs and rate changes over the last five years for each of the following: (I) Premiums, (ii) Claims costs, if any, (iii) Administrative Expenses, and (iv) Taxes and fees. *Administrative Expenses include general and administrative fees, agent and broker commissions*

Complete CA Large Group Historical Data Spreadsheet - Excel

See Health and Safety Code section 1385.045(c)(3)(C) and Insurance Code section 10181.45(c)(3)(C)

12) Changes in enrollee cost-sharing

Describe any changes in enrollee cost-sharing over the prior year associated with the submitted rate information. Describe these changes at the plan level (see definition of "plan" in the document "SB546-Additional Information.") Please include both of the following:

See Health and Safety Code section 1385.045(c)(3) (D) and Insurance Code section 10181.45(c)(3)(D)

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value based on plan benefits using the company's plan relativity model, weighted by the number of enrollees.[16]

[16] Please determine weight average actuarial value base on the company's own plan relativity model. For this purpose, the company is not required to use the CMS standard model.

13) Changes in enrollee/insured benefits

Describe any changes in benefits for enrollees/insureds over the prior year, providing a description of benefits added or eliminated, as well as any aggregate changes as measured as a percentage of the aggregate claims costs. Describe these changes at the product level (see definition of "product" in the document "SB546-Additional Information.") Please provide this information for each of the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). ***See Health and Safety Code section 1385.045(c) (3) (E) and Insurance Code section 10181.45(c)(3)(E)***

14) Cost containment and quality improvement efforts

Describe any cost containment and quality improvement efforts since prior year for the same category of health benefit plan (for this purpose, "category of health benefit plan" means product type, such as HMO, PPO, EPO, etc.). To the extent possible, describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. Companies are encouraged to structure their response with reference to the cost containment and quality improvement components of "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract:"

1.01 Coordination and Cooperation
1.02 Ensuring Networks are Based on Value
1.03 Demonstrating Action on High Cost Providers
1.04 Demonstrating Action on High Cost Pharmaceuticals
1.05 Quality Improvement Strategy
1.06 Participation in Collaborative Quality Initiatives
1.07 Data Exchange with Providers
1.08 Data Aggregation across Health Plans

See Health and Safety Code section 1385.045(c)(3)(F) and Insurance Code section 10181.45(c)(3)(F), see also California Health Benefit Exchange, April 7, 2016 Board Meeting materials: http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

Response for item 14, Cost containment and quality improvement efforts:

15) Excise tax incurred by the health plan

Describe for each segment the number of products covered by the information that incurred the excise tax paid by the health plan - applicable to year 2020 and later. ***See Health and Safety Code section 1385.045(c)(3)(G) and Insurance Code section 10181.45(c)(3)(G)***

16) Other Comments

Provide any additional comments on factors that affect rates and the weighted average rate changes included in this filing.

California Large Group Annual Aggregate Rate Data Report Form
Version 2, August 31, 2016

(File through SERFF as a PDF or excel. If you enter data on a Word version of this document, convert to PDF before submitting the form. SERFF will not accept Word documents.
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1) Company Name:

2) This report summarizes rate activity for the 12 months ending reporting year _____.[1]

3) Weighted average annual rate increase (unadjusted)[2]:
   - All large group benefit designs: _____%
   - Most commonly sold large group benefit design: _____%

   Weighted average annual rate increase (adjusted)[3]:
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   - Most commonly sold large group benefit design[4] _____%

[1] Provide information for January 1-December 31 of the reporting year.
[2] Average percent increase means the weighted average of the annual rate increases that were implemented (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives.
[3] "Adjusted" means normalized for aggregate changes in benefits, cost sharing, provider network, geographic rating area, and average age.
[4] Most commonly sold large group benefit design is determined at the product level. The most common large group benefit design, determined by number of enrollees should not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month

1	2	3	4	5	6	7
Month rate change effective	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected by Rate Change[5]	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted[6]
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
Overall		***100%***				

See Health and Safety Code section 1385.045(a) and Insurance Code section 10181.45(a)

[5] The total number of enrollees/covered lives (employee plus dependents) affected by, or subject to, the rate change.

[6] Average percent increase means the weighted average of the annual rate increases that were offered (final rate quoted, including any underwriting adjustment) (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives in columns 4 & 5.

Place comments below:

(*Include (1) a description (such as product name or benefit/cost-sharing description, and product type) of the most commonly sold benefit design, and (2) methodology used to determine any reasonable approximations used).*

5) Segment type: Including whether the rate is community rated, in whole or in part
See Health and Safety Code section 1385.045(c)(1)(B) and Insurance Code section 10181.45(c)(1)(B)

1	**2**	**3**	**4**	**5**	**6**	**7**
Rating Method	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)						
Blended (in part)						
100% Experience Rated						
Overall		***100%***				

Comments: Describe differences between the products in each of the segment types listed in the above table, including which product types (PPO, EPO, HMO, POS, HDHP) are 100% community rated, which are 100% experience rated, and which are blended. Also include the distribution of covered lives among each product type and rating method.

6) Product Type:

See Health and Safety Code section 1385.045(c)(1)(C) and Insurance Code section 10181.45(c)(1)(C)

1	**2**	**3**	**4**	**5**	**6**	**7**
Product Type	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
HMO						
PPO						
EPO						
POS						
HDHP						
Other (describe)						
Overall		***100%***				

HMO – Health Maintenance Organization PPO – Preferred Provider Organization
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HDHP – High Deductible Health Plan with or without Savings Options (HRA, HSA)

Describe "Other" Product Types, and any needed comments here.

7) The number of plans sold during the 12-months that have materially different benefits, cost sharing, or other elements of benefit design.

See Health and Safety Code section 1385.045(c)(1)(E) and Insurance Code section 10181.45(c)(1)(E)

Please complete the following tables. In completing these tables, please see definition of "Actuarial Value" in the document "SB546 – Additional Information":

HMO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

PPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

EPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

POS

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

HDHP

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

In the comment section below, provide the following:

- Number and description of standard plans (non-custom) offered, if any. Include a description of the type of benefits and cost sharing levels.
- Number of large groups with (i) custom plans and (ii) standard plans.

Place comments here:

8) Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:
See Health and Safety Code section 1385.045(c)(2) and Insurance Code section 10181.45(c)(2)

Factor	Provide actuarial basis, change in factors, and member months during 12-month period.
Geographic Region (describe regions)	
Age, including age rating factors (describe definition, such as age bands)	
Occupation	
Industry	
Health Status Factors, including but not limited to experience and utilization	
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	
Enrollees' share of premiums	
Enrollees' cost sharing	
Covered benefits in addition to basic health care services and any other benefits mandated under this article	
Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated	
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	

[7] i.e. premium tier ratios

9) Overall large group medical allowed trend factor and trend factors by aggregate benefit category:

Overall Medical Allowed Trend Factor

"Overall" means the weighted average of trend factors used to determine rate increases included in this filing, weighting the factor for each aggregate benefit category by the amount of projected medical costs attributable to that category.

Allowed Trend: (Current Year) / (Current Year – 1)

Medical Allowed Trend Factor by Aggregate Benefit Category

The aggregate benefit categories are each of the following – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(A) and Insurance Code section 10181.45(c)(3)(A)

Hospital Inpatient[8]	
Hospital Outpatient (including ER)	
Physician/other professional services[9]	
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Laboratory (other than inpatient) [11]	
Radiology (other than inpatient)	
Capitation (professional)	
Capitation (institutional)	
Capitation (other)	
Other (describe)	

[8] Measured as inpatient days, not by number of inpatient admissions.
[9] Measured as visits.
[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

10) Projected medical trend:

Use the same aggregate benefit categories used in item 9 – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). Furthermore, within each aggregate category quantify the sources of trend, i.e. use of service, price inflation, and fees and risk.

See Health and Safety Code section 1385.045(c)(3)(B) and Insurance Code section 10181.45(c)(3)(B)

Projected Medical Allowed Trend by Aggregate Benefit Category

Pricing Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]					
Hospital Outpatient (including ER)					
Physician/other professional services[13]					
Prescription Drug[14]					
Laboratory (other than inpatient)[15]					
Radiology (other than inpatient)					
Capitation (professional)					
Capitation (institutional)					
Capitation (other)					
Other (describe)					
Overall					

[12] Measured as inpatient days, not by number of inpatient admissions.
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[14] Per prescription.
[15] Laboratory and Radiology measured on a per-service basis.

11) Complete the CA Large Group Historical Data Spreadsheet to provide a comparison of the aggregate per enrollee per month costs and rate changes over the last five years for each of the following: (I) Premiums, (ii) Claims costs, if any, (iii) Administrative Expenses, and (iv) Taxes and fees. *Administrative Expenses include general and administrative fees, agent and broker commissions*

Complete CA Large Group Historical Data Spreadsheet - Excel

See Health and Safety Code section 1385.045(c)(3)(C) and Insurance Code section 10181.45(c)(3)(C)

12) Changes in enrollee cost-sharing

Describe any changes in enrollee cost-sharing over the prior year associated with the submitted rate information. Describe these changes at the plan level (see definition of "plan" in the document "SB546-Additional Information.") Please include both of the following:

See Health and Safety Code section 1385.045(c)(3) (D) and Insurance Code section 10181.45(c)(3)(D)

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value based on plan benefits using the company's plan relativity model, weighted by the number of enrollees.[16]

[16] Please determine weight average actuarial value base on the company's own plan relativity model. For this purpose, the company is not required to use the CMS standard model.

13) Changes in enrollee/insured benefits

Describe any changes in benefits for enrollees/insureds over the prior year, providing a description of benefits added or eliminated, as well as any aggregate changes as measured as a percentage of the aggregate claims costs. Describe these changes at the product level (see definition of "product" in the document "SB546-Additional Information.") Please provide this information for each of the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). ***See Health and Safety Code section 1385.045(c) (3) (E) and Insurance Code section 10181.45(c)(3)(E)***

14) Cost containment and quality improvement efforts

Describe any cost containment and quality improvement efforts since prior year for the same category of health benefit plan (for this purpose, "category of health benefit plan" means product type, such as HMO, PPO, EPO, etc.). To the extent possible, describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. Companies are encouraged to structure their response with reference to the cost containment and quality improvement components of "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract:"

1.01 Coordination and Cooperation
1.02 Ensuring Networks are Based on Value
1.03 Demonstrating Action on High Cost Providers
1.04 Demonstrating Action on High Cost Pharmaceuticals
1.05 Quality Improvement Strategy
1.06 Participation in Collaborative Quality Initiatives
1.07 Data Exchange with Providers
1.08 Data Aggregation across Health Plans

See Health and Safety Code section 1385.045(c)(3)(F) and Insurance Code section 10181.45(c)(3)(F), see also California Health Benefit Exchange, April 7, 2016 Board Meeting materials: http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

Response for item 14, Cost containment and quality improvement efforts:

15) Excise tax incurred by the health plan

Describe for each segment the number of products covered by the information that incurred the excise tax paid by the health plan - applicable to year 2020 and later. ***See Health and Safety Code section 1385.045(c)(3)(G) and Insurance Code section 10181.45(c)(3)(G)***

16) Other Comments

Provide any additional comments on factors that affect rates and the weighted average rate changes included in this filing.

State Of California
California Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE

www.healthhelp.ca.gov

Edmund G. Brown Jr.
Governor

Shelley Rouillard
Director
Department of Managed Health Care

DATE: September 2, 2016 **LETTER No. 8-K Revised**

GUIDANCE RELATED TO PREMIUM RATE FILINGS

The purpose of this letter is to provide health care service plans (health plans) with guidance concerning SB 1163 (Leno -- Stats. 2010, ch. 661), and SB 546 (Leno -- Stats. 2015, ch. 801).

Background

Under Senate Bill 1163 (Leno -- Stats. 2010, ch. 661), health plans must file specified premium rate information with the Department of Managed Health Care (DMHC), provide certain actuarial certifications, and meet specified website and consumer notice requirements.

SB 1163 also authorizes the DMHC to review premium rates including unreasonable rate increases as defined by the Patient Protection and Affordable Care Act. Thus, the DMHC will look to federal rules and guidance to help in its review process.

Pursuant to SB 1163, the Director of the DMHC may issue guidance to health plans, effective until the DMHC formally adopts regulations. Accordingly, the DMHC developed the following guidance in consultation with the CDI.

The DMHC may provide additional guidance as necessary to ensure consistent and appropriate implementation of SB 1163, and the guidance may be revised to conform with federal rules or guidance, or as otherwise necessary.

Under Senate Bill 546 (Leno -- Stats. 2015, ch. 801), health plans must file additional specified rate information with the DMHC, and meet additional

consumer notice requirements.

SB 546 also authorizes the DMHC to conduct a public meeting annually regarding large group rate changes after the DMHC has completed a review of the large group rate information required to be submitted by the plan or insurer, as specified.

The DMHC may provide additional guidance as necessary to ensure consistent and appropriate implementation of SB 546 and the guidance may be revised to conform with federal rules or guidance, or as otherwise necessary.

Individual and Small Group Health Contracts

Filing and Notice

1) For individual and small group health contracts, rate submissions for new products and rate increases for existing products must be filed at least 60 days prior to the effective date of the new product rate or the rate increase. (Health and Safety Code section 1385.03 (a), (b)(14).) At this time, health plans are not required to file rate submissions for new products or rate increases for existing products for large group contracts with the DMHC.

2) The notice to enrollees or subscribers required by Health and Safety Code section 1374.21 and 1389.25 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed.

3) For the purposes of Health and Safety Code section 1385.03(a), the concurrent filing requirement is satisfied if the health plan files its rate submission with the DMHC prior to or on the same date that it delivers its notice to the enrollees or subscribers. Consumers must receive notice consistent with Health and Safety Code sections 1374.21 and 1389.25. If a rate filing is revised after its initial submission so as to change the rates, an additional 30-day notice meeting the requirements of Health and Safety Code section 1374.21 and 1389.25 must be provided reflecting the revised rate.

4) If the implementation of a rate increase for which notice has been provided to enrollees or subscribers is delayed or the amount of the increase is reduced before the effective date of the increase, the health plan shall provide the enrollees or subscribers with a written explanation for the delay or decrease. Such explanation may be included with the first billing statement associated with the delayed or decreased rate increase.

Unreasonable Rate Increases

5) For individual and small group health plan rate filings, for the purpose of the actuarial certification required under Health and Safety Code section

1385.06(b)(2) and review under Health and Safety Code section 1385.11, the factors the DMHC will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors expressly referenced in 45 C.F.R. 154.205:

i) The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. (See interim federal rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. section 158.101-158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010), incorporated herein by reference.

ii) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

iii) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

iv) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the DMHC in connection with the filed rate increase, are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could not make an objective appraisal of the reasonableness of the rate, or which otherwise do not provide a basis upon which the reasonableness of the rate may be determined.

v) Whether the filed rates result in premium differences between enrollees within similar risk categories that are otherwise not permitted under California law or that do not reasonably correspond to differences in expected costs.

In addition, the DMHC may consider other factors specified in the California Department of Insurance (CDI) guidance dated April 5, 2011, (or as amended thereafter) including, but not limited to, the following:

vi) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible historical emerging experience data, including comparisons of experience data to projections submitted as support for prior rate filings.

vii) The annual compensation of each of the ten most highly paid officers, executives, and employees of both the health plan submitting the filing, and the parent corporation/ultimate controlling party of the health plan.

viii) The rate of return of the health plan and the parent corporation/ultimate

controlling party of the health plan, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

ix) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

x) Whether the cumulative impact of the filed rate increase, combined with previous increases over the 12 months immediately preceding the effective date of the proposed filed rate increase, would cause the rate increase to be unreasonable.

xi) The health plan's surplus condition, which may include dividend history.

xii) Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases an enrollee could receive, and how many enrollees will be subject to increases lower or higher than the average.

xiii) The nature and amount of transactions between the health plan and any affiliates.

xiv) To the extent not otherwise covered by the factors listed above, additional factors that the DMHC may consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors set forth in the most current version of federal regulations, including 45 C.F.R, section 154.301.

Actuarial Certification

6) (A) The certification required under Health and Safety Code section 1385.06 (b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8, promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41, promulgated by the Actuarial Standards Board.

(B) The certification required under Health and Safety Code section 1385.06 (b)(2) must include the following information:

i) A statement of the qualifications of the actuary issuing the certification. The

actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Health and Safety Code section 1385.06 (b) (3).

ii) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the particular market segment (i.e., small group or individual). Premium rates are actuarially sound if, for business in California and for the period covered by the certification, projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital reserves required by the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing at Health and Safety Code section 1340, et seq.

iii) For each contract included in the filing, a complete description of the data, assumptions, rating factors and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract form included in the filing.

iv) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall address, at a minimum, the first five factors listed in "Unreasonable Rate Increases" in this Guidance. In addition, statements of opinion shall discuss the criteria promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. sections 154.200 and 154.205.

v) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(ii) and (B)(iv) above, including any independent rating models and rating factors utilized.

(C) All of the information required in (B), above, must be contained within the actuarial certification.

Filing Requirements

7) Individual and small group health plan rate filings for existing products must be accompanied by the "California Rate Filing Form" that discloses the information required by Health and Safety Code section 1385.03(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Rate Filing Spreadsheet," as well as a separate spreadsheet containing rate information in response to question ten of the Rate Filing Form. The "California Rate Filing Form" and the "California Rate Filing Spreadsheet," can be found on the DMHC website and include definitions of certain required items.

8) Individual and small group health plan rate filings for existing products must be accompanied by the "California Plain Language Website Filing Form," submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Plain Language Spreadsheet" (Health and Safety Code section 1385.07(d)). The form and the spreadsheet can be found on the DMHC website.

9) Initial rate filings for new products for individual and small group health plan filings must be accompanied by the "California New Product Rate Filing Form" that discloses the information required by Health and Safety Code section 1385.03(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, accompanied by a spreadsheet containing the information described in the form which can be found on the Department's website and include definitions of certain required items.

10) The aggregate rate filing data report required by Health and Safety Code section 1385.03(c) need not be submitted with each separate rate filing but must be filed with the DMHC annually, due on or before February 15. Each such report must summarize the required data for the calendar year. The report should be identified in SERFF by placing "Aggregate Rate Filing Data Report" in the "Filing Description" under the "General Information" tab. A template form entitled "California Annual Aggregate Rate Data Report Form" may be used to meet this requirement. The terms "Segment Type," "Product Type," and "average rate increase" are defined as they are in the attached "California Rate Filing Form" for items 5, 4, and 13, respectively.

Large Group Health Contracts

Filing and Notice

1) For large group health contracts, each health plan shall file the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year, and additional aggregate rate information with the DMHC on or before October 1, 2016, and annually thereafter.

2) No change in premium rates or changes in coverage stated in a group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

3) Renewal notices delivered by plans shall include a statement comparing the proposed rate change stated in a group health plan service contract to the average rate increases negotiated by CalPERS and by Covered California. The statement must include information on:

   i) Whether the rate proposed to be in effect is greater than, less than or equal to the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

   ii) Whether the rate proposed to be in effect is greater than, less than or equal to the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year in which the rates are final.

   iii) Whether the rate change includes any portion of the excise tax paid by the health plan; however, the Department has confirmed this is not applicable in 2016 through 2019 and accordingly need not be included in the notice.

   iv) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

Filing Requirements

For large group health care service plan contracts, each health plan shall file with the DMHC annually the "California Large Group Annual Aggregate Rate Data Report" that discloses the information required by Health and Safety Code section 1385.045. A template form of the report including definitions of certain required items can be found on the Department's website.

The aggregate rate data report should be filed in SERFF on or before October 1, 2016, and annually thereafter. The report should be submitted as a PDF document identified in SERFF by entering "Large Group Aggregate Rate Data Report" in the "Filing Description" under the "General Information" tab.

If you have any questions concerning the guidance issued in this letter, please

contact the Office of Legal Services at (916) 322-6727.

Shelley Rouillard, Director

_____

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet
August 31, 2016
For Policies subject to CIC 10181.45 or CHSC 1374.21

1.	Reporting Year	2016
2.	Enter DMHC Health Plan ID/CDI NAIC No.	
3.	Legal Name	
4.	DBA	

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet
August 31, 2016
For Policies subject to CIC 10181.45 or CHSC 1374.21

Historical Data - Premium and Claims

HMO/POS		Historical Data				
		2011	2012	2013	2014	2015
1.	Premium:					
	1.1 Total premium	1,000,000,000	1,050,000,000	1,110,000,000	1,180,000,000	1,250,000,000
2.	Claims:					
	2.1 Claims Incurred and Paid	600,000,000	720,000,000	750,000,000	775,000,000	1,100,000,000
	2.2 Direct claim reserves	100,000,000	105,000,000	111,000,000	118,000,000	300,000,000
	2.3 Experience rating refunds (rate credits) paid					
	2.4 Reserve for experience rating refunds (rate credits)					
	2.5 Contingent benefit and lawsuit reserves					
	2.6 Total incurred claims	700,000,000	825,000,000	861,000,000	893,000,000	1,400,000,000
3.	Federal and State Taxes and Licensing or Regulatory Fees					
	3.1 Federal taxes and assessments					
	3.1a Federal income taxes deduct ble from premium in MLR calculations	3,000,000	3,100,000	3,200,000	3,300,000	3,400,000
	3.1b Patient Centered Outcomes Research Institute (PCORI) Fee				4,000,000	3,000,000
	3.1c Affordable Care Act section 9010 Fee		800,000	800,000	800,000	800,000
	3.1d Federal Transitional Reinsurance Fee					
	3.1e Other Federal Taxes and assessments deductible from premium					
	3.2 State Premium Tax	23,500,000	24,675,000	26,085,000	27,730,000	29,375,000
	3.3 State Income Tax					
	3.4 Regulatory authority licenses and fees					
	3.5 Other Taxes and Fees					
	3.6 Total Federal and State Taxes and fees	26,500,000	28,575,000	30,085,000	35,830,000	36,575,000
4.	Non-Claims Costs					
	4.1 Administrative Expenses	100,000,000	100,000,000	100,000,000	100,000,000	100,000,000
	4.2 Agents and brokers fees and commissions	90,000,000	30,000,000	20,000,000	5,000,000	5,000,000
	4.3 Other general and administrative expenses					
	4.4 Total non-claims costs	190,000,000	130,000,000	120,000,000	105,000,000	105,000,000
5.	Other Indicators or information					
	5.1 Number of covered lives	100,000	100,000	100,000	100,000	100,000
	5.2 Member months	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet
August 31, 2016
For Policies subject to CIC 10181.45 or CHSC 1374.21

Historical Data - Premium and Claims

PPO/EPO		Historical Data				
		2011	2012	2013	2014	2015
1.	Premium:					
	1.1 Total premium	1,000,000,000	1,050,000,000	1,110,000,000	1,180,000,000	1,250,000,000
2.	Claims:					
	2.1 Claims Incurred and Paid	600,000,000	720,000,000	750,000,000	775,000,000	srhg
	2.2 Direct claim reserves	100,000,000	105,000,000	111,000,000	118,000,000	300,000,000
	2.3 Experience rating refunds (rate credits) paid					
	2.4 Reserve for experience rating refunds (rate credits)					
	2.5 Contingent benefit and lawsuit reserves					
	2.6 Total incurred claims	700,000,000	825,000,000	861,000,000	893,000,000	300,000,000
3.	Federal and State Taxes and Licensing or Regulatory Fees					
	3.1 Federal taxes and assessments					
	3.1a Federal income taxes deduct ble from premium in MLR calculations	3,000,000	3,100,000	3,200,000	3,300,000	3,400,000
	3.1b Patient Centered Outcomes Research Institute (PCORI) Fee				4,000,000	3,000,000
	3.1c Affordable Care Act section 9010 Fee		800,000	800,000	800,000	800,000
	3.1d Federal Transitional Reinsurance Fee					
	3.1e Other Federal Taxes and assessments deductible from premium					
	3.2 State Premium Tax	23,500,000	24,675,000	26,085,000	27,730,000	29,375,000
	3.3 State Income Tax					
	3.4 Regulatory authority licenses and fees					
	3.5 Other Taxes and Fees					
	3.6 Total Federal and State Taxes and fees	26,500,000	28,575,000	30,085,000	35,830,000	36,575,000
4.	Non-Claims Costs					
	4.1 Administrative Expenses	100,000,000	100,000,000	100,000,000	100,000,000	100,000,000
	4.2 Agents and brokers fees and commissions	90,000,000	30,000,000	20,000,000	5,000,000	5,000,000
	4.3 Other general and administrative expenses					
	4.4 Total non-claims costs	190,000,000	130,000,000	120,000,000	105,000,000	105,000,000
5.	Other Indicators or information					
	5.1 Number of covered lives	100,000	100,000	100,000	100,000	100,000
	5.2 Member months	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet
August 31, 2016
For Policies subject to CIC 10181.45 or CHSC 1374.21

Historical Data - Premium and Claims

HMO/POS

		Historical Data				
		2011	2012	2013	2014	2015
1.	Total Dollars					
1.1	Premiums	1,000,000,000	1,050,000,000	1,110,000,000	1,180,000,000	1,250,000,000
1.2	Claims Costs	700,000,000	825,000,000	861,000,000	893,000,000	1,400,000,000
1.3	Administrative Expenses	190,000,000	130,000,000	120,000,000	105,000,000	105,000,000
1.4	Taxes and Fees	26,500,000	28,575,000	30,085,000	35,830,000	36,575,000
2.	PMPM					
2.1	Premiums	833	875	925	983	1,042
2.2	Claims Costs	583	688	718	744	1,167
2.3	Administrative Expenses	158	108	100	88	88
2.4	Taxes and Fees	22	24	25	30	30
3.	Average Change in Ra ing Components (%)					
3.1	Premiums	N/A	5.0%	5.7%	6.3%	5.9%
3.2	Claims Costs	N/A	17.9%	4.4%	3.7%	56.8%
3.3	Administrative Expenses	N/A	-31.6%	-7.7%	-12.5%	0.0%
3.4	Taxes and Fees	N/A	7.8%	5.3%	19.1%	2.1%

Palamarchuk, Igor@DMHC

From:	DMHC Licensing eFiling
Sent:	Wednesday, September 07, 2016 4:42 PM
To:	andersonmv@aetna.com; terry.german@wellpoint.com; kathleen.lynaugh@blueshieldca.com; cdobry@CCHPHMO.COM; william.jameson@cigna.com; JLorge@communitymedical.org; ptanquary@hsd.co.contra-costa.ca.us; Dee.Pupa@ventura.org; douglas.a.schur@healthnet.com; deborah.espinal@kp.org; JA91913@gmail.com; georgette.cook@vhp.sccgov.org; Pantovic.Linda@scrippshealth.org; DThompson2@memorialcare.org; melissa.cook@sharp.com; christina.suggett@simnsa.com; LachanG@sutterhealth.org; elizabeth.hays@uhc.com; r.downing@westernhealth.com
Cc:	Wong, Nancy@DMHC
Subject:	FW: SB Director's Letter No. 8-K Revised
Attachments:	ADDITIONAL_INFORMATION_LARGE_GROUP_AGGREGATE_RATE_FILING_SB_546_AUGUST_2....pdf; DMHC_CA_LARGE_GROUP_ANNUAL_AGGREGATE_RATE_DATA_REPORT_FORM_Fillable_pdf_....pdf; DMHC_CA_CALIFORNIA_LARGE_GROUP_ANNUAL_AGGREGATE_RATE_DATA_REPORT_FORM_SB....docx; DMHC_CA_LARGE_GROUP_HISTORICAL_DATA_SPREADSHEET_August 31_2016.xlsx; DMHC Director's Letter 8-K (9-2-16).pdf

Dear Health Plan Reviewer:

The email regarding compliance with SB 546 is being resent due to an update to the Director's Letter 8-K's revision as of 9/2/2016.

Attached are the following documents:

1. DMHC Director's Letter 8-K (9-2-16)
2. Additional Information Large Group Aggregate Rate Filing
3. DMHC CA Large Group Historical Data Spreadsheet
4. DMHC CA Large Group Annual Aggregate Rate Data Report Form in PDF (no changes)
5. DMHC CA Large Group Annual Aggregate Rate Data Report Form in Word (no changes)

For any questions, please contact the Office of Legal Services at (916) 322-6727.

Thank you for your attention to this matter.

Regards,

Nancy Wong
Deputy Director
Office of Plan Licensing
916-323-1228
Nancy.Wong@dmhc.ca.gov

From: DMHC Licensing eFiling
Sent: Friday, September 02, 2016 4:08 PM

To: 'andersonmv@aetna.com'; 'terry.german@wellpoint.com'; 'kathleen.lynaugh@blueshieldca.com'; 'cdobry@CCHPHMO.COM'; 'william.jameson@cigna.com'; 'JLorge@communitymedical.org'; 'ptanquary@hsd.co.contra-costa.ca.us'; 'Dee.Pupa@ventura.org'; douglas.a.schur@healthnet.com; 'deborah.espinal@kp.org'; 'JA91913@gmail.com'; 'georgette.cook@vhp.sccgov.org'; 'Pantovic.Linda@scrippshealth.org'; 'DThompson2@memorialcare.org'; melissa.cook@sharp.com; 'christina.suggett@simnsa.com'; 'LachanG@sutterhealth.org'; 'elizabeth.hays@uhc.com'; 'r.downing@westernhealth.com'
Cc: Wong, Nancy@DMHC
Subject: SB Director's Letter No. 8-K Revised

Dear Health Plan Reviewer:

This email regarding compliance with SB 546 is being sent to all applicable plans which arrange for Commercial Full-Service Large Group plans.

Attached you will find correspondence dated August 31, 2016, including Director's Letter 8-K Revised, the large group reporting form in Word and fillable PDF format and the historical data spreadsheet.

For any questions, please contact the Office of Legal Services at (916) 322-6727.

Thank you for your attention to this matter.

Regards,

Nancy Wong
Deputy Director
Office of Plan Licensing
916-323-1228
Nancy.Wong@dmhc.ca.gov

Large Group Annual Aggregate Rate Data Report Form

1. **Actuarial basis:** means the methodology used to determine the rating factors and the purpose of the factors.

2. **Actuarial value:** For the purpose of item 7 on the Large Group Annual Aggregate Rate Data Report Form, in reporting the number of plans according to actuarial value, the actuarial value calculation should utilize the covered benefits described in the February 20, 2013 Methodology for the federal Minimum Value (MV) Calculator. Please note that this reference to the MV Calculator methodology is only for the purpose of describing the set of covered benefits to be used in the calculation of actuarial value; this is **not** an instruction to use the MV Calculator to perform the actuarial value calculation.

   The benefits are: 1) Emergency Room Services, 2) All inpatient hospital services (including mental health & substance use disorder services), 3) Primary care visit to treat an injury or illness (excluding preventive well baby, preventive, and X-rays), 4) Specialist Visit, 4) Mental/Behavioral health and substance abuse disorder outpatient services, 5) Imaging (CT/PET scans, MRI), 6) Rehabilitative speech therapy, 7) Rehabilitative occupational and rehabilitative physical therapy, 8) Preventive care/screening/immunization, 9) Laboratory outpatient and professional services, 10) X-rays and diagnostic imaging,
   11) Skilled nursing facility, 12) Outpatient facility fee (e.g., Ambulatory Surgery Center), 12) Outpatient surgery physician/surgical services, 13) Drug categories: generics, preferred brand drugs, non-preferred brand drugs, specialty drugs.

3. **Any factors affecting the base rate, and the actuarial bases for those factors**: The health plan or insurer shall provide any factors, such as those factors, listed from Health & Safety Code Section 1385.045(c) (2) A-K or California Insurance Code Section 10181.45(c) (2) A-K, affecting the base rate and briefly describe the actuarial basis. (i.e. geographic region, age , occupation, industry, health status, employee and employee dependents, enrollee's share of premium, enrollee's cost sharing, covered benefits in addition to basic health care services, and segment type (partial or full community rates vs. experience rates)).

4. **Current Year:** means the calendar year (i.e., reporting year) that a health plan or health insurer files the California Large Group Annual Aggregate Rate Data Report Form with the Department.

5. **Custom Plan:** For item 7, "custom plan" is the opposite of a "standard plan." A "custom plan" is a large group plan in which the purchaser has the opportunity to select an array of benefits, contractual provisions, and cost sharing.

6. **Excise Tax:** The Consolidated Appropriations Act, 2016 (Pub. L. 114-113), signed into law on December 18, 2015, delayed the effective date of the excise tax on high cost employer-sponsored health coverage from taxable years beginning after December 31, 2017, to taxable years beginning after December 31, 2019. When it goes into effect in 2020, it will put a 40 percent tax on the most expensive health insurance plans whose costs exceed certain thresholds.

7. **Large Group:** means commercial full-service health care service plans as defined in Health & Safety Code section 1385.01, subdivision (a) or large group health insurance policies as defined in California Insurance Code 10181, subdivision (a). For the purpose of SB546 reporting requirements, large group plans shall include fully insured commercial products and In Home Support Services (IHSS) products.

8. **Number of Enrollees/Covered Lives:** means the number of employees, including dependents enrolled (i.e., members or covered lives), affected by rate changes during the 12-month reporting period; reasonable approximations are allowed when actual information is not available.

9. **Percent of Total Rate Changes:** means the distribution of number of rate changes.

10. **Product type:** means Health Maintenance Organization HMO), Preferred Provider Organization (PPO), Point of Service (POS), Exclusive Provider Organization (EPO), and High Deductible Health Plan (HDHP).

    "Product" references a discrete package of health insurance covered services that a health insurance issuer offers using a particular product network type within a service area.

    "Plan" means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.

11. **Projected trend:** The health plan or insurer shall provide its pricing trends for calendar year CY+1 over calendar year CY and for calendar year CY over calendar year CY-1 used in pricing health coverage premium effective during the reporting period (CY = current year).

12. **Segment type:** refers to whether the premium rate is determined using community/manual rates, in whole or in part. For the purpose of this section, segments types are 100% community/manual rated (in whole), blended (in part), and 100% experience rated (none).

13. **Standard Plan:** For item 7, "standard plan" means a large group plan that it sold to the purchaser with little or no opportunity for customization regarding benefits, contractual provisions, or cost-sharing. This term does not refer to the standardized plans sold in the individual and small group markets.