California Large Group Annual Aggregate Rate Data Report Form
Version 3, September 7, 2017

(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 "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 (Plain-Language Form)
10) Projected Medical Trend (Plain-Language Form)
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:

Kaiser Permanente Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2017.[1]

3) Weighted average annual rate increase (unadjusted)[2]:
   - All large group benefit designs: 2.4 %
   - Most commonly sold large group benefit design: -0.1 %

   Weighted average annual rate increase (adjusted)[3]:
   - All large group benefit designs: 0.6 %
   - Most commonly sold large group benefit design[4]: -2.6 %

[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	83	28%	476	0	$823.14	3.6%
February	15	5%	273	0	$848.36	-4.0%
March	14	5%	110	0	$878.98	2.5%
April	14	5%	65	0	$1,224.18	3.5%
May	11	4%	256	0	$959.97	3.3%
June	22	7%	3,668	0	$369.12	0.2%
July	31	10%	176	0	$926.17	1.8%
August	10	3%	126	0	$819.82	5.1%
September	27	9%	358	0	$831.46	9.4%
October	11	4%	61	0	$1,190.94	6.9%
November	16	5%	235	0	$1,003.75	4.1%
December	47	16%	275	0	$1,030.67	5.7%
Overall	**301**	**100%**	**6,079**	**0**	**$584.85**	**2.4%**

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

Place comments below:

[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.

(*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) The most commonly sold benefit design is EPO (based on number of members).
(2) The 2017 rates for groups that are not yet quoted are estimated using KPIC's standard rating methodology.

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)	262	87%	2,123	0	$932.56	4.1%
Blended (in part)	30	10%	288	0	$794.70	3.3%
100% Experience Rated	9	3%	3,668	0	$367.12	-0.2%
Overall	301	100%	6,079	0	$584.85	2.4%

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, other) 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.

POS/EPO - Renewal rates for groups with more than 1,000 members is 100% experienced rated. For groups with less than 1,000 members - that is, groups whose utilization is not fully credible, we use a blend of experience and community rating. For groups with less than 300 members it is 100% community rating. The credibility is determined using combined Kaiser Foundation Health Plan, Inc. (KFHP) HMO members and Kaiser Permanente Insurance Company members. KFHP HMO members are not shown in this filing.

PPO/OOA - All groups are community-rated.

Distribution of Covered Lives

	Product			
Rating Method	PPO	EPO	POS	OOA
100% Community Rated (in whole)	25.2%	0.0%	9.3%	0.3%
Blended (in part)	0.0%	0.0%	4.7%	0.0%
100% Experience Rated	0.0%	58.7%	1.7%	0.0%
Overall	25.2%	58.7%	15.7%	0.3%

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	N/A	N/A
PPO	172	57%	1,534	0	$969.53	3.7%
EPO	2	1%	3,567	0	$355.77	-0.1%
POS	123	41%	957	0	$814.76	3.7%
HDHP	0	0%	0	0	N/A	N/A
Other (describe)	4	1%	21	0	$918.78	7.6%
Overall	301	100%	6,079	0	$584.85	2.4%

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.

The "Other" row includes the Out-of-Area (OOA) product, which is an employer group plan that offers health coverage for group enrollees who live and work outside Kaiser Permanente's HMO service area and Private Healthcare Systems (PHCS) network of providers.

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	0	0%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	0	0	100%	N/A

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	12	159	10%	$250/$750 DED; $15/30% OV; 10% IP; $15/$40 RX
0.8 to 0.899	40	1,060	69%	$500/$1000 DED; $25/30% OV; 10% IP; $15/$40 RX
0.7 to 0.799	11	255	17%	$1500/$3000 DED; $40/50% OV; 30% IP; $15/$40 RX
0.6 to 0.699	3	60	4%	$2700 DED; $20/50% OV; 20% IP;$15/$40 RX
0.0 to 0.599	0	0	0%	N/A
Total	66	1,534	100%	N/A

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	0	0%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	2	3,567	100%	$1500 DED; 20% OV; 20% IP
0.0 to 0.599	0	0	0%	N/A
Total	2	3,567	100%	N/A

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	37	805	84%	$500/$1000 DED; $20/20%/40% OV; 20%IP; $10/$30 RX
0.8 to 0.899	5	152	16%	$1500/$3000 DED; $35/30%/50% OV; 30% IP; $20/$40 RX
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	42	957	100%	N/A

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	0	0%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	0	0	100%	N/A

Other (describe)

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	21	100%	$300/$600 DED; $20/40% OV; 20% IP; $5/$15 RX
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	4	21	100%	N/A

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:

(1) All of the plans are custom plans.
(2) There are 301 groups with custom plans and no group with standard plans.

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)	POS/EPO - The geographic location where members reside impacts group premiums. Northern California and Southern California have completely separate rating models due to different market and cost structure. Northern California is divided into three sub-regions, each with a different geographic factor. These geographic adjustments apply only to the manual rating methodology. The factors did not change in 2017. PPO/OOA - Rates are area-adjusted and area factors are based on zip code. The factors did not change in 2017.
Age, including age rating factors (describe definition, such as age bands)	Health care costs depend on the member's age and gender due to variations in utilization and intensity pattern. Our age / gender factor slope is based on our book of business experience. The factors did not change in 2017.
Occupation	N/A
Industry	We use industry factors to reflect the health care cost differentials attributed to the industry classification. The factors did not change in 2017.
Health Status Factors, including but not limited to experience and utilization	Our base rates reflect the claims experience of the underlying population.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	For existing groups, our rating model produces rates on a per member per month (pmpm) basis. Within broad limits, the employer is free to choose the tier ratios used to convert pmpm rates to tiered rates.
Enrollees' share of premiums	Rates may be adjusted for employer contribution.

[7] i.e. premium tier ratios

Enrollees' cost sharing	We use benefit adjustment factors to reflect the cost sharing provisions of the employee benefit plan.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Employers may buy additional benefits for an additional premium.
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	POS/EPO - Generally groups averaging 1,000+ members during the experience period are 100% experience rated. Smaller groups receive a combination of experience rating and community rating. Risk rating, which was used for group with less than 1,000 members prior to 2017, has been eliminated in 2017 rating. PPO/OOA - All groups are community-rated.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	POS/EPO - Early retirees and COBRA members are expected to incur higher health care costs, and thus adjustments are included in rating. These adjustments apply only to the manual rating methodology and apply to all members of the group. The factors did not change in 2017. PPO/OOA – the adjustment for Early retirees and COBRA status does not apply.

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)

5.4%

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]	5.2%
Hospital Outpatient (including ER)	See Hospital Inpatient above
Physician/other professional services[9]	See Hospital Inpatient above
Prescription Drug[10]	7.0%
Laboratory (other than inpatient) [11]	See Hospital Inpatient above
Radiology (other than inpatient)	See Hospital Inpatient above
Capitation (professional)	See Hospital Inpatient above
Capitation (institutional)	See Hospital Inpatient above
Capitation (other)	See Hospital Inpatient above
Other (describe)	See Hospital Inpatient above (Ambulance, Home Health, SNF, DME, etc.)

10) Projected medical trend:

[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.

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

Allowed Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars (PMPM)	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	$151	0.0%	6.1%	0.0%	6.1%
Hospital Outpatient (including ER)	$99				See Hospital Inpatient above.
Physician/other professional services[13]	$91				See Hospital Inpatient above.
Prescription Drug[14]	$108	0.0%	7.0%	0.0%	7.0%
Laboratory (other than inpatient)[15]	$8				See Hospital Inpatient above.
Radiology (other than inpatient)	$10				See Hospital Inpatient above.
Capitation (professional)	$0				See Hospital Inpatient
Capitation (institutional)	$0				See Hospital Inpatient
Capitation (other)	$0				See Hospital Inpatient
Other (describe)	$58				See Hospital Inpatient above.
Overall	$526	0.0%	6.3%	0.0%	6.3%

[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, (iv) Taxes and fees, and (v) Quality Improvement Expenses. *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, including 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).

Point of Service (POS) * In-Network Tier

(1) Outpatient Prescription Drug Benefits
In accordance with CA Assembly Bill 339, per script maximums (PSM) were applied to Essential Health Benefit (EHB) drugs on outpatient prescription drug benefits for all non-grandfathered plans.

(2) Non-Physician Provider Cost Shares
To comply with a Department of Managed Health Care (DMHC) requirement, non-physician provider office visits will have copayments less than or equal to specialty care office visit copayment.

(3) Contraceptive Annual Supply
To accordance with Senate Bill 999, KP covers up to 365 days supply of FDA-approved, self-administered hormonal contraceptives, dispensed at one time when prescribed by a physician upon patient request.

(4) Add group visits to plans with "3 Before Deductible" design
GROUP visits were added to the list of primary and specialty care office visits that currently apply to the "three visit before deductible" feature which allows a member to pay a copay/coinsurance for 3 primary care visits per year even if they haven't exhausted any part or all of their deductible.

(5) Coverage for aphakic contact lenses
To comply with a CA Department of Managed Health Care (DMHC) directive, the age limit restriction on coverage for aphakic special contact lenses was removed.

(6) Deductible plan Self-Only Thresholds
In accordance with CA Assembly Bill 1305, all non-grandfathered fully insured plans with deductibles and Out-of-Pocket (OOP) maxima will include both a per-individual deductible and a per-individual out-of-pocket maximum (OOPM). A plan that consists of a family of one will have lower deductible/out-of-pocket thresholds than the individual levels in a plan with two or more family members.

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.
If a Kaiser Permanente plan was in place after the Affordable Care Act ("ACA") was signed into law on or after March 23, 2010, it's considered a "non-grandfathered" plan.

1) Mental Health or Chemical Dependency Other Outpatient Items & Services - The following changes have been made for compliance with federal mental health parity requirements (Large Group POS, PPO & OOA)
   a) The cost share for Mental Health or Chemical Dependency Outpatient Other Items & Services received at the Participating Provider level, including Behavioral Health Treatment provided in the home for Pervasive Development Disorder or Autism, will now require plan coinsurance, not to exceed the dollar amount of plan copayment. Satisfaction of the Deductible will continue to be required for plans where these benefits were previously subject to the Deductible.
   b) Precertification through the Medical Review Program is no longer required for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (individual and group visits).

2) Outpatient Prescription Drug Benefits – Participating MedImpact Pharmacy Administration. Services (Large Group POS, PPO & OOA)
   a) Prior authorization, a utilization management program, will now be required for certain medications to assure safe and appropriate use. When the licensed prescribing provider prescribes a medication that has been identified as subject to prior authorization, the medication needs to be reviewed by KP to determine medical necessity before the prescription is filled.
   b) Step Therapy, a utilization management program, will now be required for certain high-cost medications to assure the medication is safe, appropriate and cost-effective. The step therapy program is a process whereby you may need to first try a proven, cost-effective medication (1st line medication) before using a more costly treatment (2nd line medication), if needed.

3) Outpatient Prescription Drug Benefits – Specialty Cost Share at Participating MedImpact Pharmacies Services. In accordance with the provisions of California Assembly Bill 339, the cost share and prescription maximum for Specialty Prescription Drugs has been changed as follows (Large Group POS):
   a) There will no longer be separate preferred specialty drug and non-preferred specialty drug tiers with a per script maximum of $300. All specialty drug benefits received at a Participating Pharmacy will now require a 30% coinsurance, up to a maximum of $250 for a supply of up to 30 days.

Grandfathered (GF) Plans

If a Kaiser Permanente plan was in place before ACA was signed into law on March 23, 2010, it's considered a "grandfathered" plan. Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2017.

(1) Mental Health or Chemical Dependency Other Outpatient Items & Services - The following changes have been made for compliance with federal mental health parity requirements (Large Group POS, PPO and OOA)
   a) The cost share for Mental Health or Chemical Dependency Outpatient Other Items & Services received at the Participating Provider level, including Behavioral Health Treatment provided in the home for Pervasive Development Disorder or Autism, will now require plan coinsurance, not to exceed the dollar amount of plan copayment. Satisfaction of the Deductible will continue to be required for plans where these benefits were previously subject to the Deductible.
   b) Precertification through the Medical Review Program is no longer required for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (individual and group visits).

(2) Outpatient Prescription Drug Benefits – Participating MedImpact Pharmacy Administration. Services (Large Group POS, PPO)
   a) Prior authorization, a utilization management program, will now be required for certain medications to assure safe and appropriate use. When the licensed prescribing provider prescribes a medication that has been identified as subject to prior authorization, the medication needs to be reviewed by KP to determine medical necessity before the prescription is filled.
   b) Step Therapy, a utilization management program, will now be required for certain high-cost medications to assure the medication is safe, appropriate and cost-effective. The step therapy program is a process whereby you may need to first try a proven, cost-effective medication (1st line medication) before using a more costly treatment (2nd line medication), if needed.

** The In-Network portion of the Point-of-Service (POS) Plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PPO and Indemnity tiers of the POS Plan. KPIC is a subsidiary of KFHP*

(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]

The weighted average actuarial value decreased by 0.1% from 76.9% in 2016 to 76.8% in 2017.

13) Changes in enrollee/insured benefits

[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.

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. 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)***

Point of Service (POS) * In-Network Tier

(1) Outpatient Prescription Drug Benefits
In accordance with CA Assembly Bill 339, per script maximums (PSM) were applied to Essential Health Benefit (EHB) drugs on outpatient prescription drug benefits for all non-grandfathered plans.

- This change has little to no impact on aggregate claims cost.

(2) Non-Physician Provider Cost Shares
To comply with a Department of Managed Health Care (DMHC) requirement, non-physician provider office visits will have copayments less than or equal to a specialty care office visit copayments

- This change has little to no impact on aggregate claims cost.

(3) Contraceptive Annual Supply
To accordance with Senate Bill 999, KP covers up to 365 days supply of FDA-approved, self-administered hormonal contraceptives, dispensed at one time when prescribed by a physician upon patient request.

- The cost impact is less than 0.5%.

(4) Add group visits to plans with "3 Before Deductible" design
GROUP visits were added to the list of primary and specialty care office visits that currently apply to the "three visit before deductible" feature which allows a member to pay a copay/coinsurance for 3 primary care visits per year even if they haven't exhausted any part or all of their deductible.

- This change has little to no impact on aggregate claims cost.

(5) Coverage for aphakic contact lenses
To comply with a CA Department of Managed Health Care (DMHC) directive, the age limit restriction on coverage for aphakic special contact lenses was removed.

- This change has little to no impact on aggregate claims cost.

(6) Deductible plan Self-Only Thresholds
In accordance with CA Assembly Bill 1305, all non-grandfathered fully insured plans with deductibles and Out-of-Pocket (OOP) maxima will include both a per-individual deductible and a per-individual out-of-pocket maximum (OOPM). A plan that consists of a family of one will have lower deductible/out-of-pocket thresholds than the individual levels in a plan with two or more family members.

- The cost impact varies by plan. In general, the claims cost increase is from 1 – 3%

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.
If a Kaiser Permanente plan was in place after the Affordable Care Act ("ACA") was signed into law on or after March 23, 2010, it's considered a "non-grandfathered" plan.

1) Mental Health or Chemical Dependency Other Outpatient Items & Services - The following changes have been made for compliance with federal mental health parity requirements (Large Group POS, PPO & OOA)
   a) The cost share for Mental Health or Chemical Dependency Outpatient Other Items & Services received at the Participating Provider level, including Behavioral Health Treatment provided in the home for Pervasive Development Disorder or Autism, will now require plan coinsurance, not to exceed the dollar amount of plan copayment. Satisfaction of the Deductible will continue to be required for plans where these benefits were previously subject to the Deductible.
   b) Precertification through the Medical Review Program is no longer required for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (individual and group visits).

- This change has little to no impact on aggregate claims cost

2) Outpatient Prescription Drug Benefits – Participating MedImpact Pharmacy Administration. Services (Large Group POS, PPO & OOA)
   a) Prior authorization, a utilization management program, will now be required for certain medications to assure safe and appropriate use. When the licensed prescribing provider prescribes a medication that has been identified as subject to prior authorization, the medication needs to be reviewed by KP to determine medical necessity before the prescription is filled.
   b) Step Therapy, a utilization management program, will now be required for certain high-cost medications to assure the medication is safe, appropriate and cost-effective. The step therapy program is a process whereby you may need to first try a proven, cost-effective medication (1st line medication) before using a more costly treatment (2nd line medication), if needed.

- This change has little to no impact on aggregate claims cost

3) Outpatient Prescription Drug Benefits – Specialty Cost Share at Participating MedImpact Pharmacies Services. In accordance with the provisions of California Assembly Bill 339, the cost share and prescription maximum for Specialty Prescription Drugs has been changed as follows: (Large Group POS)
   a) There will no longer be separate preferred specialty drug and non-preferred specialty drug tiers with a per script maximum of $300. All specialty drug benefits received at a Participating Pharmacy will now require a 30% coinsurance, up to a maximum of $250 for a supply of up to 30 days.

- This change has little to no impact on aggregate claims cost

Grandfathered (GF) Plans

If a Kaiser Permanente plan was in place before ACA was signed into law on March 23, 2010, it's considered a "grandfathered" plan. Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2017.

(1) Mental Health or Chemical Dependency Other Outpatient Items & Services - The following changes have been made for compliance with federal mental health parity requirements (Large Group POS, PPO and OOA)

a) The cost share for Mental Health or Chemical Dependency Outpatient Other Items & Services received at the Participating Provider level, including Behavioral Health Treatment provided in the home for Pervasive Development Disorder or Autism, will now require plan coinsurance, not to exceed the dollar amount of plan copayment. Satisfaction of the Deductible will continue to be required for plans where these benefits were previously subject to the Deductible.
b) Precertification through the Medical Review Program is no longer required for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (individual and group visits).

- This change has little to no impact on aggregate claims cost

(2) Outpatient Prescription Drug Benefits – Participating MedImpact Pharmacy Administration. Services (Large Group POS, PPO)

a) Prior authorization, a utilization management program, will now be required for certain medications to assure safe and appropriate use. When the licensed prescribing provider prescribes a medication that has been identified as subject to prior authorization, the medication needs to be reviewed by KP to determine medical necessity before the prescription is filled.
b) Step Therapy, a utilization management program, will now be required for certain high-cost medications to assure the medication is safe, appropriate and cost-effective. The step therapy program is a process whereby you may need to first try a proven, cost-effective medication (1st line medication) before using a more costly treatment (2nd line medication), if needed.

- This change has little to no impact on aggregate claims cost

** The In-Network portion of the Point-of-Service (POS) Plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PPO and Indemnity tiers of the POS Plan. KPIC is a subsidiary of KFHP.*

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. 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:

POS In-Network Tier and EPO

1.01 Coordination and Cooperation

Kaiser Permanente is structured differently than most health plans. The most important differentiator is our integrated system. Having an integrated system means that our insurance function, our network of health facilities, and our health care providers are all effectively part of one organization. Most decisions on the day- to-day management are made at the regional and local level by three separate but cooperating entities, the Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Hospitals (KFH) and the Northern and Southern Permanente Medical Groups (Permanente providers). KFHP contracts with individuals and group customers to arrange to provide comprehensive health care services under the range of KFHP benefit plans. KFHP also contracts exclusively with KFH and the Permanente providers to provide the hospital and professional medical services under these benefit plans to meet the health care needs of KFHP members.

Our integrated system brings together physicians, nurses and other health care providers to provide covered health care services to KFHP members. The integrated system supports high quality by centering on the patient. These services are provided by physician-led delivery systems, supported by cutting edge technology and an extensive care management infrastructure in order to provide superior care in the most appropriate setting for a lower overall cost, and at a better value for KFHP members.

1.02 Ensuring Networks are Based on Value

Performance Program

Kaiser Permanente participates in the Integrated Healthcare Association's (IHA) Pay for Performance (P4P) Program, which is designed to encourage evidence-based, high-quality, and cost-effective performance. The program grants “Excellence in Healthcare” awards for high performance across health care quality, patient experience, and cost measures.

IHA determines the top physician groups that have demonstrated best overall performance on select health care quality and cost effectiveness measures, including preventive care and chronic care management, patient satisfaction, and the total cost of care provided to members.

Physician groups whose overall clinical quality, patient experience, and total cost of care scores exceed the median scores for each of these domains are awarded “Excellence in Healthcare” awards.

Thirteen of the 22 California Medical Groups that met the total cost of care threshold and received a 2015 “Excellence in Healthcare” award were Permanente Medical Groups (South San Francisco, Antelope Valley, Baldwin Park, Downey, Fontana and Ontario, Kern County, Orange County, Panorama City, Riverside, San Diego, South Bay, West Los Angeles, and Woodland Hills). In addition, all Permanente Medical Groups exceed the quality and patient experience thresholds. In Northern California, the Modesto/Manteca/Stockton service area received a “Most Improved” award in 2015 as well.

Physician groups whose overall clinical quality, patient experience, and total cost of care scores exceed the median scores for each of these domains are awarded “Excellence in Healthcare” awards. Our South San Francisco medical group met the total cost of care threshold and received a 2015 “Excellence in Healthcare” award. In addition, all of the 15 Permanente Medical Groups exceed the

quality and patient experience thresholds. In Northern California, the Modesto/Manteca/Stockton service area received a “Most Improved” award in 2015 as well.

While we submit data to the IHA for the P4P Program, Kaiser Permanente does not participate in the financial incentive part of the program because our physicians are paid by salary. Participation in the IHA program allows us a venue to publicly report our data and be benchmarked against other physician groups. IHA partners with the California State Office of the Patient Advocate (OPA) to produce an annual public report card of P4P results, and select measures are publicly reported by the organization. The report card is available on OPA's website at opa.ca.gov/Pages/ReportCard.

Kaiser Permanente also has a pay-for-performance program that is different from other health plans. Our doctors are rewarded for prevention, quality care, and member satisfaction. Unlike fee-for-service health plans and claims-based organizations, our physicians are not incentivized to provide more care at higher costs for more compensation. Instead, we incentivize for providing the right care at the right time. We use a comprehensive system of performance incentives to reward our medical centers and physicians for delivering care that helps keep our members healthy and productive.

Member Satisfaction

Measuring how well Kaiser Permanente meets or exceeds members' expectations is a critical activity for quality assessment and improvement. Member satisfaction is measured through a variety of sources. Data gathered from these sources is translated into specific information, which is used to provide relevant member feedback for services delivered at every level in the organization.

To measure member satisfaction, we use a number of tools including the following:

-Consumer Assessment of Healthcare Providers and Systems care experience surveys

-Complaint and appeal data

-Member experience tracking evaluation and opinion research

-Family experience with Hospice bereavement services survey

To assess member satisfaction, ongoing comprehensive data analyses are conducted periodically at service-area levels and regional levels. Analyses are presented and updated at quarterly board meetings and executive on-site visits as well.

Kaiser Permanente engages in a variety of performance improvement interventions and strategies aimed at promoting the availability and accessibility of health care services and increasing the satisfaction of its members. Strategic service priorities are set based on identified areas of opportunity to address members' service needs. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member satisfaction.

1.03 Demonstrating Action on High Cost Providers

Kaiser Permanente is an integrated care delivery system that owns and operates our hospitals and provides comprehensive care through the Permanente Medical Groups. One hundred percent of our members receive care within our integrated model. We compensate providers via salary, thereby eliminating misaligned incentives. Providers are not paid per procedure, but rather through an exclusive partnership with the Kaiser Foundation Health Plan. This model incentivizes efficient care that keeps patients healthy — we leverage technology wherever possible to connect members to their providers in the manner best suited to their condition and circumstance.

Kaiser Permanente has pioneered many of the cost-saving strategies the rest of the industry is just now scrambling to create. For more than 70 years, we've been an innovator, providing affordable, high-quality care to our members and communities. Through our integrated model, caregivers from doctors to nurses to pharmacists work together to provide the right care at the right time — improving outcomes while keeping costs low. They're connected through our industry-leading electronic health record system and able to share accurate medical information about members in real time; this allows us to continuously check to make sure members are up-to-date with preventive care, reducing avoidable illnesses and unnecessary sick days. Our innovative online employee engagement tools give members the power to actively manage their health.

Our cost reductions focus on areas including:

Enhancing care quality and efficiency: We continue to develop and share best practices across the organization, and leverage our collaborative model to ensure better outcomes and cost efficiencies. With our coordinated, team-based approach, we have the unique ability to analyze and improve how care is delivered across the entire treatment continuum — leading to better outcomes, appropriate levels of utilization, and management of long-term expenses. Some ways we're working to ensure consistent, reliable, and safe care for our members include reducing unnecessary variations in care through predictive modeling and new protocols; continuing to lead the industry in prevention and disease management; leveraging our electronic health record system to prevent errors and duplication; and maximizing pharmacy savings through generics, formularies, and purchasing. For members who require specialized care, we offer both internal specialty centers and external Centers of Excellence (COEs). Our specialty centers perform specialized procedures not performed regionally, while our external COEs perform transplants and other specialized procedures not performed within our facilities. These COEs are located at premier medical centers, known nationally for their particular expertise.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Kaiser Permanente regards evidence-based medicine and value assessments as essential tools in managing our formulary. The formulary process uses a systematic approach in the review of drugs on the formulary. Along with a critical review of the literature, drug review takes into consideration: American Society of Clinical Oncology Value of Cancer Treatment Options, The Institute for Clinical and Economic Review Value Assessment Framework, and United Kingdom's National Institute for Health and Care Excellence when making formulary recommendations. These sources are integrated into our monograph template to ensure they are consistently reviewed and the information is captured appropriately to share with key stakeholders. Information from National Comprehensive Cancer Network (NCCN) Resource Stratification Framework and NCCN Evidence Blocks are considered.

Value assessment is one part of our formulary process and is weighed along with efficacy and safety of the drug.

Kaiser Permanente has a proactive evidence-based formulary review process that takes into account the efficacy and safety of the drug, how it compares to others in its class, and total cost of care to address cost and quality objectives. We collaborate with key stakeholders to develop strategic initiatives to manage cost and ensure quality of care. Kaiser Permanente takes advantage of the availability of generic drugs and maximizes the use of these products when feasible. We have a dedicated team that monitors drug prices and market dynamics whose information is integrated into the formulary management. Various benefit designs are used as solutions to assist in driving down total cost of care. Additionally, specific disease- focused strategies are performed to target high-cost chronic conditions to improve health outcomes and control costs (i.e., Hepatitis C, multiple sclerosis).

Within Kaiser Permanente, individual physicians determine whether a given therapy will be used. Physicians prescribe based on various factors: Clinical evaluation, available alternatives, available evidence, expert consensus, disease management plans, and their own experience.

We employ a variety of tactics to increase efficiencies, reduce costs, and eliminate waste in purchasing and distribution, including establishing quantity limits on select drugs to avoid waste if the drug is discontinued for any reason.

Our industry-leading integrated care model allows us to better serve our members because all their prescription data is captured in one electronic database. Our physicians, pharmacists, care managers, and nurses have instant access to this information and can easily view all written and dispensed prescriptions — offering safety, consistency, privacy, and cost-effectiveness to our members.

1.05 Quality Improvement Strategy

The agreements between Kaiser Foundation Health Plan and both the Permanente Medical Groups and Kaiser Foundation Hospitals are perpetually renewed and have been in place in the Northern and Southern California Regions since we were established more than 70 years ago.

Maintaining a high standard of clinical quality is a cornerstone of the care that we provide to our members. All Permanente Medical Group providers are expected to contribute to a culture of continuously improving care by taking responsibility for a variety of quality metrics — physician leaders hold their peers accountable.

Kaiser Foundation Health Plan works with the Permanente Medical Groups to identify goals each year. Measures are determined by the significance of the impact on members' health and community health, ability to improve overall performance, and ability to reduce undesirable variation. Performance monitoring includes a comparison of results from prior periods for the region overall and by medical centers.

Clinical areas include inpatient quality measures such as sepsis and stroke care; outpatient quality measures such as cancer screening, osteoporosis management, cardiovascular health, medications for asthma, depression management, pediatric immunizations, and chemical dependency; and patient safety measures such as surgical safety, hospital-acquired infections, hospital-acquired pneumonia, and intensive care unit mortality.

HEDIS® (Healthcare Effectiveness and Data and Information Set) is a group of standardized performance measures designed to ensure that the Centers for Medicare & Medicaid Services and the public have the information needed to accurately compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS measures are an integral part of health plan accreditation by the National Committee for Quality Assurance.

In addition, we monitor whole-system measures in six related domains of quality, which are used to better understand and improve the overall performance of our entire health system:

-Clinical effectiveness
-Patient safety
-Risk management
-Service
-Resource stewardship
-Equitable care

Kaiser Permanente closely tracks and monitors performance on quality and service measures and targets those measures that have not performed well for performance improvement activities. Much of our success has to do with our highly integrated, organized, and coordinated approach around how we provide care. Our philosophy, structure, and incentives make it possible for our physicians, nurses, and staff to work collaboratively to provide comprehensive care, achieve superior clinical outcomes, and help our members maximize their total health.

1.06 Participation in Collaborative Quality Initiatives

The following table (extracted from Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract) includes a list of the Plan's participation in collaborative quality initiatives.

	Describe the nature of engagement	Engaged in this market	Other markets in which engaged
Leapfrog Hospital Rewards Program	Not engaged	Not Engaged	Not applicable
California Hospital Assessment and Reporting Taskforce (CHART)	Kaiser Permanente submits data to the Collaborative.	Engaged	Not applicable
California Health Performance Information System (CHPI)	Engaged	Engaged	Not applicable
Integrated Healthcare Association (IHA) Pay for Performance Program	Engaged	Engaged	Not applicable
California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC)	We report on a number of measures to decrease maternal morbidity and mortality related to obstetric hemorrhage and preeclampsia. Kaiser Permanente is also a CMQCC partner organization; we have physicians on the CMQCC Executive Committee, which determines policy and direction for the collaborative.	Engaged	Not applicable
Appropriate use of C-sections: multi-stakeholder collaborative sponsored by the California Health and Human Services Agency (CHHS) and other statewide agencies and organizations	Kaiser Permanente representatives serve as advisory members and provide feedback on initiatives and projects.	Engaged	Not applicable
California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)	Not engaged	Not Engaged	Not applicable
California Immunization Registry sponsored by the California Department of Public Health	Engaged	Engaged	Not applicable
NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)	Engaged	Engaged	Not applicable
Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Engaged	Engaged	Not applicable
National Neurosurgery Quality and Outcomes Database (N2QOD) of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Not engaged	Not Engaged	Not applicable
IHA Payment Bundling demonstration	Not engaged	Not Engaged	Not applicable
Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)	Not engaged	Not Engaged	Not applicable

	Describe the nature of engagement	Engaged in this market	Other markets in which engaged
CMMI Comprehensive Primary Care initiative (CPC)	Not engaged	Not Engaged	Not applicable
CMMI Transforming Clinical Practice Initiative	Not engaged	Not Engaged	Not applicable
CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)	Not engaged	Not Engaged	Not applicable
CMMI Partnership for Patients Hospital Safety Initiative	Kaiser Permanente representatives provide feedback on initiatives and projects.	Engaged	Not applicable
Health plan-sponsored accountable care programs	Not engaged	Not Engaged	Not applicable
California Perinatal Quality Care Collaborative	Kaiser Permanente physicians are members of the CPQCC Executive Committee, which meets regularly to debate, review, prioritize, and plan the direction of the Collaborative. CPQCC includes 136 member hospitals, 20 of which are Kaiser Permanente hospitals. Our hospitals submit data to the CPQCC Data Center.	Engaged	Not applicable
California Quality Collaborative	Not engaged	Not Engaged	Not applicable
Statewide Workgroup on Overuse (opioids, imaging for low back pain, C-sections) sponsored by DHCS, CalPERS, and Covered California	Engaged	Engaged	Not applicable
Other (described in detail box)	Not engaged	Not Engaged	Not applicable

1.07 Data Exchange with Providers

Our paperless electronic health record (EHR) system, Kaiser Permanente HealthConnect®, is the largest private-sector EHR in the world. It enables us to improve care, reduce errors, and eliminate paper waste. Inefficient paper records add to the expense of health care with substantial costs for record storage and administrative support staff; larger medical facilities can see up to $1 million in transcription costs in a year.

While only 34 percent of office-based physicians use EHR, 100 percent of our physicians, nurses, and medical support staff use KP HealthConnect at every point of service in every medical facility, enabling richer analysis of data, remote health monitoring, and long-distance virtual consultations.

The HIMSS Analytics™ Stage 7 Award honors hospitals that operate in a paperless environment and represent best practices in the implementation of electronic medical record (EMR) systems. Nearly one in five U.S. hospitals certified by HIMSS as Stage 7 for EMR adoption — the most advanced level possible — is a Kaiser Permanente medical center. Thirty-seven Kaiser Permanente hospitals are certified as Stage 7 by HIMSS, the world's premier health information technology organization. In California, only 45 hospitals have been certified as Stage 7 and 35 of them are Kaiser Permanente facilities.

Benefits of our EHR system, KP HealthConnect, include:

- Decision support within the EHR that makes care gaps visible at the point of care using the patient's most up-to-date clinical information

- Offering clinical guidelines and powerful decision-support capabilities that enable us to implement the latest advances in evidence-based medicine rapidly

- Providing our researchers with a rich database that offers an unprecedented ability to study the health of chronic disease populations and provide evidence-based care much faster than independent medical providers

- Providing members greater online access to their own health information and self-management tools, such as HealthMedia®, which teaches members to manage chronic conditions such as allergies, asthma, back pain, chronic obstructive pulmonary disease, diabetes, high blood pressure, high cholesterol, or HIV/AIDS to improve their health

- Primary care physicians and specialists have access to the same information using the integrated EHR

1.08 Data Aggregation across Health Plans

As we are not a fee-for-service health care organization, we process a relatively small number of claims. Our members only file claims when they receive care out-of-network in an emergency situation, or for a non-Plan specialist referral. Otherwise, the claims process is invisible to providers and members — billing is not part of the patient experience.

Our electronic health record system, securely brings together all aspects of a member's care experience — medical information, test results, prescription information, visit summaries, allergies, immunizations, hospital registration, and best-practices updates — all of which are instantly available to a member's entire health care team. A crucial tool that enables collaboration among providers, KP HealthConnect enhances medical safety by alerting physicians and pharmacists of potential drug

interactions while also providing overall cost savings by eliminating unnecessary or duplicate tests, among other benefits.

Our use of evidence-based medicine means clinicians can integrate their professional expertise with established external best practices and research. Through the clinical content available on KP HealthConnect, our clinicians have access to evidence-based knowledge at the point of care.

For POS, PPO and OOA Contracted Network Tier and Out-of-Network Tier:

This response applies to Kaiser Permanente Insurance Company's (KPIC's) PPO and OOA products and tiers 2 and 3 of the POS product. In 2017 KPIC transitioned full administration of its outpatient prescription drug benefit to its Pharmacy Benefit Manager (PBM), including maintenance of its open formulary, utilization of the PBM's Pharmacy & Therapeutics and Formulary Committee (P&T Committee), and adoption of its cost containment processes. KPIC formularies, pharmacy utilization management edits and supporting medication treatment guidelines are reviewed and approved by PBM's PT&T Committee and are based upon a thorough review of the medical literature reflecting published treatment guidelines recommended by national medical organizations. The P&T Committee reviews key therapeutic drug categories on a continuous basis to ensure they reflect the most up to date medication treatment recommendations.

Drugs presented to the P&T Committee for consideration are reviewed on the following evidence-based criteria:

1. Safety, including concurrent drug utilization review (cDUR) when applicable,
2. Efficacy: the potential outcome of treatment under optimal circumstances,
3. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary,
4. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available,
5. Relevant benefits of current formulary agents of similar use,
6. Condition of potential duplication of similar drugs currently on formulary,
7. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

KPIC's PBM monitors the ability of the utilization management programs applied at point of sale to ensure that KPIC delivers a highly efficient cost effective pharmacy benefit program to our membership.

Drugs requiring prior authorization:
Prior authorization is generally applied to drugs that have multiple indications, qualify as Specialty medications per our protocol (cost >$600/month, requires complex monitoring

and/or administration, complex clinical condition/disease state), are high in cost, have a high abuse potential (topical testosterone) or have a significant safety concern.

Drugs requiring step therapy:
Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Under step therapy, KPIC insureds may first need to try a proven, cost-effective medication before using a more costly treatment.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the insured's drug history, prior to the use of another drug (2nd line agent). If the licensed prescribing provider determines that a first-line drug is not appropriate or effective, a second-line drug, may be covered after meeting certain conditions.

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)***

N/A

16) Other Comments

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

None