California Large Group Annual Aggregate Rate Data Report Form

(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) Other Comments

1) Company Name:

Blue Shield of California Life & Health Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2022 .[1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 8.2 %
   - Most commonly sold large group benefit design 8.2 %

   Weighted average annual rate increase (adjusted)[3]
   - All large group benefit designs 5.0 %

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[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.

- Most commonly sold large group benefit design[4] 5.0 %

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	9	64.3%	750	180	$534.01	6.9%
February	0	0.0%	0	0		
March	0	0.0%	0	0		
April	0	0.0%	0	0		
May	0	0.0%	0	0		
June	0	0.0%	0	0		
July	0	0.0%	0	0		
August	1	7.1%	204	0	$581.28	10.2%
September	0	0.0%	0	0		
October	0	0.0%	0	0		
November	3	21.4%	190	0	$365.60	9.9%
December	1	7.1%	105	0	$542.23	11.8%
Overall	14	100.0%	1,249	180	$518.97	8.2%

[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) PPO is the most commonly sold benefit design. 2) For 2022 projected rate increases, we estimated the numbers based on business pricing decisions.

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)	10	71.4%	1,131	0	$532.14	9.5%
Blended (in part)	4	28.6%	118	180	$469.00	3.2%
100% Experience Rated	0	0.0%	0	0		
Overall	14	100.0%	1,249	180	$518.97	8.2%

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.

For a PPO group with more than 250 subscribers, the experience is fully credible, and therefore, the group is 100% experience rated. For a PPO group with less than 100 subscribers, the group experience is deemed to have no credibility and is 100% manual rated. Groups fall in between have blended rating.

Distribution of covered lives among each product type and rating method:

Product type	100% Community/ manual Rated	Partial Community/manual Rated	100% Experience Rated
PPO	100.0%	100.0%	
EPO	0.0%	0.0%	
HMO	0.0%	0.0%	
POS	0.0%	0.0%	
PSP	0.0%	0.0%	
Overall	100.0%	100.0%	

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	0	0.0%	0	0		
PPO	14	100.0%	1,249	180	$518.97	8.2%
EPO	0	0.0%	0	0		
POS	0	0.0%	0	0		
HDHP	0	0.0%	0	0		
Other (describe)	0	0.0%	0	0		
Overall	14	100.0%	1,249	180	$518.97	8.2%

HMO – Health Maintenance Organization PPO – Preferred Provider Organization
EPO – Exclusive Provider Organization POS – Point-of-Service
HDHP – High Deductible Health Plan with or without Savings Options (HRA, HSA)

Describe “Other” Product Types, and any needed comments here.

7) The number of plans sold during the 12-months that have materially different benefits, cost sharing, or other elements of benefit design.

See Health and Safety Code section 1385.045(c)(1)(E) and Insurance Code section 10181.45(c)(1)(E)

Please complete the following tables. In completing these tables, please see definition of "Actuarial Value" in the document "SB546 – Additional Information":

HMO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	0	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	0	0	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	0	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	4	1,429	100.0%	Active Choice plan – First tier professional services, BSC pays the first $750 dollars and the rest will be paid by members until the OOPM. The second-tier hospital services, members pay 20% par/40% non-par coinsurance
0.0 to 0.599	0	0	0.0%	
Total	**4**	**1,429**	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	0	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	0	0	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	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	0	0	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	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	0	0	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	0	0.0%	
0.8 to 0.899	0	0	0.0%	
0.7 to 0.799	0	0	0.0%	
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	0	0	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:

Number of standard PPO plans: 4
The most popular PPO plan is an Active Choice plan. For first tier professional services, BSC pays the first $750 dollars and the rest will be paid by members until the OOPM. The second tier hospital services, members pay 20% par/50% non-par coinsurance%.

large groups with standard plans: 11
large groups with custom plans: 0

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)	This factor is designed to reflect the cost of health care differences caused by geographic locations. We routinely review the factors based on 12 months of experience. Overall book level impact is 0.
Age, including age rating factors (describe definition, such as age bands)	An age factor reflects the overall cost predictions based on members' demographic characteristics. We routinely review the factors based on 12 months of experience.
Occupation	We do not consider occupation in rating.
Industry	The industry factor reflects the cost of health care differentials attributed to the industry classification. We routinely review the factors based on 12 months of experience and available industry information. Where appropriate industry factors were shifted up or down by one classification resulting in at most a ±5% change in factor.
Health Status Factors, including but not limited to experience and utilization	Health status factors reflect member's overall health profile that is not captured by age and gender. We routinely review the factors based on 12 months of experience.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	Tier factor reflects the family composition of the contract. The four tiers used in rating are employee only, employee and spouse, employee and children, and family. We routinely review the factors based on 12 months of experience.
Enrollees' share of premiums	We do not consider enrollee's share of premium in rating.
Enrollees' cost sharing, including cost sharing for prescription drugs	Plan factor reflects enrollee's cost sharing. We routinely review the factors based on 12 months of experience.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Additional benefits (including infertility services, substance abuse services, hearing aid, chiropractic, and acupuncture) are available as riders with additional PMPM costs. We routinely review the factors based on 12 months of experience.
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	For an HMO group with more than 500 subscribers or a PPO group with more than 250 subscribers, the experience is fully credible, and therefore, the group is 100% experience rated. For an HMO group with less than 250 subscribers or a PPO group with less than 100 subscribers, the group experience is deemed to have no credibility and is 100% manual rated. Groups fall in between have blended rating.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	

[7] i.e. premium tier ratios

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

a) 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)

3.6%

b) 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]	-3.8%
Hospital Outpatient (including ER)	4.1%
Physician/other professional services[9]	5.1%
Prescription Drug[10]	10.2%
Laboratory (other than inpatient) [11]	1.6%
Radiology (other than inpatient)	1.6%
Capitation (professional)	0.0%
Capitation (institutional)	0.0%
Capitation (other)	11.7%
Other (describe) - ambulance, DME, orthotics, prosthetics etc.	1.6%

[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.

Please provide an explanation if any of the categories under 9(b) are zero or have no value.

No professional or institutional capitation for PPO products, therefore no applicable trend.
Capitation (other) is mental health services.
Other includes DME, Prosthetics, Ambulance, Hospice, Chiro, some Home Health.

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

			Trend attributable to:		
Allowed Trend: (Current Year + 1) / (Current Year)	Current Year - Aggregate Dollars (PMPM)	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	$146.48	-5.5%	2.4%	N/A	-3.2%
Hospital Outpatient (including ER)	$183.24	5.1%	2.8%	N/A	8.0%
Physician/other professional services[13]	$178.88	3.5%	0.9%	N/A	4.4%
Prescription Drug[14]	$101.11	0.7%	9.5%	N/A	10.3%
Laboratory (other than inpatient)[15]	*Other	-5.1%	0.4%	N/A	-4.7%
Radiology (other than inpatient)	*Other	-5.1%	0.4%	N/A	-4.7%
Capitation (professional)	$0.00	N/A	N/A	N/A	0.0%
Capitation (institutional)	$0.00	N/A	N/A	N/A	0.0%
Capitation (other)	$15.53	N/A	N/A	N/A	16.6%
Other (describe)	$46.66	-5.1%	0.4%	N/A	-4.7%
Overall	$671.89	0.9%	3.0%	N/A	4.3%

Please provide an explanation if any of the categories above are zero or have no value.

No professional or institutional capitation for PPO products, therefore no applicable trend.
Capitation (other) is mental health services.
Other includes DME, Prosthetics, Ambulance, Hospice, Chiro, some Home Health.

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

11) Complete the CA Large Group Historical Data Spreadsheet to provide a comparison of the aggregate per enrollee per month costs and rate changes over the last five years for each of the following:

(i) Premiums
(ii) Claims Costs, if any
(iii) Administrative Expenses
(iv) Taxes and Fees
(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).

N/A

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

The 2022 aggregate actuarial value decreased by 0.2% to 61.1% compared to the 2021 aggregate actuarial value of 61.2%, mostly due to two plans leaving CDI to be overseen by a different regulator. The aggregate actuarial values are weighted by the number of covered lives in the respective years.

[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)

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/2016/407/2017%20QHP%20Issuer%20Contract_Attachment%207_Individual_4-6-2016_CLEAN.pdf

Quality Improvement programs:

Program	**Line of Business**	**Results**
IHA Value Based Pay for Performance	HMO *ACO* *Medicaid*	Physician incentives for good management of quality, utilization and cost outcomes [current range $1M-$4M annually for HMO based on performance; $4M for Medicaid, ACO results pending]
Covered California Quality Improvement Strategy (related to "Attachment 7")	All products on exchange PPO ACO HMO ACO PPO	Meet the quality requirements of Covered CA expectations for health plans, including differential payment for data-driven, team based, high quality care and action on improving health care disparities
Federal Employee Program – Quality improvements	PPO	Improvements in 21 HEDIS and CAHPS measures monitored by the Office of Personnel Management
Member outreach and incentives	All commercial members	Year-round proactive and care gap outreach to members due for

		screening and care for chronic conditions
MediCal San Diego, Rapid Improvement	Medicaid members in San Diego	Year-round proactive and care gap outreach to members due for screening and care for chronic conditions and Year-round provider engagement, statewide to achieve improvement in member care outcomes for patients with chronic conditions and preventive screening needs; frontline care team partnerships with Medicaid medical groups
Trio Rapid improvement	ACO members	Year-round provider engagement, statewide to achieve improvement in member care outcomes for patients with chronic conditions and preventive screening needs; frontline care team partnerships with ACO medical groups

Quality Assurance programs: **KIM 10/05/21**

Program	**Lines of Business**	**Results**
Review of potential quality issues	All products (HMO, PPO, Marketplace, Medicare, Medi-Cal, Cal-MediConnect)	Meet regulatory and accreditation requirements and investigate referred providers for quality of care issues through Peer Review process that may require corrective action, up to and including network termination recommendation
Oversight of IPAs/medical groups delegated for utilization management (UM) activities	All products (HMO, PPO, Marketplace, Medicare, Medi-Cal, Cal-MediConnect	Ensure IPAs/medical groups meet regulatory and accreditation requirements for delegated UM, Claims, Credentialing and IT/Security activities
NCQA accreditation	All products (HMO, PPO, Marketplace, Medicare,, Medi-Cal, Cal-MediConnect	Meet NCQA accreditation standards requirements. Coordinate successful NCQA surveys.
DMHC Medical Survey	HMO, PPO (regulated by DMHC), Marketplace	Meet DMHC medical requirements, as demonstrated through routine and non-routine medical surveys. Coordinate successful DHMC survey and follow-up activity

Quality activities to meet regulatory and accreditation requirements, e.g., quality trilogy documents (Program, Workplan, Annual evaluation), committees	All products (HMO, PPO, Marketplace, Medicare, , Medi-Cal, Cal-MediConnect	Meet regulatory and accreditation requirements for maintaining a core quality program.
Quality annual assessments (medical record review, coordination of care, quality assurance delegation oversight etc.)	All products (HMO, PPO, Marketplace, Medicare, Medi-Cal, Cal-MediConnect	Meet regulatory and accreditation requirements for annual assessment and reporting of selected quality activities.
Credentialing and recredentialing of practitioners and organizational providers	All products (HMO, PPO, Marketplace, Medicare Medi-Cal, Cal-MediConnect)	Meet regulatory and accreditation requirements and assess and monitor the medical qualifications of practitioners and organizational providers in the network.
DMHC/DHCS Medi-Cal Regulatory Audits	Medi-Cal	Meet DMHC/ DHCS medical requirements, as demonstrated through routine and non-routine regulatory audits s as coordinated by compliance
LA Care Oversight Requirements	Medi-Cal	Meet LA Care regulatory requirements, as demonstrated through routine and non-routine regulatory audits as coordinated by compliance.

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 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C)

17) Other Comments

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