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:
Aetna Life Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2016.[1]

3) Weighted average annual rate increase (unadjusted)[2]:
- All large group benefit designs: 6.4 %
- Most commonly sold large group benefit design: 7.4 %

Weighted average annual rate increase (adjusted)[3]:
- All large group benefit designs: 6.3 %
- Most commonly sold large group benefit design[4] 6.6 %

[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	249	38.1%	45,483	0	558.00	5.8%
February	20	3.1%	1,188	0	801.00	23.0%
March	28	4.3%	2,324	0	497.66	8.9%
April	44	6.7%	2,892	0	610.71	3.6%
May	35	5.4%	1,521	0	565.46	4.8%
June	48	7.4%	2,531	0	590.20	5.3%
July	70	10.7%	4,712	0	619.75	5.4%
August	31	4.7%	2,237	0	552.40	4.4%
September	37	5.7%	1,448	0	571.80	10.1%
October	36	5.5%	1,762	0	598.83	8.5%
November	26	4.0%	2,856	0	533.00	7.9%
December	29	4.4%	1,240	0	577.52	12.0%
Overall	653	100.0%	70,194	0	568.21	6.4%

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).*

(1) Due to the large number of customizable benefit designs sold, the most commonly sold plan is a small portion of total large group business. The most common plan design is a POS plan with deductible $250, OOP max $2250, Inpatient 90%, PCP $15, Spec $15, Rx Tier 1 $10.
(2) Approximations are derived from rating factors and underwriting reports.

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)	2	0.3%	13	0	785.51	9.8%
Blended (in part)	618	94.6%	47,517	0	568.83	6.3%
100% Experience Rated	33	5.1%	22,664	0	566.79	6.6%
Overall	653	100.0%	70,194	0	568.21	6.4%

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.

All products types are offered for each segment.

Membership distribution is as follows:

Segment	PPO	POS	EPO	Other - Indemnity
100% Community Rated (in whole)	0.21%	0.01%	0.00%	0.00%
100% Experience Rated	1.18%	33.48%	46.58%	81.59%
Blended (in part)	98.61%	66.51%	53.42%	18.41%

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	0	0.0%	0	0	0.00	0.0%
PPO	50	7.2%	4,117	0	564.57	1.2%
EPO	8	1.2%	397	0	477.85	5.0%
POS	626	90.1%	65,410	0	567.00	6.5%
HDHP	0	0.0%	0	0	0.00	0.0%
Other - Indemnity	11	1.6%	270	0	755.56	14.0%
Overall	695	100.0%	70,194	0	567.08	6.2%

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.

Under the Aetna Traditional Choice (Indemnity) plan, members have the freedom to choose any recognized provider for covered services without a referral. The plan coinsurance percent is the same, regardless of whether a provider is contracted with Aetna or not. Plan sponsors save if a member obtains services from network providers who we reimburse based on their contracted fee schedule.

HDHP is included in the other product categories.

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	10	1,016	24.7%	Deduct $100, OOP $1200, Rx Deduct $0, IP 90%/$10, PCP 100%/$10, SPC 100%/$10, OP Surg 90%/$0, Xray 90%/$0, Lab 90%/$0, PT 95%/$10, ER 91%/$30
0.8 to 0.899	32	2,994	72.7%	Deduct $800, OOP $2700, Rx Deduct $200, IP 86%/$70, PCP 100%/$20, SPC 100%/$30, OP Surg 86%/$10, Xray 89%/$0, Lab 89%/$0, PT 90%/$20, ER 94%/$110
0.7 to 0.799	4	107	2.6%	Deduct $2400, OOP $4500, Rx Deduct $900, IP 79%/$0, PCP 96%/$20, SPC 96%/$20, OP Surg 79%/$0, Xray 79%/$0, Lab 79%/$0, PT 81%/$0, ER 94%/$90
0.6 to 0.699	0	0	0.0%	NA
0.0 to 0.599	0	0	0.0%	NA
Total	46	4,117	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	4	193	48.6%	Deduct $100, OOP $2300, Rx Deduct $0, IP 93%/$250, PCP 100%/$20, SPC 100%/$30, OP Surg 93%/$0, Xray 100%/$0, Lab 100%/$0, PT 93%/$30, ER 100%/$130
0.8 to 0.899	2	204	51.4%	Deduct $400, OOP $3100, Rx Deduct $0, IP 86%/$0, PCP 100%/$30, SPC 100%/$40, OP Surg 81%/$0, Xray 95%/$0, Lab 95%/$0, PT 86%/$40, ER 86%/$50
0.7 to 0.799	0	0	0.0%	NA
0.6 to 0.699	0	0	0.0%	NA
0.0 to 0.599	0	0	0.0%	NA
Total	6	397	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	77	10,951	16.7%	Deduct $200, OOP $474100, Rx Deduct $0, IP 91%/$50, PCP 99%/$20, SPC 99%/$20, OP Surg 91%/$0, Xray 91%/$0, Lab 91%/$0, PT 93%/$10, ER 92%/$100
0.8 to 0.899	464	47,561	72.7%	Deduct $500, OOP $2700, Rx Deduct $100, IP 85%/$100, PCP 99%/$20, SPC 99%/$30, OP Surg 85%/$10, Xray 86%/$0, Lab 86%/$0, PT 93%/$20, ER 88%/$100
0.7 to 0.799	123	6,260	9.6%	Deduct $2000, OOP $4100, Rx Deduct $900, IP 81%/$100, PCP 93%/$20, SPC 93%/$20, OP Surg 81%/$10, Xray 81%/$0, Lab 81%/$0, PT 91%/$20, ER 83%/$60
0.6 to 0.699	19	638	1.0%	Deduct $4300, OOP $5800, Rx Deduct $3500, IP 79%/$0, PCP 84%/$10, SPC 84%/$10, OP Surg 78%/$0, Xray 79%/$0, Lab 82%/$0, PT 81%/$0, ER 80%/$10
0.0 to 0.599	0	0	0.0%	NA
Total	683	65,410	100%	

HDHP - ***Included within other product categories***

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:

Standard plans and number of groups sold are listed below.

Standard Plans	Groups Sold
OAMC Ded $100/$200, OOP $1500/$3000, Coins 90%/70%, IP 10% AD, PCP $10 DW, SPC $20 DW	5
OAMC Ded $100/$200, OOP $1500/$3000, Coins 90%/70%, IP 10% AD, PCP $15 DW, SPC $30 DW	2
OAMC Ded $100/$200, OOP $1500/$3000, Coins 90%/70%, IP 10% AD, PCP $20 DW, SPC $40 DW	5
OAMC Ded $250/$500, OOP $2000/$4000, Coins 80%/60%, IP 20% AD, PCP $15 DW, SPC $30 DW	10
OAMC Ded $500/$1000, OOP $2000/$4000, Coins 80%/60%, IP 20% AD, PCP $20 DW, SPC $40 DW	26
OAMC Ded $500/$1000, OOP $2000/$4000, Coins 80%/60%, IP 20% AD, PCP $25 DW, SPC $50 DW	17
OAMC Ded $1000/$2000, OOP $4000/$8000, Coins 70%/50%, IP 30% AD, PCP $30 DW, SPC $50 DW	15
OAMC Ded $2600/$3000, OOP $3000/$7500, Coins 90%/70%, IP 10% AD, PCP 10% AD, SPC 10% AD	11
OAMC Ded $2600/$5000, OOP $4000/$8000, Coins 80%/60%, IP 20% AD, PCP 20% AD, SPC 20% AD	11
OAMC Ded $4000/$8000, OOP $5500/$11000, Coins 70%/50%, IP 30% AD, PCP 30% AD, SPC 30% AD	4

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)	Geographic regions are based on counties and cost differences between regions. Area factors are developed using Aetna's book of business data. Area factors were recalibrated for business effective 7/1/16. Approximately 60,000 member months were affected.
Age, including age rating factors (describe definition, such as age bands)	Age rating factors vary by age and gender, and are developed using Aetna's book of business data. Age rating factors have not changed during the 12-month period covered by this rate review.
Occupation	Occupation rating factors are considered under the same umbrella as industry factors.
Industry	Industry factors vary by SIC code, and are developed using Aetna's book of business data. Industry factors have not changed during the 12-month period covered by this rate review.
Health Status Factors, including but not limited to experience and utilization	Member-level prospective risk scores used in manual rating are derived from claims history and diagnosis data. Risk score methodology has not changed during the 12-month period covered by this rate review.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	Premium tiers are as follows: Employee Only, Employee + Spouse, Employee + Children, and Employee + Family Premium tiers have not changed during the 12-month period covered by this rate review.

[7] i.e. premium tier ratios

Enrollees' share of premiums	There are no rating factors based on enrollees' share of premiums.
Enrollees' cost sharing	Benefit pricing factors based on enrollee cost sharing vary according to plan design. The majority of business is under custom plans.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Custom benefit riders are offered on a case by case basis.
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	All large group market segments use a credibility table based on number of covered lives to determine whether the group is fully experience rated or partially community rated.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	Network factor decisions are informed by contracting and cost analysis. Network factors were recalibrated for business effective 7/1/16. Approximately 60,000 member months were affected.

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)

9.0%

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]	8.7%
Hospital Outpatient (including ER)	9.6%

[8] Measured as inpatient days, not by number of inpatient admissions.

Physician/other professional services[9]	7.3%
Prescription Drug[10]	12.4%
Laboratory (other than inpatient) [11]	9.6%
Radiology (other than inpatient)	9.6%
Capitation (professional)	0.0%
Capitation (institutional)	0.0%
Capitation (other)	0.0%
Other (describe)	0.0%

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 PMPM	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	79.55	3.3%	4.3%	0.9%	8.7%
Hospital Outpatient (including ER)	91.80	4.5%	4.3%	0.5%	9.6%

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

Physician/other professional services[13]	192.92	4.1%	3.0%	0.0%	7.3%
Prescription Drug[14]	82.77	1.6%	10.6%	0.0%	12.4%
Laboratory (other than inpatient)[15]	24.77	4.5%	4.3%	0.5%	9.6%
Radiology (other than inpatient)	30.85	4.5%	4.3%	0.5%	9.6%
Capitation (professional)	0.00	0.0%	0.0%	0.0%	0.0%
Capitation (institutional)	0.00	0.0%	0.0%	0.0%	0.0%
Capitation (other)	0.00	0.0%	0.0%	0.0%	0.0%
Other (describe)	0.00	0.0%	0.0%	0.0%	0.0%
Overall	502.66	3.7%	4.8%	0.3%	9.0%

[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).

Average change in cost sharing on renewal by benefit category shown in table below.

Benefit	Average Change
Medical Deductible	$71.00
Out-of-Pocket Maximum	-$122.00
Inpatient Coinsurance	0%
Inpatient Copay	-$1.00
Primary Care Physician Coinsurance	0%
Primary Care Physician Copay	$0.00
Specialist Coinsurance	0%
Specialist Copay	$0.00
OP surgery hospital Coinsurance	0%
OP surgery hospital Copay	-$1.00
Lab Coinsurance	0%
Lab Copay	$0.00
Xray Coinsurance	0%
Xray Copay	$0.00
Complex Imaging Coinsurance	0%
Complex Imaging Copay	$0.00
Speech Therapy Coinsurance	-1%
Speech Therapy Copay	$1.00
Physical Therapy Coinsurance	0%

Physical Therapy Copay	$1.00
ER Coinsurance	0%
ER Copay	$2.00
Rx Deductible	$77.00
Rx Generic Coinsurance	0%
Rx Generic Copay	$0.00
Rx Preferred Coinsurance	0%
Rx Preferred Copay	$0.00
Rx Nonpreferred Coinsurance	-1%
Rx Nonpreferred Copay	$0.00

(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]

Aggregate change in enrollee cost sharing for all benefit categories on renewal as measured by Aetna's internal benefit pricing model is worth approximately -0.6%.

[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)***

- Transplant Coverage – added optional coverage for corneal transplants; travel and lodging clarifications
- General Cost-Sharing Modifications – to provide enhanced flexibility for plan sponsors within available plan designs
- Gender Reassignment (Sex Change) Surgery – added optional coverage for injectable hormone replacement therapy
- Autism Spectrum Coverage – as allowable under state law, add flexibility in coverage description and cost-sharing
- Recognized Charge Glossary Term – revised definition to include clarification on National Accounts plan sponsor options
- Pharmacy Revisions
  - Add 'lesser of' cost-sharing to OON tier for non-standard plans
  - Add variability to remove OON column for any plan
  - Align cost-sharing amounts between tiers
  - Split non-preferred brand/generic category to support separate cost-sharing
  - Add 'higher cost' generics category for alignment to non-preferred brand category
  - Add mandatory generic clarifications

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:

Cost Containment and Quality Improvement Efforts – Aetna

Initiatives	Cost Containment	Quality
Value Based P4P (Integrated Healthcare Association): Applicable to HMO products. Rewards IPAs for cost efficiency and quality.	Yes	Yes
Pay for Performance Program – Physician/Hospital: Rewards physician groups or hospitals for meeting performance metrics based on both efficiency and quality.	Yes	Yes
Patient Centered Medical Home Program: Rewards physician groups for effectively managing the health of a population based on measurement of both cost efficiency and quality metrics.	Yes	Yes
High Performance Network/ACO Program model: Rewards health systems for effectively managing the health of a population based on measurement of both overall medical costs and quality metrics.	Yes	Yes
Institutes of Quality/Institutes of Excellence – Organ transplant, Bone Marrow Transplant; Bariatric; Orthopedic, Cardiac: Providers are selected for participation in these networks based on volume/outcomes and cost criteria.	Yes	Yes
Oncology Cost/Quality Improvement: Shared savings model in use with oncology groups, rewards providers for following clinical guidelines/evidence based medicine.	Yes	Yes
In-Network Behavioral Health Cost/Quality: Focused on managing costs and quality associated with Autism, Substance Abuse and Inpatient Behavioral Health confinement.	Yes	Yes
Out of Network ASC and Behavioral Health Costs: Cost containment program focuses on over-billing. Involves special claims oversight, network review and litigation.	Yes	Yes
Other Cost Containment Initiatives: Aetna defines multiple additional market level and national cost reduction actions annually or more frequently as needed.	Yes	Yes

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)***

Not applicable.

16) Other Comments

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

In the CA Large Group Historical Data Spreadsheet, we are unable to split out SG and LG for 2011-2012.