

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:

Kaiser Permanente 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: -2.9 %
- Most commonly sold large group benefit design: -10.0 %

Weighted average annual rate increase (adjusted)³:

- All large group benefit designs: 2.4 %
- Most commonly sold large group benefit design⁴ 3.7 %

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
<u>Month rate change effective</u>	Number of Renewing Groups	Percent of Renewing groups <i>(number for each month in column 2 divided by overall total)</i>	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	88	26.7%	756	7	\$849.73	0.7%
February	14	4.2%	239	0	\$892.98	4.3%
March	19	5.8%	122	0	\$810.46	6.7%
April	15	4.5%	117	0	\$990.56	3.5%
May	6	1.8%	36	0	\$851.21	16.9%
June	23	7.0%	4,245	0	\$370.87	-9.2%
July	38	11.5%	272	0	\$971.77	2.3%
August	11	3.3%	204	0	\$783.88	-3.3%
September	29	8.8%	260	0	\$886.87	0.7%
October	14	4.2%	68	1	\$1,045.65	1.4%
November	21	6.4%	294	0	\$916.19	-0.1%
December	52	15.8%	317	3	\$898.65	4.8%
Overall	330	100.0%	6,930	11	\$571.30	-2.9%

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

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 benefit design is EPO (based on number of members).
 (2) The 2016 rates for groups that are not yet quoted are estimated using KPIC's standard rating methodology.

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 implemented (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.

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 <i>(number for each month in column 2 divided by overall total)</i>	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)	211	63.9%	1,923	8	\$915.43	0.6%
Blended (in part)	109	33.0%	796	3	\$804.12	5.7%
Risk Adjusted/Experience Rated	15	4.5%	173	0	\$864.84	5.5%
Risk Adjusted/Community	94	28.5%	623	3	\$787.35	5.8%
100% Experience Rated	10	3.0%	4,211	0	\$369.32	-9.4%
Overall	330	100%	6,930	11	\$571.30	-2.9%

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.

All PPO and OOA groups are 100% community rated. All EPO groups are 100% experienced rated. For groups whose utilization is not fully credible, we include the use of pharmacy-based risk scores. We included two sub-segments under the Blended (in part) segment – Risk Adjusted/Experience Rated and Risk Adjusted/Community Rated.

Distribution of Covered Lives

Rating Method	Product			
	PPO	EPO	POS	OOA
100% Community Rated (in whole)	25.0%	0.0%	2.6%	0.3%
Blended (in part)	0.0%	0.0%	11.5%	0.0%
Risk-Adjusted/Experience Rated	0.0%	0.0%	2.5%	0.0%
Risk-Adjusted/Community Rated	0.0%	0.0%	9.0%	0.0%
100% Experience Rated	0.0%	59.1%	1.6%	0.0%
Overall	25.0%	59.1%	15.7%	0.3%

6) Product Type:

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

1	2	3	4	5	6	7
Product Type	Number of Renewing Groups	Percent of Renewing groups <i>(number for each month in column 2 divided by overall total)</i>	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
HMO	0	0.0%	0	0	N/A	N/A
PPO	185	56.1%	1,727	7	\$928.17	0.3%
EPO	2	0.6%	4,099	0	\$357.43	-10.0%
POS	139	42.1%	1,085	4	\$802.86	5.0%
HDHP	0	0.0%	0	0	N/A	N/A
Other (describe)	4	1.2%	19	0	\$871.79	-3.3%
Overall	330	100%	6,930	11	\$571.30	-2.9%

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

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

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

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

HMO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	0	0	0%	
0.8 to 0.899	0	0	0%	
0.7 to 0.799	0	0	0%	
0.6 to 0.699	0	0	0%	
0.0 to 0.599	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	9	130	7.4%	\$250/\$750 DED; \$15/30% OV; 10% IP; \$15/\$40 RX
0.8 to 0.899	44	1,290	73.6%	\$1000/\$2000 DED; \$25/50% OV; 30% IP; \$15/\$40 RX
0.7 to 0.799	11	254	14.5%	\$1500/\$3000 DED; \$40/50% OV; 30% IP; \$15/\$40 RX
0.6 to 0.699	2	79	4.5%	\$2600 DED; \$20/50% OV; 20% IP; \$15/\$40 RX
0.0 to 0.599	0	0	0.0%	
Total	66	1,753	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	2	4,099	100.0%	\$1500 DED; 20% OV; 20% IP
Total	2	4,099	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	36	1,009	92.7%	\$500/\$1000 DED; \$20/20%/40% OV; 20% IP; \$20/\$40 RX
0.8 to 0.899	5	80	7.3%	\$1500/\$3000 DED; \$35/30%/50% OV; 30% IP; \$20/\$40 RX
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	41	1,089	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	0	0	0%	
0.6 to 0.699	0	0	0%	
0.0 to 0.599	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:

All of the plans are custom plans.
There are 330 groups with custom plans and no group with standard plans.

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

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

Factor	Provide actuarial basis, change in factors, and member months during 12-month period.
Geographic Region (describe regions)	<p>POS Rating: The geographic location where members reside impacts group premiums. Northern California and Southern California have completely separate rating models due to different market and cost structure. Northern California is divided into three sub-regions, each with a different geographic factor. These geographic adjustments apply only to manually rated groups. The factors did not change in 2016.</p> <p>PPO Rating: Rates are area-adjusted and area factors are based on zip code.</p>
Age, including age rating factors (describe definition, such as age bands)	Health care costs depend on the member's age and gender due to variations in utilization and intensity pattern. Our age / gender factor slope is based on our book of business experience. The factors did not change in 2016.
Occupation	N/A
Industry	Based on a study of our claims experience, certain industries incur higher health care cost than book of business average, and therefore an adjustment is applied. The factors did not change in 2016.
Health Status Factors, including but not limited to experience and utilization	Our base rates reflect the claims experience of the underlying population.
Employee, and employee and dependents, ⁷ including a description of the family composition used in each premium tier	For existing groups, our rating model produces rates on a per member per month (pmpm) basis. Within broad

⁷ i.e. premium tier ratios

	limits, the employer is free to choose the tier ratios used to convert pmpm rates to tiered rates.
Enrollees' share of premiums	Rates may be adjusted for employer contribution.
Enrollees' cost sharing	We use benefit adjustment factors to reflect the cost sharing provisions of the employee benefit plan.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Employers may buy additional benefits for an additional premium.
Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated	<p>POS: Generally groups averaging 1,000+ members during the experience period are 100% experience rated. Smaller groups receive some combination of experience rating, risk rating, and community rating. The group size thresholds in the rating method did not change in 2016.</p> <p>PPO: All groups are community-rated.</p>
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	Early retirees and COBRA members are expected to incur higher health care costs, and thus adjustments are included in rating. These adjustments apply to all members of the group. The factors did not change in 2016.

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

Overall Medical Allowed Trend Factor

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

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

5.4%

Medical Allowed Trend Factor by Aggregate Benefit Category

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

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

Hospital Inpatient ⁸	4.9%
Hospital Outpatient (including ER)	See Hospital Inpatient above.
Physician/other professional services ⁹	See Hospital Inpatient above.
Prescription Drug ¹⁰	9.9%
Laboratory (other than inpatient) ¹¹	See Hospital Inpatient above.
Radiology (other than inpatient)	See Hospital Inpatient above.
Capitation (professional)	Reflected in Physician/other professional services above

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.

Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	See Hospital Inpatient above (Ambulance, Home Health, SNF, DME, etc.)

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	5.2%				
Hospital Outpatient (including ER)	See Hospital Inpatient above.				
Physician/other professional services ¹³	See Hospital Inpatient above.				
Prescription Drug ¹⁴	7.0%				
Laboratory (other than inpatient) ¹⁵	See Hospital Inpatient above.				
Radiology (other than inpatient)	See Hospital Inpatient above.				
Capitation (professional)	Reflected in Physician/other professional services above.				
Capitation (institutional)	N/A				
Capitation (other)	N/A				
Other (describe)	See Hospital Inpatient above (Ambulance, 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.

	SNF, DME, etc.)				
Overall	5.4%				

- 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).

POS Tier 1

(1) Pediatric Vision: End-of-Month of 19th Birthday

- Effective 1/1/2016 vision eye exams/hardware are federally mandated to be covered until the end of the month that the member turns age 19.
 - A pediatric member is defined as a member from birth through the end of the month of his or her 19th birthday. For example, if you turn 19 on June 25, you will be an adult member starting July 1.
 - An adult member is defined as a member who is 19 years old and not a pediatric member. For example, If you turn 19 on June 25, you will be an adult member starting July 1.

(2) Mental Health Parity and Addiction Equity Act

- In compliance with the federal Mental Health Parity and Addiction Equity Act, and at the direction of regulators, many health plans, including Kaiser Permanente, have revised coverage and cost sharing for mental health and chemical dependency services to ensure compliance with applicable laws and regulations.
 - Expanded coverage for Residential Treatment
 - Some services were revised so they are no longer subject to the deductible.
 - Some cost share types were corrected, but the member out of pocket at the point of

service has not increased.

POS, PPO, and OOA Tier 2 and 3

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.

If your Kaiser Permanente plan was in place after the Affordable Care Act (“ACA”) was signed into law on or after March 23, 2010, it’s considered a “non-grandfathered” plan.

Large Group Preferred Provider (PPO) NGF Plans, including HDHP plans with HSA option I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Specialty Prescription Drug Benefit Category has been added. (The definition of specialty prescription drugs means high-cost drugs that are listed on KPIC’s specialty drug list.)

The cost share and prescription maximum has been changed as follows:

- a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$200 per prescription; Applies to PPO NGF Plans Only, not including metal plans.*
- b. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 20% coinsurance up to a maximum of \$150 per prescription: Applies to PPO NGF Metal Plans Only.*

V. Orally administered anti-cancer drugs plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. The maximum copay or coinsurance charged for oral anti-cancer drugs has been reduced from \$200 to \$150. Applies to PPO NGF Metal Plans Only.

Here are the plan IDs for the plans that are affected by the above changes:

5694, 5695, 5696, 5697, 5698, 5699, 5700, 5701, 5702, 5703, 5704, 5705, 5706, 5707, 5708, 5709, 5710, 5711, 5712, 5713, 5714, 5715, 5716, 5717, 5718, 5719, 5721, 5722, 5724, 5725, 5726, 6144, 6754, 6755, 6766, 6767, 6810, 6811, 6812, 6813, 7197, 7206, 7493, 7496, 7538, 7539, 7563, 7565, 7707, 7708, 7743, 7760, 7790, 7810, 7811, 8102, 8103, 8312, 8342, 8721, 8722, 8731, 8732, 8769, 8770, 8925, 8926, 8947, 8948, 9142, 9432, 9433

Large Group Point of Service (POS)* NGF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Specialty Prescription Drug Benefit Category has been added. (The definition of specialty prescription drugs means high-cost drugs that are listed on KPIC's specialty drug list.)

The cost share and prescription maximum has been changed as follows:

- a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$300 per prescription.*
- b. Specialty Drug Non-Formulary Benefits received at the Participating Pharmacy level will require a 30% coinsurance.*

Here are the plan IDs for the plans that are affected by the above changes:

5669, 5670, 5671, 5672, 5673, 5674, 5675, 5676, 5677, 5678, 5679, 5680, 5681, 5682, 5683, 5684, 5685, 5686, 5687, 5688, 5689, 5690, 5691, 5692, 6013, 6014, 6117, 7196, 7205, 7374, 7395, 7446, 7447, 7471, 7472, 7793, 7796, 8719, 8720, 9030, 9038, 9436, 9437, 9438, 9439, 9460, 9461

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

Large Group Out-of-Area Indemnity (OOA) NGF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible have been expanded or updated to include the following:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Specialty Prescription Drug Benefits have replaced the Self-Administered Injectable Medications category. (The definition of specialty prescription drugs has been expanded to mean high-cost drugs that are listed on KPIC's specialty drug list.)

The cost share and prescription maximum has been changed as follows:

a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$200 per prescription.

Here are the plan IDs for the plans that are affected by the above changes:

5729, 5731, 5732, 5733, 5734, 5735, 5736, 5737, 5738

Grandfathered (GF) Plans

If your Kaiser Permanente plan was in place before ACA was signed into law on March 23, 2010, it's considered a "grandfathered" plan. **Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2016.**

Large Group Preferred Provider (PPO) GF Plans

I. Coverage of Preventive Services in accordance with ACA requirements.

*a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following**:*

i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.

ii. Aspirin in the prevention of preeclampsia in pregnant women.

iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

***This change applies to large groups who **elected** to include ACA preventive care benefits under their grandfathered plan.*

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Contraceptive coverage has been expanded due to a new California law to include the

following:

a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

Here are the plan IDs for the plans that are affected by the above changes:
1933, 1941, 1943, 1945, 2047, 2062, 2238, 3002, 3003, 3110, 3233, 3235, 5063, 5066, 5068, 5071, 5072, 5074, 5075, 5079, 5084, 5085, 5086, 5087, 5089, 5090, 5091, 5094

Large Group Point of Service (POS)* GF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

*a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following**:*

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

***This change applies to large groups who **elected** to include ACA preventive care benefits under their grandfathered plan.*

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Contraceptive coverage has been expanded due to a new California law to include the following:

a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

Here are the plan IDs for the plans that are affected by the above changes:
1871, 1872, 2057, 2694, 5023, 5024, 5025, 5026, 5027, 5029, 5030, 5032, 5035, 5036, 5039, 5043, 5049, 5051, 5054, 5056, 5059, 5426, 6173

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

Large Group Out-of-Area Indemnity (OOA) GF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

*a. The preventive care services that are covered at no charge and not subject to any Deductible have been expanded or updated to include the following**:*

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-*

approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.
ii. Aspirin in the prevention of preeclampsia in pregnant women.
iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

****This change applies to large groups who elected to include ACA preventive care benefits under their grandfathered plan.**

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

IV. Contraceptive coverage has been expanded due to a new California law to include the following:

a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

Here are the plan IDs for the plans that are affected by the above changes:

1958, 2240, 3234, 5107, 5108, 5117

There are no other changes in enrollee cost sharing over the prior year at the plan level.

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

The weighted average actuarial value decreased by 5.1% from 76.2% in 2015 to 71.1% in 2016.

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)*

POS Tier 1

(1) Pediatric Vision: End-of-Month of 19th Birthday

- Effective 1/1/2016 vision eye exams/hardware are federally mandated to be covered until the end of the month that the member turns age 19.
 - A pediatric member is defined as a member from birth through the end of the month of his or her 19th birthday. For example, if you turn 19 on June 25, you will be an adult member starting July 1.
 - An adult member is defined as a member who is 19 years old and not a pediatric member. For example, If you turn 19 on June 25, you will be an adult member starting July 1.
- This change has little to no impact on aggregate claims cost.

(2) Mental Health Parity and Addiction Equity Act

- In compliance with the federal Mental Health Parity and Addiction Equity Act, and at the direction of regulators, many health plans, including Kaiser Permanente, have revised coverage and cost sharing for mental health and chemical dependency services to ensure compliance with applicable laws and regulations.
 - Expanded coverage for Residential Treatment
 - Some services were revised so they are no longer subject to the deductible.
 - Some cost share types were corrected, but the member out of pocket at the point of service has not increased.
- The impact of this change is approximately an increase in 0.5% of aggregate claims cost.

POS, PPO, and OOA Tier 2 and 3

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.

If your Kaiser Permanente plan was in place after the Affordable Care Act (“ACA”) was signed into law on or after March 23, 2010, it’s considered a “non-grandfathered” plan.

Large Group Preferred Provider (PPO) NGF Plans, including HDHP plans with HSA option

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Specialty Prescription Drug Benefit Category has been added. (The definition of specialty prescription drugs means high-cost drugs that are listed on KPIC's specialty drug list.)

The cost share and prescription maximum has been changed as follows:

a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$200 per prescription; Applies to PPO NGF Plans Only, not including metal plans.

b. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 20% coinsurance up to a maximum of \$150 per prescription: Applies to PPO NGF Metal Plans Only.

The impact of this change is approximately an increase in 0.3% of aggregate claims cost.

V. Orally administered anti-cancer drugs plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. The maximum copay or coinsurance charged for oral anti-cancer drugs has been reduced from \$200 to \$150. Applies to PPO NGF Metal Plans Only.

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

Large Group Point of Service (POS)* NGF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.*
- ii. Aspirin in the prevention of preeclampsia in pregnant women.*
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.*

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Specialty Prescription Drug Benefit Category has been added. (The definition of specialty prescription drugs means high-cost drugs that are listed on KPIC's specialty drug list.)

The cost share and prescription maximum has been changed as follows:

a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$300 per prescription.

b. Specialty Drug Non-Formulary Benefits received at the Participating Pharmacy level will require a 30% coinsurance.

The impact of this change is approximately an increase in 0.3% of aggregate claims cost.

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

Large Group Out-of-Area Indemnity (OOA) NGF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible have been expanded or updated to include the following:

i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.

ii. Aspirin in the prevention of preeclampsia in pregnant women.

iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Specialty Prescription Drug Benefits have replaced the Self-Administered Injectable Medications category. (The definition of specialty prescription drugs has been expanded to mean high-cost drugs that are listed on KPIC’s specialty drug list.)

The cost share and prescription maximum has been changed as follows:

a. Specialty Drug Benefits received at the Participating Pharmacy level will now require a 30% coinsurance up to a maximum of \$200 per prescription.

The impact of this change is approximately an increase in 0.3% of aggregate claims cost.

Grandfathered (GF) Plans

If your Kaiser Permanente plan was in place before ACA was signed into law on March 23, 2010, it’s considered a “grandfathered” plan. **Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2016.**

Large Group Preferred Provider (PPO) GF Plans

I. Coverage of Preventive Services in accordance with ACA requirements.

*a. The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider level have been expanded or updated to include the following**:*

i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.

ii. Aspirin in the prevention of preeclampsia in pregnant women.

iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

***This change applies to large groups who **elected** to include ACA preventive care benefits under their grandfathered plan.*

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Contraceptive coverage has been expanded due to a new California law to include the following:

a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

The impact of this change is approximately an increase in 0.2% of aggregate claims cost.

Large Group Point of Service (POS)* GF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

a. The preventive care services that are covered at no charge and not subject to any Deductible

when received at the Participating Provider level have been expanded or updated to include the following**:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.
- ii. Aspirin in the prevention of preeclampsia in pregnant women.
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

**This change applies to large groups who *elected* to include ACA preventive care benefits under their grandfathered plan.

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

- a. Hospice Care Services no longer have a visit limitation of 180 days.

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

- a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Contraceptive coverage has been expanded due to a new California law to include the following:

- a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

The impact of this change is approximately an increase in 0.2% of aggregate claims cost.

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

Large Group Out-of-Area Indemnity (OOA) GF Plans only

I. Coverage of Preventive Services in accordance with ACA requirements.

- a. The preventive care services that are covered at no charge and not subject to any Deductible have been expanded or updated to include the following**:

- i. Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.
- ii. Aspirin in the prevention of preeclampsia in pregnant women.
- iii. Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.

**This change applies to large groups who elected to include ACA preventive care benefits under their grandfathered plan.

These changes have little to no impact on aggregate claims cost.

II. Hospice Care Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Hospice Care Services no longer have a visit limitation of 180 days.

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

III. Rehabilitation, Multidisciplinary, and Habilitative Outpatient Therapy Services plan design changes listed below have been made for plan design simplification and/or to maintain affordability.

a. Rehabilitative, multidisciplinary, and habilitative outpatient therapy services no longer have visit limitations of 60 days.

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

IV. Contraceptive coverage has been expanded due to a new California law to include the following:

a. Coverage for contraceptives now includes all FDA-approved contraceptive drugs and devices for women, including over the counter contraceptives, when prescribed by a licensed health care professional authorized to prescribe drugs and obtained at a Participating Pharmacy.

The impact of this change is approximately an increase in 0.2% of aggregate claims cost.

There are no other changes in enrollee cost sharing over the prior year at the plan level.

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](http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract%20Attachment%207%20Individual%204-6-2016%20CLEAN.pdf)

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

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract is a new (2017) exhibit that has not yet been filed. Kaiser Permanente Insurance Company is in the process of developing the information to complete this exhibit. However, it is not yet available. Consequently, we are filing the information below on cost containment and quality improvement efforts in a format similar to what has been included in our Small Group filings. For next year's 2017 filing, we anticipate being able to switch to the recommended format of Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract.

KPIC had no new health care cost containment and quality improvement efforts in 2016. Provided below is a high-level description of cost containment initiatives that relate to the HMO in-network tier of the POS product and the EPO product, both of which use the Kaiser Permanente integrated delivery system. (The HMO in-Network portion of the Point-of-Service (POS) Plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PPO and Indemnity tiers of the POS Plan. KPIC is a subsidiary of KFHP.)

Kaiser Permanente is recognized nationally by the media, business coalitions, and health care advocacy groups as a leader in prevention, best-in-class care, and innovation. Over the past several years, our commitment to quality has earned Kaiser Permanente top rankings in independent, third-party report cards for member satisfaction, quality of care, chronic disease management, and preventive care.

In response to SB 546 Section 1385.045(c)(3)(E), the Plan will provide a high-level description of certain cost containment initiatives. These are program-wide, systemic initiatives, and aren't specific to the individual plans contained in this filing.

In a comparison of all health plans in California, done by the national consulting firm Aon Hewitt, we outperformed other plans in clinical quality for the sixth year in a row. Kaiser Permanente plans scored better than the all-plan average in both Northern California and Southern California. These industry comparisons come directly from the most recent Aon Hewitt survey (2014, using 2013 data).

This integrated care delivery model is made even more effective by our industry-leading electronic health record system, Kaiser Permanente HealthConnect[®]. Kaiser Permanente HealthConnect[®] links every authorized Plan physician and caregiver to secure, real-time member health information, including prescriptions, lab results, and specialist reports. This real-time connectivity makes care delivery safer and more efficient:

- Electronic prescriptions are sent directly to our pharmacies, eliminating handwriting mistakes.
- Patient safety is enhanced by built-in alerts that indicate potentially dangerous medication

interactions and patient allergies when prescriptions are ordered.

- When prescriptions are ordered, built-in alerts enhance patient safety by indicating potentially dangerous medication interactions and patient allergies.
- Electronic prescription orders can't be duplicated or altered, and are easily monitored to track adherence.
- Fewer medication errors in hospital-bar code scanning has reduced medication errors by 57 percent.

Other examples of how Kaiser Permanente's unique integrated system helps reduce costs caused by some of the major drivers of health care expenses:

- The Centers for Medicare & Medicaid Services (CMS) gave Kaiser Permanente's Northern and Southern California region 5 out of 5 stars in its 2014 Medicare star quality ratings. The ratings are based on performance in more than 50 measures, across a number of categories, including staying healthy, managing chronic conditions, health plan responsiveness and care, member experience with drug plan, and customer service. In the 2014 ratings, only 11 Medicare plans in the country earned 5 stars for the overall rating. Five of those plans were Kaiser Permanente Medicare plans, representing more than 80 percent of the 1.5 million beneficiaries enrolled in Medicare 5-star plans.ⁱ

- Fourteen Kaiser Permanente medical facilities have been nationally recognized as "Top Performers on Key Quality Measures" in The Joint Commission's "Improving America's Hospitals" annual report for 2014. In order to earn this "Top Performers" recognition, facilities must have met three 95 percent performance thresholds on 2012 accountability measure data.

- In May 2015, *U.S. News & World Report* recognized 22 Kaiser Permanente hospitals (17 hospitals in California) in its "Best Hospitals" rankings, which honor high performance in key medical specialties. Nearly 4,600 hospitals nationwide, in metropolitan areas with at least 1 million people, were considered.

- Kaiser Permanente health plans were ranked among the nation's best for the fourth year in a row in the National Committee for Quality Assurance (NCQA) Health Insurance Plan Rankings 2014–2015. Out of 617 plans reviewed by the National Committee for Quality Assurance, we had the top commercial plans in the state. And our California plans ranked 7th and 8th in the nation. All seven Kaiser Permanente regions are in the top 5 percent of all ranked commercial plans.

- Out of 507 Medicare plans reviewed by the National Committee for Quality Assurance, Kaiser Permanente's California plans were the top two Medicare plans in the nation — for the second consecutive year. The rankings are based on combined scores for health plans in HEDISP® P(Healthcare Effectiveness Data and Information Set), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and NCQA accreditation standards scores. All seven Kaiser Permanente regions are in the top 2 percent of all ranked Medicare plans.

- In 2014, Kaiser Permanente led California with the highest rates in 42 HEDIS® effectiveness-of-care measures — the most of any health plan. The closest competitor led in only three.ⁱⁱ Northern California was first in the nation for controlling high blood pressure, and Southern California led the nation in the use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease.

- In the 2013 eValue8 study, Kaiser Permanente Northern California was the highest rated HMO plan overall — setting the national benchmark for 2013; and Kaiser Permanente Southern California was ranked as the next top performing plan among national HMO plans. Both Kaiser

Permanente Southern and Northern California set the benchmark scores for chronic disease management; Northern California was the benchmark plan for Behavioral Health Management and Southern California ranked second.

- For a record-setting seventh year in a row, Kaiser Permanente is the only plan to achieve perfect scores in the California Office of the Patient Advocate's Health Care Quality Report Card. In the 2014–15 edition of the HMO quality report card, Kaiser Permanente Northern and Southern California scored a perfect four stars for clinical quality. That's a benchmark no other health plan in the state has been able to reach.
- If members are identified as being at risk for developing a health condition, they're automatically enrolled in Complete Care, our award-winning disease management program, without an opt-in or additional cost to members or employers.
- For the ninth consecutive year, the nonprofit Integrated Healthcare Association (IHA) recognized the Southern California Permanente Medical Group (SCPMG) as one of the top-performing physician organizations in California. SCPMG has 6,030 partner physicians throughout the region and provides medical care to nearly 3.7 million Kaiser Permanente members in 13 geographic service areas, from Kern to San Diego County. Only 39 of the nearly 200 physician groups evaluated achieved the highest overall benchmark for quality, based on the IHA statewide program measures.
- Over 80 percent of the California hospitals certified by HIMSS as Stage 7 for electronic medical record (EMR) adoption — the most advanced level possible — are Kaiser Permanente medical centers. HIMSS, a nonprofit organization dedicated to improving health information technology, awards Stage 7 certification to hospitals that demonstrate superior use of health IT systems tied to better performance, quality, and safety.
- Kaiser Permanente's California hospitals were named on Hospitals & Health Networks magazine's Health Care's Most Wired 2014 Survey list (July 2014), recognizing the health care organization's use of IT to improve all aspects of its operations, ultimately improving care and value for members. This is the second consecutive year Kaiser Permanente has been on the list, which measures technology integration across the health care spectrum.

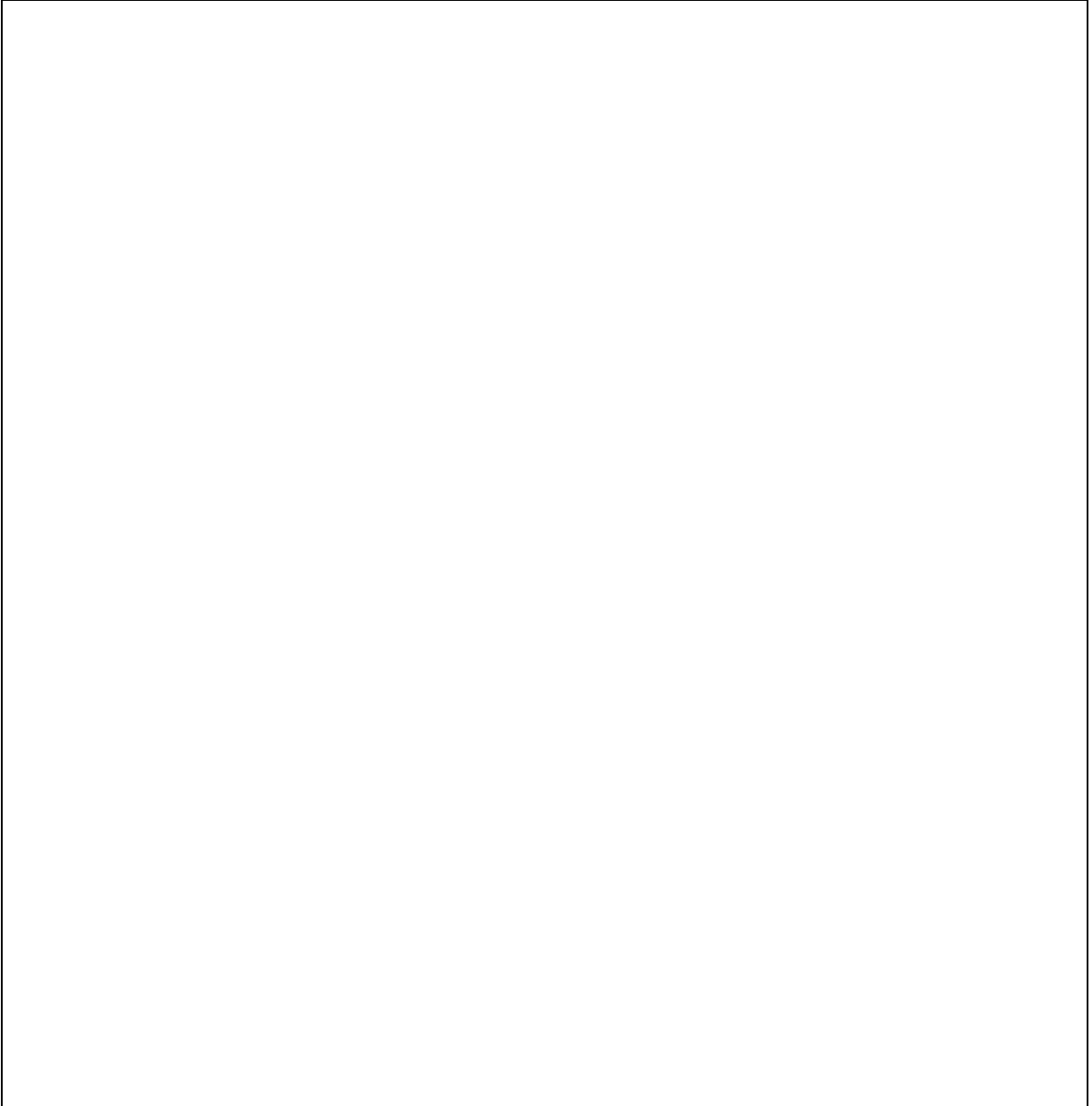
15) Excise tax incurred by the health plan

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)*

No excise tax is paid in the reporting year.

16) Other Comments

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

A large, empty rectangular box with a thin black border, intended for providing additional comments on factors that affect rates and the weighted average rate changes included in the filing.