California Large Group Annual Aggregate Rate Data Report Form
Version 2, August 31, 2016

(File through SERFF as a PDF or excel. If you enter data on a Word version of this document, convert to PDF before submitting the form. SERFF will not accept Word documents.
Note "SB 546 Large Group Annual Aggregate Rate Data Report" in the SERFF "Filing Description" field)

The aggregate rate information submission form should include the following:

1) Company Name (Health Plan)
2) Rate Activity 12-month ending date
3) Weighted Average Rate Increase, and Number Enrollees subject to rate change
4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month
5) Segment Type
6) Product Type
7) Products Sold with materially different benefits, cost share
8) Factors affecting the base rate
9) Overall Medical Trend
10) Projected Medical Trend
11) Per Member per Month Costs and Rate of Changes over last five years
-submit CA Large Group Historical Data Reporting Spreadsheet (Excel)
12) Changes in Enrollee Cost Sharing
13) Changes in Enrollee Benefits
14) Cost Containment and Quality Improvement Efforts
15) Number of products that incurred excise tax paid by the health plan
16) Other Comments

1) Company Name:

Blue Shield of California Life & Health Insurance Company

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

3) Weighted average annual rate increase (unadjusted)[2]:

- All large group benefit designs: 8.9 %
- Most commonly sold large group benefit design: 8.6 %

Weighted average annual rate increase (adjusted)[3]:

- All large group benefit designs: 11.1 %
- Most commonly sold large group benefit design[4] 10.8 %

[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	21	49%	2,810	0	$503.79	9.3%
February	2	5%	574	0	$358.13	14.3%
March	1	2%	123	0	$468.37	9.4%
April	2	5%	91	0	$629.32	9.4%
May	3	7%	234	0	$614.62	12.3%
June	2	5%	333	0	$499.68	6.4%
July	3	7%	65	0	$393.05	7.3%
August	0	0%	0	0		
September	3	7%	61	0	$724.46	5.8%
October	2	5%	414	0	$538.37	-0.3%
November	1	2%	107	0	$409.47	12.3%
December	3	7%	178	120	$515.72	7.3%
Overall	43	***100%***	4,990	120	$496.36	8.9%

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) PPO is the most commonly sold benefit design.
2) For 2016 projected rate increases, we estimated them based on business pricing decisions and enhanced them with underwriting tracking for best estimated sold rates.

5) Segment type: Including whether the rate is community rated, in whole or in part
See Health and Safety Code section 1385.045(c)(1)(B) and Insurance Code section 10181.45(c)(1)(B)

1	**2**	**3**	**4**	**5**	**6**	**7**
Rating Method	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)	34	79%	2,496	0	$556.78	8.3%
Blended (in part)	6	14%	786	120	$484.07	4.5%
100% Experience Rated	3	7%	1,708	0	$414.62	12.2%
Overall	43	***100%***	4,990	120	$496.36	8.9%

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) 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% community rated. Groups with subscribers 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	81%	82%	28%
EPO	0%	0%	0%
HMO	0%	0%	0%
POS	0%	0%	0%
HDHP	19%	18%	72%
Overall	**100%**	**100%**	**100%**

6) Product Type:

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

1	**2**	**3**	**4**	**5**	**6**	**7**
Product Type	Number of Renewing Groups	Percent of Renewing groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
HMO	0	0%	0	0		
PPO	38	86%	3,119	120	$502.81	8.6%
EPO	0	0%	0	0		
POS	0	0%	0	0		
HDHP	6	14%	1,871	0	$485.21	9.5%
Other (describe)	0	0%	0	0		
Overall	44	***100%***	4,990	120	$496.36	8.9%

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.

Customers can have more than one type of product. Therefore, the total number of renewing groups shown in the above table is larger than the total unique groups.

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		
0.8 to 0.899	0	0		
0.7 to 0.799	0	0		
0.6 to 0.699	0	0		
0.0 to 0.599	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%	
0.8 to 0.899	0	0	0%	
0.7 to 0.799	0	0	0%	
0.6 to 0.699	4	3,239	100%	Active Choice plan – For the first tier professional services, BSC pays the first $750 dollars and the rest will be paid by members until the OOPM. For the second tier hospital services, members pay 20% par/40% non-par coinsurance%
0.0 to 0.599	0	0	0%	
Total	4	3,239	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		
0.8 to 0.899	0	0		
0.7 to 0.799	0	0		
0.6 to 0.699	0	0		
0.0 to 0.599	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		
0.8 to 0.899	0	0		
0.7 to 0.799	0	0		
0.6 to 0.699	0	0		
0.0 to 0.599	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%	
0.8 to 0.899	0	0	0%	
0.7 to 0.799	3	1,871	100%	A calendar year deductible of $1500, 20% IN coinsurance, 50% OON coinsurance and $4500 OOPM
0.6 to 0.699	0	0	0%	
0.0 to 0.599	0	0	0%	
Total	3	1,871	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:

Product	# Standard Plan	Description
PPO	6	The most popular PPO plan is an Active Choice plan. For the first tier professional services, BSC pays the first $750 dollars and the rest will be paid by members until the OOPM. For the second tier hospital services, members pay 20% par/40% non-par coinsurance%
HDHP	1	This HDHP has a calendar year deductible of $1500, 20% IN coinsurance, 40% OON coinsurance and $4500 OOPM

# large groups with standard plans	37
# large groups with standard and custom plans	2
# large groups with custom plans	4

8) Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

See Health and Safety Code section 1385.045(c)(2) and Insurance Code section 10181.45(c)(2)

Factor	Provide actuarial basis, change in factors, and member months during 12-month period.
Geographic Region (describe regions)	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.
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	N/A
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.
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	N/A
Enrollees' cost sharing	N/A
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 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.
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:

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)

6.7%

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]	3.9%
Hospital Outpatient (including ER)	6.4%
Physician/other professional services[9]	5.4%
Prescription Drug[10]	13.3%
Laboratory (other than inpatient) [11]	6.1%
Radiology (other than inpatient)	6.1%
Capitation (professional)	0.0%
Capitation (institutional)	0.0%
Capitation (other)	5.9%
Other (describe) ambulance, DME, orthotics, prosthetics etc.	6.1%

[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

Pricing Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	$7.71M	-1.5%	4.8%	N/A	3.3%
Hospital Outpatient (including ER)	$7.19M	0.9%	4.6%	N/A	5.6%
Physician/other professional services[13]	$4.32M	2.4%	1.8%	N/A	4.3%
Prescription Drug[14]	$5.77M	0.5%	12.4%	N/A	13.0%
Laboratory (other than inpatient)[15]	$0.50M	3.2%	2.6%	N/A	5.8%
Radiology (other than inpatient)	$0.57M	3.2%	2.6%	N/A	5.8%
Capitation (professional)	$6.83M	N/A	N/A	N/A	0.0%
Capitation (institutional)	$2.02M	N/A	N/A	N/A	0.0%
Capitation (other) MHSA	$0.83M	N/A	N/A	N/A	6.4%
Other (describe) ambulance, DME, orthotics, prosthetics etc.	$0.50M	3.2%	2.6%	N/A	5.8%
Overall	$36.24M	0.8%	5.2%	N/A	6.1%

[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, and (iv) Taxes and fees. *Administrative Expenses include general and administrative fees, agent and broker commissions*

Complete CA Large Group Historical Data Spreadsheet - Excel

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

12) Changes in enrollee cost-sharing

Describe any changes in enrollee cost-sharing over the prior year associated with the submitted rate information. Describe these changes at the plan level (see definition of "plan" in the document "SB546-Additional Information.") Please include both of the following:

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

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

We withdrew some Rx plans with no membership in 2016. Deductible and OOPM changes were also made to an existing PSP standard plan due to HHS OOPM mandate and AB 1305. The aggregate medical CoHC impact on all CDI regulated plans is 0.27%.

For all plans, the out of network limits for dialysis services now match the out of network facility limits. The CoHC impact is immaterial.

(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 2016 aggregate actuarial value drops by 13% compared to the 2015 aggregate actuarial value mostly due to changes in membership mix. 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. Describe these changes at the product level (see definition of "product" in the document "SB546-Additional Information.") Please provide this information for each of the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). ***See Health and Safety Code section 1385.045(c) (3) (E) and Insurance Code section 10181.45(c)(3)(E)***

We added acupuncture benefits to our Active Choice plans to match all other standard PPO plan designs.

14) Cost containment and quality improvement efforts

Describe any cost containment and quality improvement efforts since prior year for the same category of health benefit plan (for this purpose, "category of health benefit plan" means product type, such as HMO, PPO, EPO, etc.). To the extent possible, describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. Companies are encouraged to structure their response with reference to the cost containment and quality improvement components of "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract:"

1.01 Coordination and Cooperation
1.02 Ensuring Networks are Based on Value
1.03 Demonstrating Action on High Cost Providers
1.04 Demonstrating Action on High Cost Pharmaceuticals
1.05 Quality Improvement Strategy
1.06 Participation in Collaborative Quality Initiatives
1.07 Data Exchange with Providers
1.08 Data Aggregation across Health Plans

See Health and Safety Code section 1385.045(c)(3)(F) and Insurance Code section 10181.45(c)(3)(F), see also California Health Benefit Exchange, April 7, 2016 Board Meeting materials: http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

Response for item 14, Cost containment and quality improvement efforts:

The Plan engages in a wide variety of cost containment and quality improvement efforts across all categories of health insurance policies. These include:
• Provider Quality Reporting – Quality reporting for hospitals and physicians
• Early Detection of Disease – Clinical programs aimed at increasing early detection of disease through member outreach and screenings
• 24/7 Nurse Support
• Case Management – Patient centered interventions including frequent nurse home visits, facility visits, regular phone calls, and coordination with providers and caregivers
• Disease Management – Patient centered interventions for members with chronic conditions
• Medication Compliance – Support for medication compliance and quality programs to promote the use of evidence based clinical guidelines
• Transplant Case Management
• Post Discharge Planning – Includes inpatient post-discharge member contact for medication reconciliation and compliance
• Pharmacy Clinical Review – Prospective review of coverage requests for quality and safety reasons
• Rx Call Center – Support for members and pharmacies
• Member Communication and Notification – Communication to members to promote safety and reduce medical errors
• Medical Review for Best Clinical Practices – Medical directors working with delegated IPA's and medical groups to establish best clinical practices
• Center for Health and Wellness – Management and oversight of wellness programs (e.g. tobacco cessation)
• Online Health Content
• Health Reminder Mailings – Health prevention reminders (immunizations, screenings, etc.)
• Wellcheck Worksite Visits – biometric screenings designed to educate members on health risks and improve outcomes
• Quality Analytics – Monitoring, measuring, and reporting clinical effectiveness
• Health Business Intelligence Technology – Provides analytic support to employer groups in managing healthcare for their employees
• Health Business Applications – Support for health and wellness education content
• Nurse Case Management Tool – Nurse monitoring of severity and intensity of services and care provided to direct clinically-appropriate care
• Online Member Tools – Searchable database of drug formularies and an online Ask the Pharmacist tool to promote patient safety and the use of evidence based medicine

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.