California Large Group Annual Aggregate Rate Data Report Form

Version 5, August 7, 2018

(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) Covered Prescription Drugs
    - *submit SB 17 - Large Group Prescription Drug Cost Reporting Form (Excel)*
17) Prescription Drug Costs
    - *submit SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans (Excel)*
18) Other Comments

1) Company Name:

Anthem Blue Cross Life and Health Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year _2018_.[1]

3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs __6.1__%
   - Most commonly sold large group benefit design __5.6__%

   Weighted average annual rate increase (adjusted)[3]

[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.

- All large group benefit designs __8.1__%
- Most commonly sold large group benefit design[4] __8.1__%

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

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

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	152	39.0%	41,737	3,991	$537.30	7.8%
February	11	2.8%	208	32	$637.26	9.0%
March	22	5.6%	5,818	0	$572.37	7.7%
April	18	4.6%	809	0	$662.77	12.5%
May	18	4.6%	1,145	0	$602.86	8.2%
June	21	5.4%	1,161	59	$430.74	2.3%
July	34	8.7%	35,480	311	$587.02	2.9%
August	9	2.3%	1,221	0	$472.04	2.6%
September	18	4.6%	1,039	0	$562.54	8.8%
October	20	5.1%	970	0	$562.80	14.7%
November	16	4.1%	664	0	$563.66	9.1%
December	51	13.1%	3,300	0	$469.42	11.1%
Overall	***390***	***100.0%***	***93,552***	***4,393***	***$555.87***	***6.1%***

[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.

[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) The most commonly sold product is PPO.
(2) The projected rate change for groups where the renewal process has not started is assumed to be the year-to-date average rate change.

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 rating method 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)	322	77.6%	14,575	312	$556.73	6.9%
Blended (in part)	13	3.1%	1,479	0	$589.15	10.5%
100% Experience Rated	80	19.3%	77,498	4,081	$555.11	5.9%
Overall	***415***	***100.0%***	***93,552***	***4,393***	***$555.87***	***6.1%***

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.

All three rating methodologies are available for all products.

Distribution of covered lives:

- 100% Community Rated

HMO	NA
PPO	96.4%
EPO	0.5%
POS	NA
HDHP	3.1%

- Blended

HMO	NA
PPO	100.0%
EPO	NA
POS	NA
HDHP	NA

- 100% Experience Rated

HMO	NA
PPO	71.9%
EPO	3.1%
POS	NA
HDHP	25.0%

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 product type 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	N/A	N/A	N/A	N/A	N/A	N/A
PPO	384	92.3%	73,449	1,013	$564.71	5.6%
EPO	6	1.4%	2,634	0	$495.24	7.9%
POS	N/A	N/A	N/A	N/A	N/A	N/A
HDHP	26	6.3%	17,469	3,380	$531.97	7.5%
Other (describe)	N/A	N/A	N/A	N/A	N/A	N/A
Overall	***416***	***100.0%***	***93,552***	***4,393***	***$555.87***	***6.1%***

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.

N/A

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	87	28,516	38%	Most popular cost sharing: Deductible=$250, OOPM=$1,500
0.8 to 0.899	161	45,580	61%	Most popular cost sharing: Deductible=$500, OOPM=$2,500

0.7 to 0.799	8	366	<1%	Most popular cost sharing: Deductible=$5,500, OOPM=$7,350
0.6 to 0.699				
0.0 to 0.599				
Total	256	74,462	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	6	2,634	100%	Most popular cost sharing: Deductible=$0, OOPM=$2,000
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total	6	2,634	100%	

POS

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

HDHP

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899	12	3,749	18%	Most popular cost sharing: Deductible=$1,500, OOPM=$3,000
0.7 to 0.799	17	17,100	82%	Most popular cost sharing: Deductible=$2,700, OOPM=$3,425

0.6 to 0.699				
0.0 to 0.599				
Total	29	20,849	100%	

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				
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:

- 80 standard plans (including grand-fathered plans) offered
  - PPO, EPO and HDHP are offered.
  - All products provide major medical/pharmacy coverage
    - PPO - provides 2 tier benefits; namely, in-network/out-of-network benefits, with variety of deductible/coinsurance combination
    - EPO - provides coverage only for in-network providers.
    - HDHP - provides 2 tier benefits; namely, in-network/out-of-network benefits, with a high deductible and Health Savings Account, Health Reimbursement Account, or Health Incentive Account.
- 293 groups with standard plans; 100 groups with custom plans
  - 3 groups are included in group count for standard plans as well as custom plans as those groups offer both standard plans and custom plans to their employees.

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)	• The objective is to set one of the rating variables so that manual claims cost equals to actual experience for each product, plan design, and market combination. Therefore, area factors which account for geographic and network differences are adjusted according to our manual rate study • Eight geographic regions in CA: Bay Area / Central Valley / Sacramento / Los Angeles / Orange / Riverside / San Diego / Santa Barbara. • Overall factor was decreased. • This impacts 39,537 members months
Age, including age rating factors (describe definition, such as age bands)	• No change • Factors assigned to each subscriber according to the subscriber's quinquennial attained age rating band and gender. • The age rating band is 0-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+ and gender factor is male/female. • These factors reflect claims cost due to age/gender make-up of insureds for contracts under each age/gender rating band, not accounted for by family composition factors.
Occupation	N/A
Industry	• No change • Factors assigned to each employer group per industry classification based on the Standard Industrial Classification (SIC) Code. • These factors recognize that some industries tend to experience higher claim levels due to greater risk of accident or due to riskier lifestyles of typical industry employees.
Health Status Factors, including but not limited to experience and utilization	N/A

Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	• No change • Factors assigned to each family tier reflecting expected age/gender distribution by family composition tier. • Each employer group can choose from two tiers, three tiers, four tiers and five tiers for family composition tiers.
Enrollees' share of premiums	N/A
Enrollees' cost sharing, including cost sharing for prescription drugs	N/A
Covered benefits in addition to basic health care services and any other benefits mandated under this article	N/A
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	N/A
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	N/A

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)

9.4%

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,

[7] i.e. premium tier ratios

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]	9.0%
Hospital Outpatient (including ER)	9.0%
Physician/other professional services[9]	9.0%
Prescription Drug[10]	11.4%
Laboratory (other than inpatient) [11]	9.0%
Radiology (other than inpatient)	9.0%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	N/A

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

Allowed Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate	Use of Services	Price Inflation	Fees and Risk	Overall 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.

	Dollars (PMPM)				
Hospital Inpatient[12]	$142.37	2.6%	2.8%	N/A	5.5%
Hospital Outpatient (including ER)	$138.43	2.6%	2.8%	N/A	5.5%
Physician/other professional services[13]	$184.69	2.6%	2.8%	N/A	5.5%
Prescription Drug[14]	$110.63	5.1%	7.4%	N/A	12.8%
Laboratory (other than inpatient)[15]	$20.45	2.6%	2.8%	N/A	5.5%
Radiology (other than inpatient)	$28.69	2.6%	2.8%	N/A	5.5%
Capitation (professional)	N/A	N/A	N/A	N/A	N/A
Capitation (institutional)	N/A	N/A	N/A	N/A	N/A
Capitation (other)	N/A	N/A	N/A	N/A	N/A
Other (describe)	N/A	N/A	N/A	N/A	N/A
Overall	$625.26	3.1%	3.5%	N/A	6.8%

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
(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] 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.

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).

Standard Plans
- No Change

Custom Plans
- With exception of state mandates, cost-sharing changes are initiated by clients and the resulting changes vary widely by clients.

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

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

Aggregate AV has increased by 3.1% over 2017 renewal.

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. 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)

N/A

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

1.01: Coordination and Cooperation

1. Transition of Care Complex Discharge Coordinator Enhancement (UCLA, Stanford, Lucille Packard)

- Anthem nurses evaluate our members' discharge needs. Utilization Management nurses that review inpatient stays for medical necessity also collaborate with the facility Case Managers/Discharge Planners to arrange for non-complicated discharge needs, e.g. standard Durable Medical Equipment or Home Health visits with an Anthem contracted provider. Several years ago, Anthem identified the need for a specialized nurse to address discharge planning for members with more complicated medical conditions, special needs or social situations. Thus, Anthem developed the unique nurse role of a Complex Discharge Coordinator (CDC). The CDCs work very closely with facility Utilization Review and Social Work departments to coordinate safe, timely discharges by ensuring all barriers to discharge have been addressed well in advance of the actual discharge. They collaborate with the reviewing Anthem nurse to assist with moving the member along the continuum of care, to the most appropriate / cost effective level of care. Through arranging for an Anthem contracted Acute Rehabilitation facility, Skilled Nursing Facility or Long Term Acute Care Hospital or home care with outpatient services, the CDC makes sure that the member experiences a safe, well planned discharge. CDCs support several facilities for their assigned Care Teams.
- As a result of a CDC related initiative in California Utilization Management, the CDC role was enhanced to provide additional nurses

that would focus on a single high volume facility with higher acuity patients. A total of five facilities were targeted for a Dedicated CDC - Cedars-Sinai, UCLA, Stanford, Lucile Packard and Doctors Medical Center - Modesto. Our goals for the single-focused CDC were enhanced discharge planning, reduction in length of stay and reduction of readmission rates, resulting in lowering inpatient costs for both Anthem and our members. Through manual tracking logs, we were able to document CDC interventions that demonstrated how acute bed days were saved and what barriers were identified. We also experienced enhanced collaboration with facility discharge planners and social workers, who began to reach out to our dedicated CDC directly and they expressed great satisfaction with Anthem's responsiveness. Members also conveyed gratitude for Anthem's role in providing effective discharge arrangements, including follow-up. In addition, our CDCs engaged Anthem Case Managers while members were in the facility to support member transition to home or the next level of care.

2. Remote Facility Electronic Medical Record (EMR Access)

- Upon admission to a facility and throughout the inpatient stay, Anthem Utilization Management (UM) nurses review the medical necessity for each inpatient day. Anthem requests clinical information from the facility in order to determine whether or not the member meets medical necessity criteria per MCG™ guidelines. In order to meet California's strict regulatory and accreditation case decision turnaround times, timely information must be provided by the facility via fax, phone or the Interactive Care Reviewer (ICR) portal. If the clinical information is not received within established timeframes, cases are sent for physician review and denied for Lack of Clinical Information. This results in delays for discharge planning and increased administrative costs for both the facility and Anthem due to multiple case touch points.
- To mitigate these issues with obtaining clinical information Anthem has established real-time, remote access to 53 high volume California facilities. Of our total inpatient admission volume, 37% of our hospital admissions are reviewed via Electronic Medical Records (EMR) access through facility-provided web portals. EMR access allows Anthem nurses to review current inpatient records for clinical status, history, medications, consultations, discharge planning and lab/x-ray results - a comprehensive view of each admission. This decreases multiple case touch points, reduces the need for the facility to provide clinical information to Anthem, decreases lack of information denials, decreases facility accounts receivables, provides more timely UM decisions and decreases post-service review with provision of hard copy medical records. Anthem benefits by meeting regulatory and accreditation timeframes, thus avoiding regulatory penalties related to turnaround time. Medical costs are lowered because we are performing earlier discharge planning and identifying opportunities to transition members to a lower level of care or transition home. EMR access has been identified as a best practice among other Anthem

markets and divisions. Additional facilities are planned for future implementation in 2018 and beyond.

3. NICU Progression of Care Guidelines
    - Implemented in January, 2017, new Enterprise/Medical Policy & Technology Assessment Committee-approved NICU clinical guidelines
    - NICU Utilization Management Program RNs utilize guidelines to support more timely, safe, supportive discharge planning focusing on the Right Care, Right Resources, Right Provider and supporting the Right Cost
    - NICU Program dedicated Specialty RNs use the Progression of Care Guidelines in their daily interactions with members and NICU facilities to facilitate individualized, member-specific education and preparation that result in safer discharge
    - Weekly and/or ad hoc multi-disciplinary Case Rounds with dedicated NICU Anthem Medical Director that include creative brainstorming and consultation with Behavioral Health, Social Workers, Pharmacy, as well as discussions with NICU facility physicians and/or other involved providers.
    - As a result of implementation, decreased NICU readmits and lower average length of stay observed

4. NICU Program Level of Care
    - Anthem's NICU Program implemented a process for review of initial NICU admission and assigning appropriate level of care from the beginning of the admission; prior to that, initial NICU days were authorized to pay "level of care as billed".
    - Supports Right Care with Right Provider at the Right Cost
    - Improved coordination of care between NICU Program RNs and NICU facility
    - Ensure members are treated at right level of care from admission while managing cost

5. Enhanced Personal Health Care Expansion
    - Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs): Anthem's value-based payment initiative, Enhanced Personal Health Care (EPHC), is applicable to any provider organization with a foundation in primary care. EPHC, which is composed of both Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), uses a payment model that includes a support system of data, analytics and insights to help promote providers' success around prevention, disease management and population health improvement.
    - The EPHC payment model gives providers the opportunity to earn shared savings bonus payments when they successfully manage quality and overall health care costs. To qualify for shared savings, providers must first meet quality thresholds built on a scorecard of nationally recognized measures of clinical quality, utilization and member engagement. This scorecard not only determines eligibility for shared savings, but also calibrates the percent of shared savings for

which providers are eligible. We also support participating providers through fixed per member per month clinical coordination payments, which support important clinical interventions that occur between patient visits.

- EPHC further supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. Anthem couples this analytic support with a team of health care delivery transformation experts who help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem has a dedicated focus on physician practices serving rural/remote populations.
- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being. Currently we have 21 larger Medical Groups/IPAs/Integrated Systems participating in our ACOs while 38 smaller practices participate in our PCMH model. Our ACOs and PCMHs are responsible for coordinating the care of over 600K attributed PPO lives in California. Anthem continues to evaluate areas of opportunities and partnerships to expand the EPHC program.

6. Diabetes Prevention Program Expansion

- Enrollment with weight loss milestone attainment in Anthem CA Diabetes Prevention Program has increased 239% from year 1 (7/2016-7/2017) to Year 2 (8/2017-7/2018).

7. Palliative Care Program

- Anthem has deployed an intensive palliative care case management approach in partnership with Aspire beginning in July 2018 and have enrolled over 100 members. The program includes claims based identification of eligible members, multi-channel engagement outreach to both member and their physician, and implementation of palliative support appropriate for the member's needs. Both telephonic and home based palliative care are offered depending on the situation.

8. CM Stabilization

- In late 2016, we instituted the CM Stabilization Post Discharge Management Process (PDM) to focus Care Manager interventions on

behaviors that can help prevent readmissions through telephonic outreach.

- Readmission predictive scores are used to prioritize members for outreach and the initial contact is attempted prior to discharge. This process is derived from the Coleman Pillars, which provide the overarching framework for member management. PDM focuses on:

    - Red Flag Recognition
    - Medication Reconciliation
    - Follow-Up Care
    - Member Centered Health Record (PHR)
    - Common components of a member's personal health record (PHR) are:
        - A list of health problems
        - A list of medications
        - Red flags for re-admission and action plan
        - Provider appointment dates and times
        - Issues for discussion with the care team (providers, case
        - manager)
        - Encourage member to create and use things like note book,
        - index cards, calendar, file folder.
- Case Duration is targeted at 27-33 calendar days post IP discharge date to home.
- Cost of Care savings are realized through a reduction in post discharge admissions. A recent report showed significant savings through a greater reduction in IP use and readmission rates in all LOBs.

1.02: Ensuring Networks are Based on Value:

- Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers. Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from "unit price" or volume-based payment models to payment models that involve a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver. Driven by that strategy, Anthem Blue Cross ("Anthem") supports value based provider

networks to achieve the most value for members. This strategy is implemented in part through our on-going efforts in the following areas:

Hospitals:

- Anthem's Quality-In-Sights®' Hospital Incentive Program (Q-HIP®) is designed to recognize facilities for practicing evidence-based medicine and implementing nationally endorsed best practices in patient safety, health outcomes and member satisfaction from standard setting organizations such as The Joint Commission (TJC), the National Quality Forum (NQF) and other respected authorities. Hospitals enter into a written agreement with Anthem Blue Cross in order to participate in the program. The better a hospital performs on the selected indicators, the greater the Q-HIP Adjustment to contract compensation the hospital may receive. More than 50% of member admissions to Anthem's State-wide hospital network are to a hospital that participates in QHIP.

Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs):

- Anthem's value-based payment initiative, Enhanced Personal Health Care (EPHC), is applicable to any provider organization with a foundation in primary care. EPHC, which is composed of both Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), uses a payment model that includes a support system of data, analytics and insights to help promote providers' success around prevention, disease management and population health improvement.
- The EPHC payment model gives providers the opportunity to earn shared savings bonus payments when they successfully manage quality and overall health care costs. To qualify for shared savings, providers must first meet quality thresholds built on a scorecard of nationally recognized measures of clinical quality and utilization. This scorecard not only determines eligibility for shared savings, but also calibrates the percent of shared savings for which providers are eligible. We also support participating providers through fixed per member per month clinical coordination payments, which support important clinical interventions that occur between patient visits.
- EPHC further supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. Anthem couples this analytic support with a team of health care delivery transformation experts who help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem

has a dedicated focus on physician practices serving rural/remote populations.

- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being.

1.03: Demonstrating Action on High Cost Providers

1. Converting NPAR to PAR:

- Using data that showed non-par providers driving allowed pmpm and high unit cost trend, the CA provider solutions team intensified its efforts to convert non-par to par providers. In this initiative Wave #4472 and #4474, BH, hospitals and professional were recruited to par status with total annualized savings of $2.7M.

2. Standardizing Fee Schedule:

- Another significant effort to reduce high cost providers was to build standardized fee schedules for implants, including Wave #107036 and #4499 and #4915, In addition, we also stepped up our OON enforcement efforts for reimbursements through Wave #s 1777 and #1422. All of these initiatives yielded a combined saving s of $1.2M for CA's fully insured population.

3. Other:

- Finally, the creation of our new CA Contract Compliance Unit designed to ensure compliance and claims provider payment accuracy led to significant savings of $4.4M through Wave #2510 and #4498.

1.04: Demonstrating Action on High Cost Pharmaceuticals

- Pharmacy's biggest initiatives to reduce high cost pharmaceuticals include Formulary Optimization and Hep. C Marvyret which replaced Harvoni in the specialty drug list. These two initiatives yielded approximately$23.4M savings for CA.

1.05: Quality Improvement Strategy

- Anthem's vision is committed to excellence in the quality of care and services provided to members, and to the competence of provider networks. There is dedication to member satisfaction, improving the health status and quality of care for members and the public, providing value-added services, improving member safety, and promoting member access to medical services.
- The goals, objectives, and structure of the QI Program are responsive to the changing needs of members, providers, and the health care community; evolving and building upon the culture to focus on being a valued health partner across the health care continuum.

- The Commercial/Exchange Quality Improvement Committee (CEQIC) has been designated by the Board of Directors as the responsible committee to oversee the Quality Improvement Program and all related quality activities. The CEQIC provides routine reports on updates to the program, the annual work plan, and the evaluation of the annual work plan to the Board of Directors. The CEQIC has designated the day to day management of quality including quality management projects and activities to the business areas that support quality. As designated by the quality leadership, the Medical Director who chairs the Commercial/Exchange Quality Improvement Committee is responsible to help ensure that cross-disciplinary collaboration occurs to improve the quality of member care and services. The CEQIC Chair engages with the leadership of various CEQIC sub-committees and other areas of the organization to help ensure quality goals and accreditation standards are being met and members are receiving the benefit of programs that are interconnected, non-duplicative and value-added in nature.
- The Senior Vice President, Health Care Management: has overall responsibility for the quality improvement program aligning the goals/objectives of the Quality Improvement program with business objectives, and setting quality program strategy. In addition, is responsible for implementation and maintenance of the quality program priorities that will demonstrate improved provider and member outcomes.
- The Quality Improvement Program Description (QIPD) is an ongoing, comprehensive, and integrated system which defines how departments support quality, objectively and systematically monitors and evaluates the quality, safety, and appropriateness of medical and BH care and services offered by the health network, and to identify and act on opportunities for continuous improvement. These values provide an overall foundation for success, helping define what is done and how it's done. Quality activities are often interdepartmental and collaborative in nature, and are offered through several business units. The pursuit of excellence guided by Anthem's four strategic pillars – *Provider Collaboration, Consumer Centricity, Quality, and Managing the Total Cost of Care* – is the foundation for many programs and initiatives across the company to deliver meaningful and measurable quality outcomes for members. The five Quality dimensions that make up the quality pillars are clinical quality, service quality, quality compliance, clinical programs, and wellness.
- To enable comprehensive assessment of the system and meaningful prioritization of initiatives, critical monitors are selected from CM, DM, provider services, pharmacy management, utilization medical management, and customer service to develop the annual Anthem Blue Cross Commercial/Marketplace Quality Improvement Work Plan. The annual work plan includes multiple interventions to improve the quality of care and safety to Anthem members.
- The QI Plan addresses medical and behavioral health quality programs and activities many of which are delivered from an enterprise perspective. Our quality programs include HEDIS measures for

Prevention, Health Management, Behavioral Health, and Pharmacy, Patient Safety, Continuity and Coordination of Care, Utilization Management (UM) and Case Management (CM), Disease Management, CAHPS, and Service Operations. Quality activities are often interdepartmental and collaborative in nature and are offered through several business units. Products in scope include Commercial HMO, POS, and PPO (EPO is included) and Marketplace HMO, POS, and PPO. The Work Plan identifies and tracks priority metrics for quality activities that can be impacted with initiatives. The work plan contains priority metrics previously noted by business owners as not meeting goal and/or performance is to be maintained at goal level

1.06: Participation in Collaborative Quality Initiatives

- Anthem Blue Cross and Blue Shield of California have joined together to share health data and improve patient care by launching the California Information Data Exchange (Cal INDEX). Cal INDEX, a next generation Health Information Exchange, was created through a joint investment of $80 million and will allow health care providers to share health data and improve patient care. Utilizing the records of nine million people, more than 25% of the state's population, Cal INDEX will be one of the largest health information exchanges in the country. Cal INDEX houses a comprehensive collection of patient records on a secure, electronic platform. It includes clinical data from multiple health care providers and insurers and allow physicians and hospitals throughout the state to share patients' health information to help them give their patients the best care possible. Cal INDEX has been set up as a not-for-profit organization that will be open to all doctors, hospitals and health plans that contribute data.
- Anthem is engaged with Integrated Health Association (IHA), CMS Physician Quality Reporting System and fund California HealthCare Performance Information System (CHPI), and CalHospital Compare.
- Anthem has provider collaboration as a key focus and data integration is a critical component. Anthem currently has electronic admission and ER notification from over 300 hospitals that is shared with the members' medical groups and physicians for both HMO and ACO PPO.
- In addition, Anthem, with Blue Shield of California was a founding partner of Cal Index, a not-for-profit organization developing a statewide, next-generation health information exchange. This comprehensive collection of electronic patient records will include clinical data from healthcare providers and health insurers like Anthem Blue Cross. Cal INDEX provides the underlying data and technology platform to improve quality of care by providing doctors with a unified statewide source of integrated patient information, as well as improve efficiency and reduce the cost of healthcare. Cal INDEX is designed to improve the inefficiency and complexity of the current system by: 1) Collecting and integrating clinical data from multiple healthcare providers and health insurers; 2) Centralizing and storing that data; 3) Allowing doctors, nurses and hospitals to share vital patient information easily, reliably and securely.

- For HMO patients, Anthem provides the medical groups and physicians both the electronic hospital census as well as quality data feeds that are loaded into the medical groups' electronic health records. Anthem is working with the HMO medical groups through Joint Operating Meetings, delegation process and ongoing education and communication exchanges to improve the vertical integration of Anthem-hospitals and medical groups. In addition, Anthem is an active participant with IHA P4P and other statewide collaborative to improve data. In the last two years, Anthem has been working with the HMO medical groups to improve the encounter data. Anthem has improved the encounter data from 80% complete and accurate to closer to 85-90% and this is a top priority to continue to improve encounter data. Another area of data integration is with the HMO medical groups and hospitals that work from a full capitation arrangement.
- For PPO patients, the Anthem ACO program Enhanced Personal Health Care has data integration as a key component. Anthem works with the groups on providing reports.
- Population Health Management and Care Delivery Transformation
  At Anthem, we support our providers with tools and resources to practice patient-centered care and maximize the value of the data we provide. Anthem takes claims data feeds through our analytics engines to deliver actionable reports in real-time, through a multi-payor platform. In contrast, even though other plans provide claims data, they fall short of translating raw claims into actionable insights that providers can use to determine which patients need attention and why. Anthem analytics engines deliver actionable reports in real time through a multi-payer platform, facilitating seamless care coordination. Anthem is the only payer offering innovative transformation assistance to the extent that we do and our population health technology and consulting services are second to none in the market.
- Multiple resources and programs available on Anthem's site such as My Health Coach, Healthy lifestyles, Future Moms, Behavioral Health and Employee Assistance Program, Care Management programs that are available to all members. Also, available are resources for cancer prevention program specifically related to Colon Cancer, Cervical cancer and Breast cancer. Additional resources are available on Anthem's website to help all members with understanding on basics of health insurance, customer service topics such as how to get the most out of your health plan, what to do when you get a bill form your doctor, what to do when you get a new ID card, planning ahead for your next doctor's visit, tools to help with cost and quality, claims, find a doctor and Health Record etc.
- Participation in multiple statewide programs as listed: State Health Report, Journey Forward Program for cancer survivors, Better Choices, Better Health Diabetes, National MS Society, LLS Night the Light, Conejo Valley Senior Concerns/Love Run, Susan G. Komen Race for the Cure, AIDS Walk LA, Diabetes program for Downtown Women's Center, ADA Step out walk, Diabetes Prevention Youth Camp, CA Equality Institute. Participation in many state wide programs

to support non-health related activities such as finding for Jessie Rees Foundation, Santa Barbara County/Salute to Teachers, ADA/Diabetes Prevention Youth Camp, MEND, Santa Barbara County/Salute to Teachers

- Community health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative. Patient Safety First Launched in 2010, Patient Safety First (HQInstitute.org/PSF) united key stakeholders from different geographic regions within the state to improve quality of care provided to Californians, save lives by targeting zero avoidable medical errors, and reduce healthcare costs to allow for reinvestment into the system.
- Anthem Corporate Scholars Program for college students. Each year 15 students will participate in an 8-week internship in different markets over the term of the grant.
- Convergence Center for Policy: This grant will help fund the building and testing "Smart Receipts" to influence and encourage a shoppers-behavior towards more healthful purchases. Participation in geographic disaster relief efforts (e.g., weather, fire, environmental) American Red Cross: Provide Appropriate disaster relief as needed. Americares: Support Ebola Relief Efforts, Portlight Strategies: Disaster Response Program.

1.07: Data Exchange with Providers

EPHC

- Anthem's EPHC program supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. In addition, providers will have access to Anthem's longitudinal health record, Patient360, a compliance tool that facilitates the sharing of a comprehensive range of patient data with our ACOs/PCMH. The robust reporting helps to promote providers' success around prevention, disease management and population health improvement. Anthem couples this analytic support with a team of health care delivery transformation experts who serve as an extension of the physician practice, providing transparent access to health and cost data and help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem has a dedicated focus on physician practices serving rural/remote populations.
- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member

experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being. Currently we have 21 larger Medical Groups/IPAs/Integrated Systems participating in our ACOs while 38 smaller practices participate in our PCMH model. Our ACOs and PCMHs are responsible for coordinating the care of over 600K attributed PPO lives in California. Anthem continues to evaluate areas of opportunities and partnerships to expand the EPHC program.

1.08: Data Aggregation across Health Plans

Cost Atlas

- Anthem is an active participant in the IHA Cost Atlas initiative which aggregates data across 10 plans to illustrate the cost of care, resource use and clinical quality measures in all 19 regions of the Covered California health benefits exchange and examines the variation in these measures across regions and payer types and for particulate sub-populations. The atlas uses claims, encounters, eligibility, and cos data for both HMO and non-HMO products form three payer types: commercial, Medicare, and Medi-Cal, as well as data previously submitted by Plan and Other Plan/Insurers to Data Aggregator or IHA for other IHA performance measurement initiatives

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) Complete the SB 17 - Large Group Prescription Drug Cost Reporting Form to provide the information on covered prescription drugs dispensed at a plan pharmacy, network pharmacy or mail order pharmacy for outpatient use for each of the following:

(i) Percent of Premium Attributable to Prescription Drug Costs

(ii) Year-Over-Year Increase, as Percentage, in Per Member Per Month, Total Health Plan Spending
(iii) Year-Over-Year Increase in Per Member Per Month Costs for Drug Prices Compared to Other Components of Health Care Premium
(iv) Specialty Tier Formulary List
(v) Percent of Premium Attributable To Drugs Administered in a Doctor's Office, if available
(vi) Health Plan/Insurer Use of a Prescription Drug (Pharmacy) Benefit Manager, if any

Complete SB 17 - Large Group Prescription Drug Cost Reporting Form - Excel

See Health and Safety Code section 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C) and Insurance Code section 10181.45(c)(4)(A), 10181.45(c)(4)(B), 10181.45(c)(4)(C)

17) Complete the SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans to provide the information on covered prescription drugs dispensed at a plan pharmacy, network pharmacy or mail order pharmacy for outpatient use for each of the following:

(i) 25 Most Frequently Prescribed Drugs
(ii) 25 Most Costly Drugs by Total Annual Plan Spending
(iii) 25 Drugs with the Highest Year-Over-Year Increase in Total Annual Plan Spending
(iv) Overall Impact of Drug Costs on Health Care Premiums

Complete SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans - Excel

See Health and Safety Code section 1367.243(a)(2)(A), 1367.243(a)(2)(B), 1367.243(a)(2)(C), 1367.243(b) and Insurance Code section 10123.205(a)(2)(A), 10123.205(a)(2)(B), 10123.205(a)(2)(C), 10123.205(b)

18) Other Comments

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

In this report for 2018 renewal year, estimate of non-capitated claims is reflected in premium PMPM for minimum premium cases. In the reports for prior renewal years, premium PMPM for minimum premium cases did not reflect any non-capitated claims.