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:

Anthem Blue Cross Life and Health 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 5.9 %
- Most commonly sold large group benefit design 4.5 %

Weighted average annual rate increase (adjusted)[3]

- All large group benefit designs 8.2 %
- Most commonly sold large group benefit design[4] 6.9 %

[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	182	41.7%	51,718	1,020	$390.58	7.2%
February	11	2.5%	1,033	0	$382.52	-3.7%
March	25	5.7%	1,691	5,228	$539.88	3.1%
April	15	3.4%	665	72	$502.86	7.1%
May	20	4.6%	1,202	0	$559.99	6.1%
June	18	4.1%	797	70	$595.79	9.8%
July	40	9.2%	35,317	35	$556.95	4.4%
August	13	3.0%	1,207	53	$479.30	8.1%
September	19	4.4%	942	7	$509.15	3.6%
October	25	5.7%	2,586	19	$550.99	8.3%
November	22	5.0%	1,243	0	$479.18	10.3%
December	46	10.6%	3,369	0	$408.66	5.1%
Overall	***436***	***100.0%***	***101,770***	***6,504***	***$466.16***	***5.9%***

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

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

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

Place comments below:

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

(1) 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)	348	73.3%	16,124	341	$542.73	7.8%
Blended (in part)	31	6.5%	4,863	718	$476.84	4.4%
100% Experience Rated	96	20.2%	80,783	5,445	$450.85	5.7%
Overall	***475***	***100.0%***	***101,770***	***6,504***	***$466.16***	***5.9%***

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	86.1%
EPO	0.1%
POS	NA
HDHP	13.8%

- Blended

HMO	NA
PPO	64.7%
EPO	2.7%
POS	NA
HDHP	32.6%

- 100% Experience Rated

HMO	NA
PPO	70.5%
EPO	2.9%
POS	NA
HDHP	26.6%

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	NA	NA	NA	NA	NA	NA
PPO	410	86.0%	72,852	5,740	$528.74	4.5%
EPO	7	1.5%	2,494	147	$185.72	10.7%
POS	NA	NA	NA	NA	NA	NA
HDHP	60	12.6%	26,424	617	$311.68	9.7%
Other (describe)	NA	NA	NA	NA	NA	NA
Overall	***477***	***100.0%***	***101,770***	***6,504***	***$466.16***	***5.9%***

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 low average premium PMPM for EPO is driven by a large portion of EPO members on the minimum premium funding arranagment. Minimum premium funding arrangement is a funding arrangement that requires the employer group to pay premiums only for administration and capitation (if applicable), and self-fund the full claim cost up to a pre-determined level.

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	75	30,747	39%	Most popular cost sharing: Deductible=$250, OOPM=$1,500
0.8 to 0.899	115	32,369	41%	Most popular cost sharing: Deductible=$500, OOPM=$25,000
0.7 to 0.799	74	13,700	17%	Most popular cost sharing: Deductible=$3,500, OOPM=$9,850
0.6 to 0.699	20	1,776	2%	Most popular cost sharing: Deductible=$5,000, OOPM=$11,350
0.0 to 0.599				
Total	284	78,592	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	7	2,641	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	7	2,641	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	22	12,389	46%	Most popular cost sharing: Deductible=$2,600, OOPM=$3,425
0.7 to 0.799	39	14,491	54%	Most popular cost sharing: Deductible=$2,500, OOPM=$5,000
0.6 to 0.699	5	161	<1%	Most popular cost sharing: Deductible=$3,000, OOPM=$5,000
0.0 to 0.599				
Total	66	27,041	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:

- 69 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.
- 285 groups with standard plans; 151 groups with custom 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)	• 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 increased. • This impacts 102,619 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	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

[7] i.e. premium tier ratios

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

Overall Medical Allowed Trend Factor

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

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

8.5%

Medical Allowed Trend Factor by Aggregate Benefit Category

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

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

Hospital Inpatient[8]	8.1%
Hospital Outpatient (including ER)	8.1%
Physician/other professional services[9]	8.1%
Prescription Drug[10]	10.7%
Laboratory (other than inpatient) [11]	8.1%
Radiology (other than inpatient)	8.1%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	N/A

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

10) Projected medical trend:

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

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

Projected Medical Allowed Trend by Aggregate Benefit Category

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]	$137.73	2.5%	2.8%	N/A	5.4%
Hospital Outpatient (including ER)	$123.32	2.5%	2.8%	N/A	5.4%
Physician/other professional services[13]	$164.47	2.5%	2.8%	N/A	5.4%
Prescription Drug[14]	$100.55	2.5%	7.2%	N/A	10.0%
Laboratory (other than inpatient)[15]	$19.98	2.5%	2.8%	N/A	5.4%
Radiology (other than inpatient)	$26.30	2.5%	2.8%	N/A	5.4%
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	$572.35	2.5%	3.5%	N/A	6.1%

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

[13] Measured as visits.

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).

Standard Plans

- Move to standard multipliers for Out-of-Network (OON) Deductible, OON Out-of-Pocket Maximum (OOPM) and Family Multiplier
  - Increase/add a separate OON deductible equal to 3x In-Network (i.e. INN) deductible with exception made for Premier PPO plans to have one combined deductible
  - Increase OON OOPM to 3x INN OOPM
  - Increase Family deductible as follows:
    - For plans w/INN Deductible < $1500 = 3x individual amounts
    - For plans w/INN Deductible $1500 or more = 2x individual amounts

- Reduce Live Health Online (LHO) copay to $10 (PPO Plans)
  - Decrease LHO copay to $10 to incent member utilization
  - Promotes steerage to a lower cost alternative from ER and Urgent Care

- Split Generic Tiers
  - Split Tier 1 (Generics) into two tiers with appropriate member cost shares
  - Previous cost share $10 for Tier 1 -> $5/$15 for Preferred Generics/Non-preferred Generics
  - Previous cost share $15 for Tier 1 -> $5/$20 for Preferred Generics/Non-preferred Generics

- Solution PPO 3500/35/35
  - The copay for PCP visit decreased by $5 (from $35 to $30).
  - Medical coinsurance has decreased by 5% (from 35% to 30%)

Custom plans

- With exception of federal/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]

Enrollee cost sharing decreased by 12.9% from 2016 to 2017.

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

13) Changes in enrollee/insured benefits

Describe any changes in benefits for enrollees/insureds over the prior year, providing a description of benefits added or eliminated, as well as any aggregate changes as measured as a percentage of the aggregate claims costs. 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)***

- Embed biometric screening for standard pooled plans
  - Offer to fully insured, pooled and 101-300 size groups only; all others groups would be offered as a buy-up
- Essential Formulary
  - Expand the Essential drug list to pooled standard plans
  - Essential Formulary made available for all non-pooled plans
- A narrow network for Rx ("Preferred Rx Network") made available for non-pooled business.

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**

ER Frequent Flyer Program:

- Focused/dedicated RN Case Manager outreach to members with 4 or more Emergency Room visits within a 3 month period; RN Case Manager performs in depth case specific research and analysis to determine members ER utilization behavior patterns and clinical root cause prior to member and/or provider engagement.
- Individualized member specific case management with provider collaboration to facilitate resolution of root cause of frequent ER usage.
- Dedicated Case Manager works closely with designated ER Frequent Flyer Anthem Medical Director and provides "Peer to Peer" outreach to primary treating physician and/or ER physician to facilitate alternative options for routine, non-emergent care.
- Weekly and/or ad hoc multi-disciplinary huddles that include creative brainstorming and consultation with Behavioral Health, Social Workers, Pharmacy, as well as discussions with providers including ER, Urgent Care, member's specialists and/or PCPs.

Clinical Multidisciplinary Team Rounds:

- Our multi-disciplinary teams' Case Rounds are convened twice per week to support more comprehensive discharge planning through a holistic view of our members.

- Since the inception of our Multidisciplinary Team model, the parameters for our rounds frequency and member identification for rounds discussion have been enhanced.
- In 2016, new parameters for discussion of members in rounds were established: Review of any member at 10 day length of stay and every 10 days thereafter plus focused review on traumatic brain injury patients and members in acute rehab/SNF with input from one of our Anthem physiatrists.
- The goals of our collaboration include identifying barriers to safe discharge, prevention of readmission and facilitation of more timely, cost effective level of care transitions.
- Discussion participants include not only Utilization Management Nurses and Anthem Medical Directors, but also, as appropriate, Anthem Complex Discharge Coordinators, Case Management/Disease Management, Behavioral Health Utilization Management/Case Management, Pharmacy/Specialty Pharmacy, Social Workers, Transition Assistance and others, resulting in successful benefit management for members.

<u>Expedited Transfer to SNF:</u>

- Late in 2016, we determined that member transfers to a Skilled Nursing Facility (SNF) were sometimes delayed due to awaiting supplemental medical information to review for medical necessity of the transfer, mostly prior to a weekend.
- An initiative was implemented in April 2017, providing a process for authorization of up to five initial Skilled Nursing Facility days by the nurse, based on the clinical information available during the inpatient stay review.
- UM Nurses review the appropriateness of the transfer based on our Clinical Guideline, inpatient medical information and their clinical judgment to approve the transfer when the majority of the clinical criteria are met and SNF placement is the most appropriate level of care.
- Cost of Care savings are realized through more expedient transfer to the lower level of care from the more costly acute inpatient setting resulting in fewer acute inpatient bed days.

<u>AIM Genetic Testing:</u>

- This is a provider-focused AIM program in coordination with Informed DNA (IDNA) to provide pre-service medical necessity review for genetic testing for fully insured commercial business.
- AIM provided outcome guidance based on Anthem medical policies/ guidelines, as well as recommended genetic counseling, education and other value-added interventions.
- CA savings yielded $12M in 2016.

Cancer Care Pathways:

- The Cancer Care Quality Program is a cross-functional, multi-department collaborative oncology program aimed at increasing adoption of Cancer Treatment Pathways that improve quality, reduce readmissions, and accelerate outcomes.
- The program completed trend evaluations and actions that addressed them. The program also involved provider engagement strategies that supported the different cancer treatment pathways.
- Program resulted in $4M savings for CA.

HLOS Process:

- Hospital admissions and length of stays are evaluated based upon MCG criteria (guidelines) for medical necessity. Historical data on Anthem admissions has shown that high length of stay cases account for approximately 41% of inpatient claims costs.
- As hospital length of stays become protracted, often the clinical treatment plan can become complex and may require more advanced planning and coordination of services.
- All of the HLOS cases are reviewed during our twice-weekly Clinical Rounds with the team Medical Director to ensure that the LOS is appropriate. Our Complex Discharge Coordinator nurses, as well as our Case Managers, weigh in on possible discharge and continued care options.
- High Length of Stay (HLOS) reports are reviewed monthly. Case summary information plan of care and expected out-comes are reviewed with the Anthem Medical Directors. Monthly HLOS meetings, with participants from UM, Finance, and Actuary, have been crucial in managing length of stay and assisting the business to set reserves for claims payment. The increased focus has been beneficial in decreasing overall length of stay.
- In addition, certain ASO clients now receive HLOS reports that enhance their ability to control costs. Specified UM associates assist with providing supplementary information regarding actions taken by Care Management to closely manage the member's care.

Complex Discharge Planning Enhancements (e.g., Cedars Sinai):

- The role of the Complex Discharge Planner (CDC) has been in place for several years to focus efforts on cases with specific referral criteria, acting as a bridge between Utilization Management and Case Management. CDC case referrals were enhanced to include (but not limited to) cases involving air ambulance transfers, non-par to par redirection, benefit substitutions, high dollar cases, complicated cases

identified in Case Rounds, cases involving rate negotiations, and cases at risk for readmission.

- These enhancements allow for improved management of cases within Utilization Management and prior to referring to Case Management. In January 2017, our CDC program was enhanced further, as a result of a CA specific initiative, to implement a dedicated CDC at our highest volume, highest cost facilities in CA.
- The dedicated CDC allows for more focused discharge planning for all Anthem Commercial members at the facility, enhanced relationships and collaboration with the facility Case Managers / Discharge Planners, earlier intervention to address barriers to discharge and increased knowledge of area resources.
- As a result of the role, facility personnel are reaching out to the CDC more frequently and members are moving along the continuum of care more expeditiously. Due to the success of the pilot, expansion of the model to four additional CA facilities is planned for late 2017 / early 2018.

Complex prosthetic cases:

- For select prostheses (e.g. microprocessor-controlled prosthetics for the lower limb), we have implemented a process whereby requests that do not meet medical necessity criteria after medical director review are subject to a second-look by a certified and licensed prosthetist. The intent is to assist in cost containment but also to help improve the quality of the review process for complex prosthetic requests.

Enhanced Personal Health Care:

- 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.

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:

<u>Hospitals</u>

- 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 one third of Anthem's State-wide hospital network participates in QHIP today.

Physicians

- The goal of Anthem's Physician Quality Incentive Program (PQIP) is to provide a comprehensive pay for performance program for our capitated Participating Medical Groups (PMGs) that rewards efficient care coupled with quality. PQIP integrates quality, appropriate resource use ("ARU") and cost of services provided by Anthem's commercial health maintenance organization (HMO) Participating Medical Groups (PMGs). PQIP was developed in collaboration with the Integrated Healthcare Association ("IHA"), health plans, and physician organizations participating in Pay for Performance ("P4P") as a strategic initiative to moderate HMO cost trend in California while continuing to improve quality of care and utilization of health care services.
- PQIP evaluates participating Medical Groups for compliance with clinical guidelines and protocols, patient outcomes, member satisfaction, and use of meaningful IT. PQIP designed to share savings with participating PGGs if the PMG achieves improvements on individual ARU measures. Performance on total cost of care trend serves as a gate, and performance on quality serves both as a gate and an adjustment to the incentive payout if savings are achieved. Two thirds or Anthem's State-wide HMO PMGs participate in PQIP.

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.
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1.03 **Demonstrating Action on High Cost Providers**
Sovereign / Program Integrity:

- Anthem has a rigorous Program Integrity cost of care initiative that includes special investigations of fraud and abuse, provider audit, payment recovery, and pre-pay reviews. Through ongoing deep dive data analysis of trends and outliers, the PI team identified various high cost providers such as Sober Living Homes and Sovereign Health which resulted in local and federal investigations. As a result of these investigations, these high cost providers are now being prosecuted for termination in the state of CA.
- Various cost of care initiatives have been implemented at Anthem to recruit non-par facilities, providers and professional labs to par aimed at improving affordability and quality.
- The effort also included changes in reimbursement methodology that aligns with standard CMS reimbursement rates and minimize huge variabilities in service rates.
- The combination of these recruitment and reimbursement alignment initiatives yielded $8.5M savings for CA in 2016.

1.04 **Demonstrating Action on High Cost Pharmaceuticals**
Specialty Redirection:

- This program involved the review of specialty pharmacy requests for appropriateness of site of care based on clinical guidelines. Members then receive education and counseling with recommendations for other appropriate sites of care that optimize quality and cost effectiveness.
- Program resulted in $4.4M 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**

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

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1.08 **Data Aggregation across Health Plans**

- 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) Other Comments

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

Historical financial data report, included as an answer to #11, is based on HHS MLR calculation, which excludes Minimium Premium business.