

Public Meeting on Large Group Aggregate Rates and Prescription Drug Costs

March 5, 2020

Panel

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Department of Managed Health Care

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Health Access California

Overview of the DMHC

**Jenny Phillips, Deputy Director
Legislative Affairs**

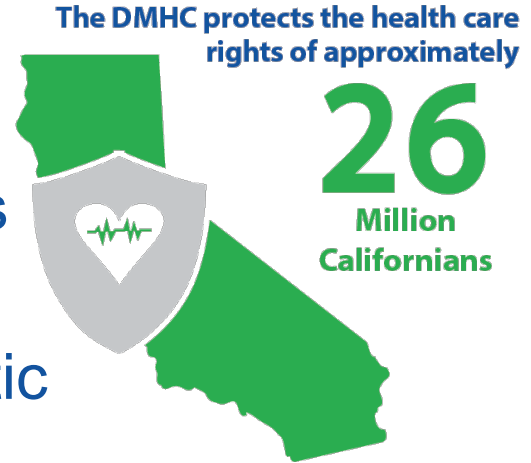
DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

What is the DMHC?

Regulator of full service and specialized health plans

- All HMO and some PPO/EPO products
- Individual, Small and Large Group products
- Medi-Cal Managed Care plans
- Dental, vision, behavioral health, chiropractic and prescription drug
- Medicare Advantage (for financial solvency)

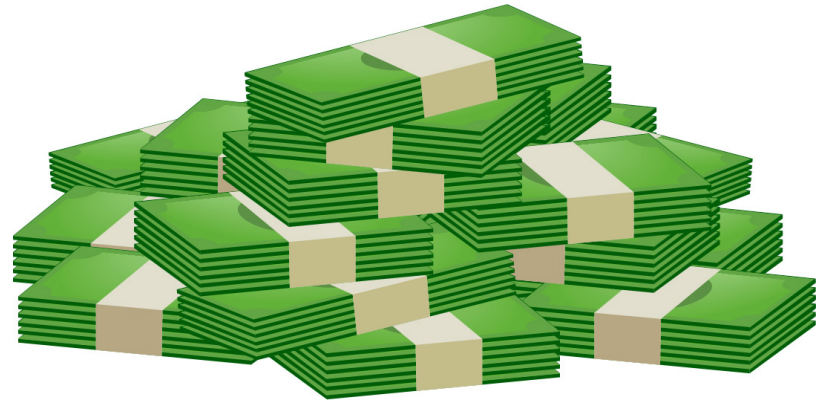


DMHC Key Functions

- Consumer Protection / DMHC Help Center
- License Health Plans & Ensure Compliance with State laws
- Medical Surveys of Health Plan Operations
- Financial Exams to Ensure Financial Stability
- Review Proposed Premium Rate Changes
- Take Enforcement Action Against Plans that Violate the Law

Health Care Premiums Saved Through the Rate Review Program

\$296 Million
Dollars
Since 2011



DMHC Help Center

1-888-466-2219

HealthHelp.ca.gov

Large Group Aggregate Rates Report Measurement Year 2019

Jenny Phillips, Deputy Director
Legislative Affairs

Requirements of Large Group Aggregate Rates Report

- Requires large group health plans to file aggregate rate information and specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs annually.
- The information submitted on October 1, 2019, was for the period of January 1, 2019 – December 31, 2019.

Requirements of Large Group Aggregate Rates Report (continued)

- Requires the DMHC to conduct a public meeting in every even-numbered year to permit a public discussion regarding changes in the rates, benefits and cost sharing in the large group market.
- Requires health plans 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.

Covered California and CalPERS Rates

	Covered California	CalPERS
2017	13.2%	3.9%
2018	21.1%	2.5%
2019	8.7%	1.1%
2020	0.8%	5.1%

Summary of 2019 Large Group Rate Filings

Pritika Dutt, Deputy Director
Office of Financial Review

What is Premium Rate?

- Premium Rate is the amount you or your employer pays for health coverage.
- Factors that impact large group premium rates include:
 - Age, Geography/Location, Family size, Occupation/Industry, Health Status

Summary of 2019 Filing

- 24 Health Care Service Plans were required to file:
 - Seven statewide plans
 - Ten regional plans
 - Two cross-border plans
 - Five In-Home Supportive Services (IHSS) Plans
- Over 7.6 million enrollees in roughly 13,600 renewing groups are affected by the rate changes.
- Subsequent analysis excludes data for Cross-Border and IHSS Plans.

Average Rate Increase

	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Number of Enrollees	Average Premium PMPM
All Plans	3.6%	3.9%	7,712,941	\$500.70
Kaiser	2.9%	3.1%	5,186,211	\$481.78
All Plans Excluding Kaiser	4.8%	5.3%	2,526,730	\$539.36

Statewide Plans

Health Plan Name	Number of Enrollees	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
Kaiser	5,186,211	2.9%	3.1%	\$481.78
Anthem Blue Cross	1,009,232	4.7%	6.1%	\$535.88
Blue Shield	459,799	4.4%	3.9%	\$546.30
Health Net	288,020	3.6%	4.5%	\$559.40

Statewide Plans (continued)

Health Plan Name	Number of Enrollees	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
United Health	264,877	7.2%	7.1%	\$544.17
Aetna Health	127,427	6.2%	6.7%	\$488.91
Cigna Healthcare	117,158	4.6%	3.9%	\$546.07
Statewide Plans Total	7,452,724	3.5%	3.9%	\$499.43

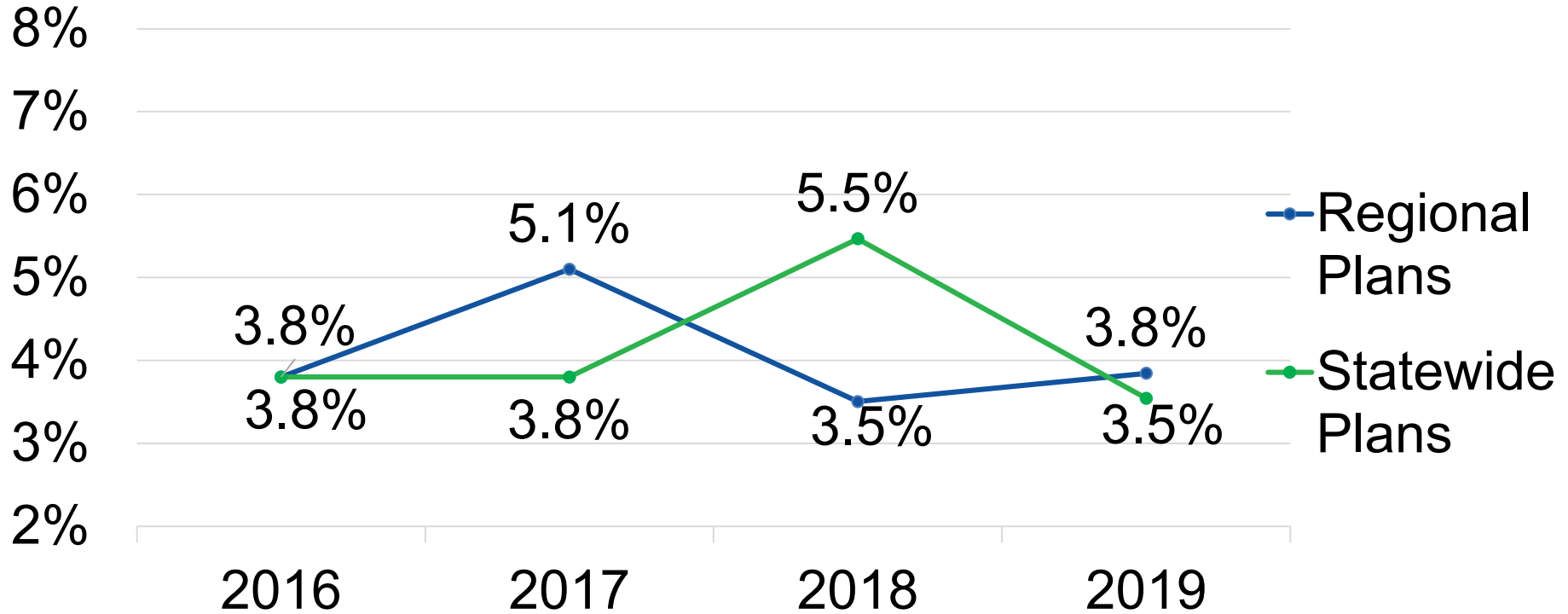
Regional Plans

Health Plan Name	Number of Enrollees	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
Western Health Advantage	75,861	4.0%	5.0%	\$545.34
Sharp Health	61,094	2.8%	2.4%	\$505.79
Sutter	51,590	4.0%	3.6%	\$508.17
Valley Health	22,841	5.2%	5.2%	\$746.28
Scripps	14,022	-3.9%	-3.9%	\$460.70

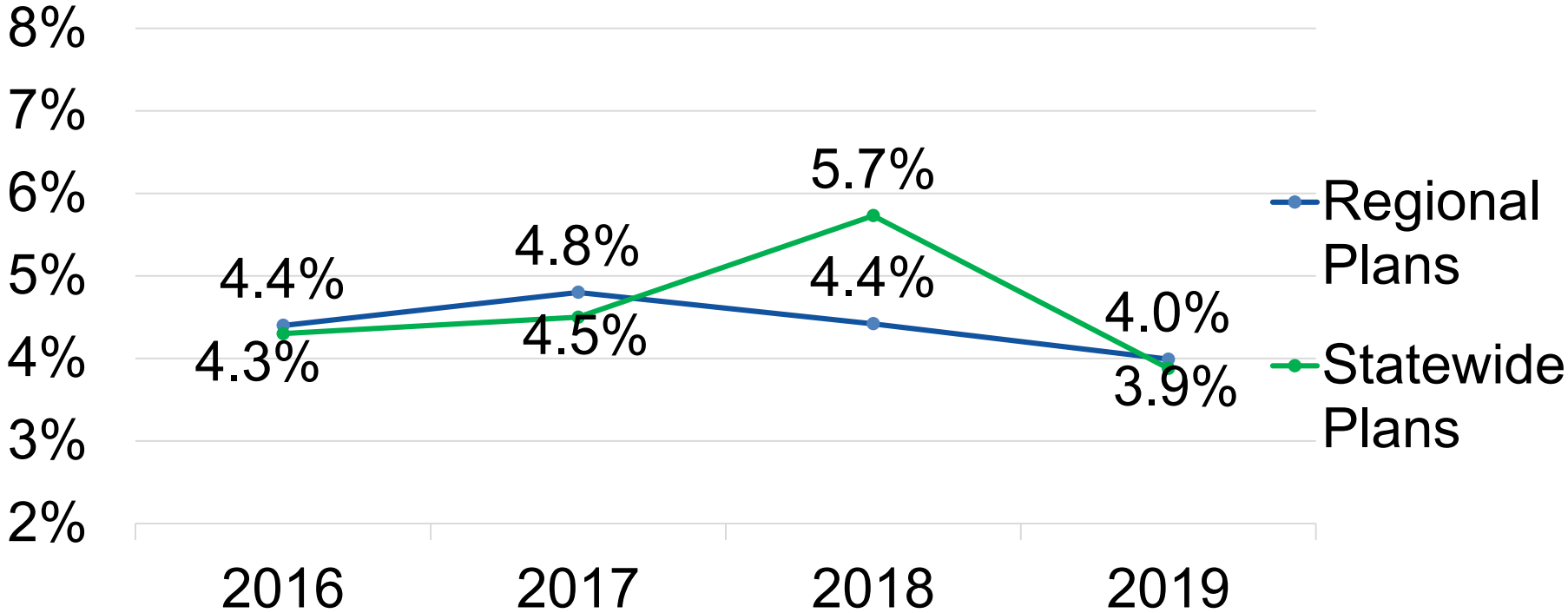
Regional Plans (continued)

Health Plan Name	Number of Enrollees	Unadjusted Average Rate Increase	Adjusted Average Rate Increase	Average Premium PMPM
Ventura County	13,350	8.5%	8.5%	\$495.10
Community Care	10,000	2.4%	2.4%	\$452.00
Contra Costa	8,733	9.0%	9.0%	\$614.27
Chinese Community	2,478	3.0%	3.0%	\$464.29
Seaside	248	0.0%	0.0%	\$529.44
Regional Plans Total	260,217	3.8%	4.0%	\$537.12

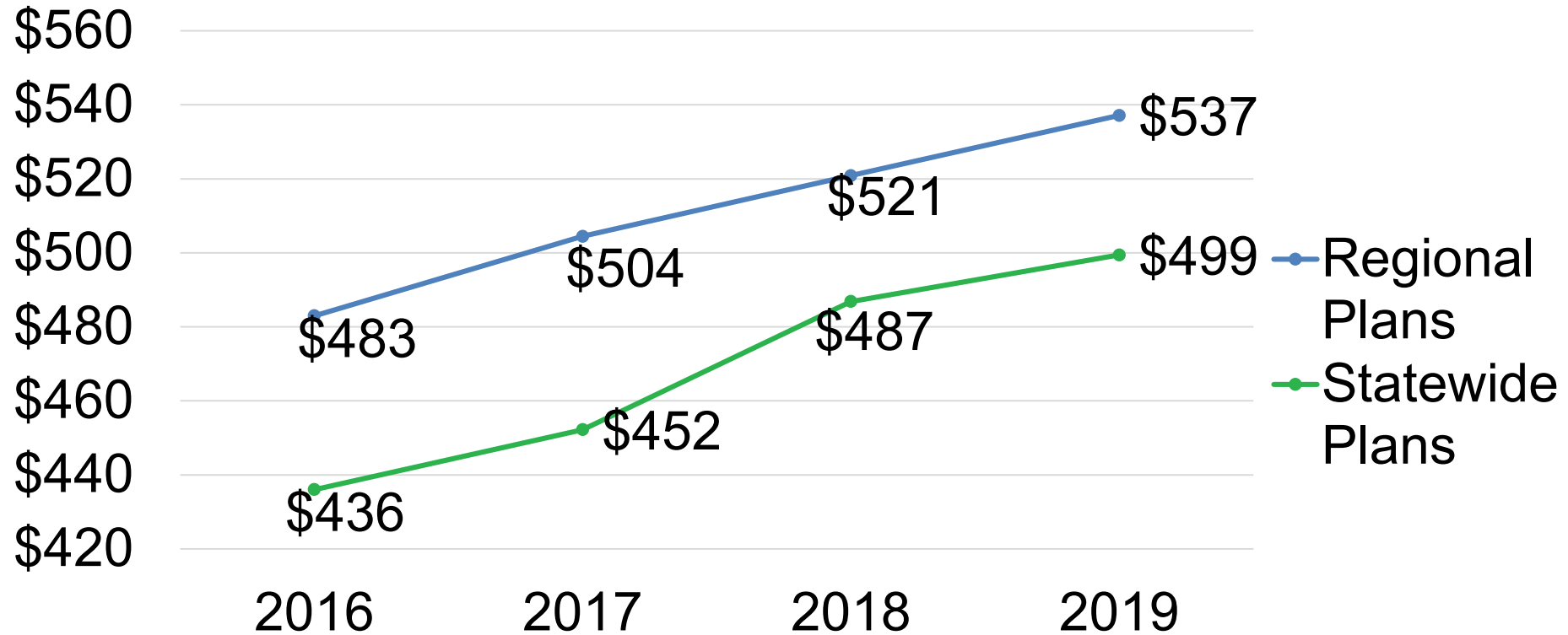
Unadjusted Average Rate Increase



Adjusted Average Rate Increase



Average Premium PMPM



Product Type

Product Type	Average Rate Increase	Minimum	Maximum	Average Premium PMPM
HMO	3.4%	-3.9%	9.0%	\$495.94
PPO	5.0%	0.0%	5.7%	\$603.61
EPO	3.0%	0.0%	3.0%	\$544.94
POS	1.8%	-0.8%	4.1%	\$566.80
HDHP	4.5%	0.0%	7.5%	\$447.82

Rating Method

Category	Percentage of Renewing Groups	Number of Enrollees Affected	Unadjusted Average Rate Increase	Average Premium PMPM
Community Rated	71.2%	1,171,158	4.2%	\$500.66
Blended	18.9%	1,036,363	4.3%	\$488.44
Experience Rated	9.9%	5,410,578	3.3%	\$503.09

Number of Covered Lives by Actuarial Value

Product Type	0.9 – 1.00	0.8 – 0.89	0.7 – 0.79	0.6 – 0.69	< 0.60
HMO	5,796,515	748,640	175,595	34,821	0
PPO	246,804	187,344	6,876	0	0
HDHP	38,105	129,044	210,841	82,803	1,045
POS	62,144	491	685	0	0
EPO	24,224	356	0	0	0
Total	6,167,792	1,065,875	393,997	117,624	1,045

Actuarial Value for HMO Members

Actuarial Value	Statewide Plans (Excluding Kaiser)	Kaiser	Regional Plans
0.9 -1.00	82.2%	87.2%	75.3%
0.8-0.89	13.4%	10.2%	18.7%
0.7-0.79	3.2%	2.4%	3.7%
0.6-0.69	1.2%	0.2%	2.3%
<0.60	0.0%	0.0%	0.0%

Medical Expenses as a Percentage of Premium in 2018

Plan Type	Premium	Medical Expenses	Medical Expenses as Percentage of Premium
All Plans	\$466	\$407	87.3%
Statewide Plans (Excluding Kaiser)	\$458	\$389	84.9%
Kaiser	\$468	\$414	88.4%
Regional Plans	\$510	\$460	90.2%

Administrative Expenses as a Percentage of Premium in 2018

Plan Type	Premium	Admin Expenses	Admin Expenses as Percentage of Premium
All Plans	\$466	\$26	5.5%
Statewide Plans (Excluding Kaiser)	\$458	\$44	9.5%
Kaiser	\$468	\$15	3.2%
Regional Plans	\$510	\$42	8.3%

Net Income as a Percentage of Premium in 2018

Plan Type	Premium	Net Income	Net Income as Percentage of Premium
All Plans	\$466	\$19	4.1%
Statewide Plans (Excluding Kaiser)	\$458	\$7	1.6%
Kaiser	\$468	\$26	5.6%
Regional Plans	\$510	\$3	0.5%

Medical Allowed Trend

Plan Type	2016	2017	2018	2019	2020
All Plans	6.2%	5.5%	5.4%	5.0%	5.0%
Statewide Plans (Excluding Kaiser)	6.8%	6.6%	6.8%	7.0%	6.3%
Kaiser	4.4%	4.4%	5.1%	4.5%	3.8%
Regional Plans	6.1%	5.0%	5.0%	4.3%	3.7%

Pharmacy Allowed Trend

Plan Type	2016	2017	2018	2019	2020
All Plans	8.9%	7.4%	7.0%	9.2%	7.7%
Statewide Plans (Excluding Kaiser)	13.7%	11.3%	11.8%	10.0%	8.9%
Kaiser	8.9%	6.0%	6.0%	5.0%	5.0%
Regional Plans	6.1%	4.0%	5.5%	8.5%	6.8%

Large Group Prescription Drug Cost Report Measurement Year 2019

- Prescription drug costs accounted for 11.7% of the total health care premium.
- Specialty drugs represented more than 46% of total prescription drug spending.
- The average premium increase was 2.7%, 1.0% of which was attributed to pharmacy cost.
- 22 of the 24 health plans used a Pharmacy Benefit Manager.

Breakdown of the Health Plan Premium Per Member Per Month

Component of Premium (PMPM)	2019
Medical Expenses Paid by Health Plan	\$365.17
Prescription Drug Expenses	\$72.37
Manufacturer Rebate (Negative)	(\$5.67)
Administrative Expenses	\$35.64
Profit/Loss	\$24.24
Total Health Care Premium	\$491.75

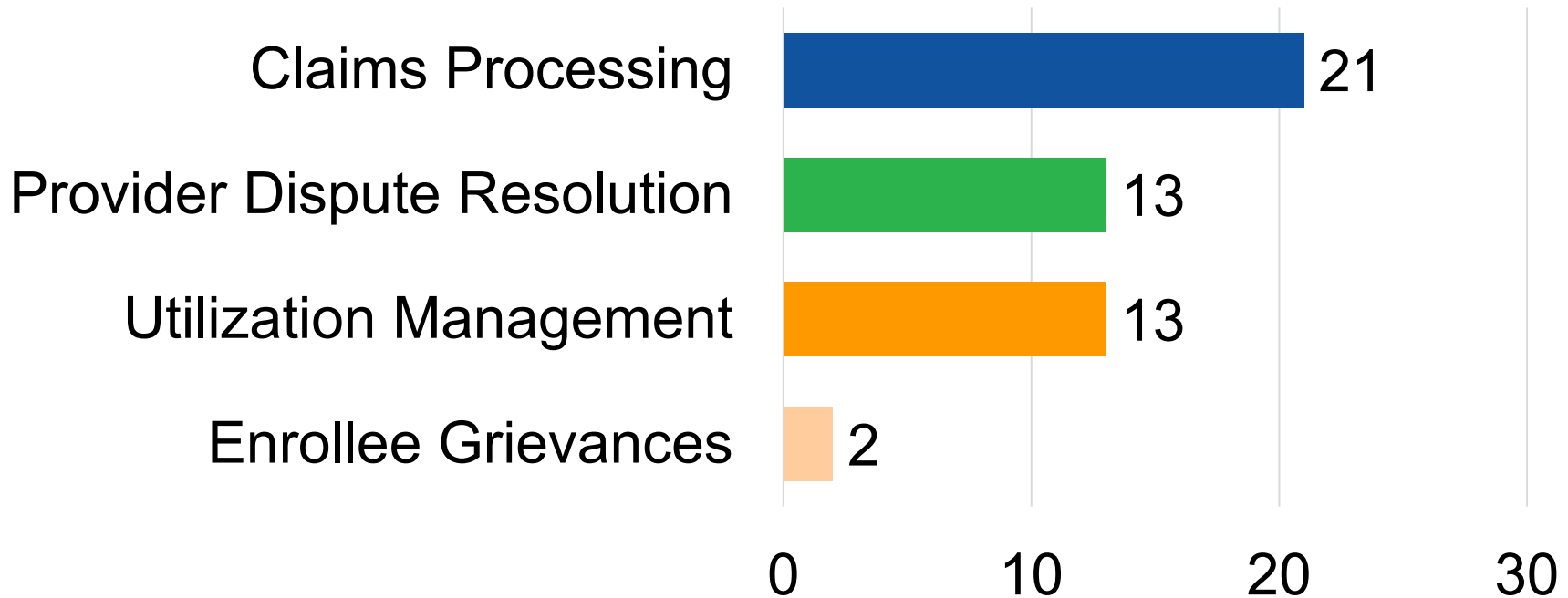
Year-over-Year Percentage Increase in Premium Attributable by Component

Component of Premium (PMPM)	2019
Medical Expenses	2.5%
Prescription Drug Expenses	1.0%
Administrative Expenses	-0.2%
Taxes	-0.9%
Profit/Loss	0.3%
Total Health Care Premium	2.7%

2019 Pharmacy Costs Paid by Health Plans as a Percentage of Premium

Category	All Plans	Statewide Plans (Excluding Kaiser)	Kaiser	Regional Plans
Generic	2.9%	3.0%	2.8%	2.6%
Brand	2.8%	4.0%	2.2%	5.3%
Specialty	6.0%	9.2%	4.8%	7.1%
Total	11.7%	16.2%	9.8%	15.0%

Pharmacy Benefit Manager Functions



Summary of the Prescription Drug Cost Transparency Report for Measurement Year 2018

Pritika Dutt

Deputy Director, Office of Financial Review

Requirements of Prescription Drug Cost Transparency Report

- Health plans must report to the DMHC:
 - 25 most frequently prescribed drugs
 - 25 most costly drugs by total annual spending
 - 25 drugs with highest year-over-year increase in total annual spending
- Annual Reporting Requirement for health plans and DMHC

Reporting Parameters and Limitations

- Plan reporting is limited to prescription drug costs associated with the pharmacy benefit.
- Health plans do not include prescription drug costs for inpatient drugs (hospital) or costs borne by delegated medical groups (such as infusion drugs administered in a physician's office).
- Prescription drug costs for self-funded arrangements, Medical Managed Care, Medicare Advantage and plans/insurers not regulated by the DMHC are not reported.
- Only 26 commercial health plans covering approximately 12.3 million Californians.

Key Findings

- Health plans paid nearly \$9.1 billion for prescription drugs administered through the pharmacy benefit in 2018.
- Prescription drugs accounted for 12.7% of total health plan premiums.
- Manufacturer drug rebates accounted for approximately \$1.058 billion or about 11.7% of the \$9.1 billion spent on prescription drugs.

Key Findings (continued)

- While specialty drugs accounted for 1.6% of all prescription drugs, they accounted for over half (52.6%) of total annual spending on prescription drugs.
- For the 25 most frequently prescribed drugs, enrollees paid approximately 3% of the cost of specialty drugs and over half (55.7%) of the cost of generics.
- The Prescription Drug Cost Transparency Report is available on the DMHC's website.

Large Group Rate Review

**Jenny Phillips, Deputy Director
Legislative Affairs**

Requirements of AB 731

- Expands the rate review practice that the state already has in place for the individual and small group markets to the large group market.
- Effective July 1, 2020, health plans with large group products that are blended rated, community rated or experienced rated, must file specified information 120 days before any change in methodology, factors or assumptions that would affect rate paid by a large group employer.

Requirements of AB 731 (continued)

- DMHC will review the methodology, assumptions and factors used by plans to determine whether the premium rates are unreasonable or not justified.
- Require rate review filings to include specified information such as annual medical trend factor assumptions and the amount of projected trends by geographic areas to provide greater insight into the differences in price across the state.
- DMHC will conduct a public meeting regarding large group rates in every even-numbered year.

1-888-466-2219

HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC HELP CENTER

HealthHelp.ca.gov

Public Comment

*Public comment may be submitted to
publiccomments@dmhc.ca.gov*

Closing Remarks

**Jenny Phillips, Deputy Director
Legislative Affairs**