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:

Kaiser Permanente Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year _2019_.[1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs _5.2_ %
   - Most commonly sold large group benefit design _7.4_ %

   Weighted average annual rate increase (adjusted)[3]

[1] Provide information for January 1-December 31 of the reporting year.
[2] Average percent increase means the weighted average of the annual rate increases that were implemented (actual or a reasonable approximation when actual information is not available). The average shall be weighted by the number of enrollees/covered lives.
[3] "Adjusted" means normalized for aggregate changes in benefits, cost sharing, provider network, geographic rating area, and average age.

- All large group benefit designs _6.9_ %
- Most commonly sold large group benefit design[4] _9.7_ %

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	77	34%	607	0	$984.30	3.0%
February	10	4%	309	0	$896.28	-1.9%
March	6	3%	38	0	$838.17	10.9%
April	11	5%	34	0	$1,052.82	4.0%
May	9	4%	60	0	$744.82	1.7%
June	17	8%	3,306	0	$423.24	7.1%
July	27	12%	141	0	$1,117.49	4.5%
August	11	5%	113	0	$1,004.78	8.1%
September	21	9%	207	0	$1,129.65	6.0%
October	9	4%	41	0	$1,269.03	2.4%
November	10	4%	132	0	$1,136.20	9.5%
December	17	8%	67	0	$1,087.45	7.2%
Overall	**225**	**100%**	**5,055**	**0**	**$626.27**	**5.2%**

[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) The most commonly sold benefit design is EPO (based on number of members).
(2) The 2019 rates for groups that are not yet quoted are estimated using KPIC's standard rating methodology.

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)	185	82%	1,541	0	$1,034.39	3.5%
Blended (in part)	34	15%	256	0	$852.80	4.7%
100% Experience Rated	6	3%	3,258	0	$415.43	7.4%
Overall	**225**	**100%**	**5,055**	**0**	**$626.27**	**5.2%**

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.

POS/EPO - Renewal rates for groups with more than 1,000 members is 100% experienced rated. For groups with less than 1,000 members - that is, groups whose utilization is not fully credible, we use a blend of experience and community rating. For groups with less than 300 members it is 100% community rating.

PPO/OOA - All groups are community-rated.

Distribution of Covered Lives	**Product**				
Rating Method	PPO	EPO	POS	OOA	**Total**
100% Community Rated (in whole)	23%	0%	8%	0%	**30%**
Blended (in part)	0%	0%	5%	0%	**5%**
100% Experience Rated	0%	64%	1%	0%	**64%**
Overall	**23%**	**64%**	**14%**	**0%**	**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 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	N/A	N/A
PPO	121	54%	1,138	0	$1,093.41	3.5%
EPO	2	1%	3,227	0	$411.77	7.4%
POS	100	44%	688	0	$858.18	4.1%
HDHP	0	0%	0	0	N/A	N/A
Other (describe)	2	1%	2	0	$1,141.88	5.9%
Overall	**225**	**100%**	**5,055**	**0**	**$626.27**	**5.2%**

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.

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%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**0**	**0**	**0%**	**N/A**

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	4	76	7%	$250/$750 DED; $15/30% OV; 10% IP; $15/$40 RX
0.8 to 0.899	25	853	75%	$500/$1000 DED; $25/30% OV; 10% IP; $15/$40 RX
0.7 to 0.799	7	193	17%	$1500/$3000 DED; $40/50% OV; 30% IP; $15/$40 RX
0.6 to 0.699	3	16	1%	$2700 DED; $20/50% OV; 20% IP; $15/40RX
0.0 to 0.599	0	0	0%	N/A
Total	**39**	**1,138**	**100%**	**N/A**

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%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	2	3,227	100%	$1700 DED; 20% OV; 20% IP
0.0 to 0.599	0	0	0%	N/A
Total	**2**	**3,227**	**100%**	**N/A**

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	28	620	90%	$500/$1000 DED; $20/20%/40% OV; 20%IP; $20/$40 RX
0.8 to 0.899	6	68	10%	$1500/$3000 DED; $35/30%/50% OV; 30% IP; $20/$40 RX
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**34**	**688**	**100%**	**N/A**

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%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**0**	**0**	**100%**	**N/A**

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	2	2	100%	500/$1000 DED; $20/20% OV; 20% IP
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**2**	**2**	**100%**	**N/A**

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:

(1) All of the plans are custom plans.
(2) There are 225 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)	POS/EPO - 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 the manual rating methodology. The factors did not change in 2019. PPO/OOA - Rates are area-adjusted and area factors are based on zip code. The factors did not change in 2019.
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 2019.
Occupation	N/A
Industry	We use industry factors to reflect the health care cost differentials attributed to the industry classification. The factors did not change in 2019.
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,[1] 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 limits, the employer is free to choose the tier ratios used to convert pmpm rates to tiered rates.

[7] i.e. premium tier ratios

Enrollees' share of premiums	Rates may be adjusted for employer contribution.
Enrollees' cost sharing, including cost sharing for prescription drugs	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	POS/EPO - Generally groups averaging 1,000+ members during the experience period are 100% experience rated. Smaller groups receive a combination of experience rating and community rating. PPO/OOA - All groups are community-rated.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	POS/EPO - Early retirees and COBRA members are expected to incur higher health care costs, and thus adjustments are included in rating. These adjustments apply only to the manual rating methodology and apply to all members of the group. The COBRA factor increased and the early retiree factor decreased in 2019. PPO/OOA – The adjustment for Early retirees and COBRA status does not apply.

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)

4.4%

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[2]	4.4%
Hospital Outpatient (including ER)	4.4%
Physician/other professional services[3]	4.4%
Prescription Drug[4]	5.0%
Laboratory (other than inpatient) [5]	4.4%
Radiology (other than inpatient)	4.4%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	4.4% (Ambulance, Home Health, SNF, DME, etc.)

[2] Measured as inpatient days, not by number of inpatient admissions.
[3] Measured as visits.
[4] Per prescription.
[5] 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.

N/A

10) Projected medical trend:

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

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

Projected Medical Allowed Trend by Aggregate Benefit Category

		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]	$135	0.0%	4.6%	0.0%	4.6%
Hospital Outpatient (including ER)	$127	0.0%	4.6%	0.0%	4.6%
Physician/other professional services[13]	$118	0.0%	4.6%	0.0%	4.6%
Prescription Drug[14]	$101	0.0%	6.0%	0.0%	6.0%
Laboratory (other than inpatient)[15]	$11	0.0%	4.6%	0.0%	4.6%
Radiology (other than inpatient)	$13	0.0%	4.6%	0.0%	4.6%
Capitation (professional)	$0	N/A	N/A	N/A	N/A
Capitation (institutional)	$0	N/A	N/A	N/A	N/A
Capitation (other)	$0	N/A	N/A	N/A	N/A
Other (describe)	$59	0.0%	4.6%	0.0%	4.6%
Overall	**$564**	**0.0%**	**4.8%**	**0.0%**	**4.8%**

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

KPIC does not pay capitation.

[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).

Point of Service (POS) * In-Network Tier

(1) Behavioral Health Treatment (BHT) & Applied Behavioral Analysis (ABA) Benefit Change

Pursuant to guidance provided by the California Department of Managed Healthcare (DMHC), given that Kaiser Foundation Health Plan (KFHP) views Behavioral Health Treatment (BHT) and Applied Behavior Analysis (ABA) services as a treatment program usually delivered in a member's home or location other than an office, KP will reclassify such services more appropriately as "other items and services."

To ensure continued compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), KFHP has changed cost sharing for BHT/ABA Services from outpatient office visit (currently aligns with primary care office visit in most cases) to outpatient other items and services at NO charge ($0) for all 2018 Covered California plan designs that may not have a determinable "substantially all" cost share type. Such impacted plans that may not have a "substantially all" cost share type include those plans where services with the highest utilization may have hybrid cost share types (e.g., complex imaging coinsurance and outpatient surgery copayment).

Based on the financial requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) quantitative treatment limits (QTLs), the deductible applicability for the outpatient mental health and substance use disorder (MH/SUD) other items and services need to be modified on certain DHMO accumulation type plans.

Based on the financial requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) quantitative treatment limits (QTLs), the cost share type and cost share value for the substantially all medical/surgical benefits and MH/SUD will be modified on certain DHMO plans.

(2) Tobacco Cessation Medication Without Cost Share for all KPCA Commercial Members

Clinical evidence and cost studies show that quitting smoking is beneficial to health at any age. Tobacco cessation medication is a highly cost-effective preventive service, and comprehensive coverage at no cost share increases the use of tobacco cessation medication and increases quit rates.

KPCA will extend coverage of tobacco cessation medication without cost share to the 11% of KP California Commercial members who do not already have this coverage.

(3) Direct Admit Observation Benefit Service Hierarchy

To align the member experience for direct admit observation with admit to observation through the emergency department (ED), the cost share for ancillary services such as lab, x-ray, etc. received while in observation status will be $0. Before this benefit change, members who were admitted directly (not through ED) into observation status were charged a separate copay for each of these ancillary services.

Effective 01/01/2019, a new benefit service (EMRGHANC) will bundle ancillary services

received when admitted directly into in observation status.

(4) Add Rx Safety Glasses to Optical hardware benefit

Effective 1/1/19, allow members in commercial plans to use their optical hardware allowance to purchase prescription safety glasses for personal (not employment-related) use. For example, a carpentry hobbyist who uses prescription safety glasses for wood-working.

(5) Addition of Laparoscopy and Salpingectomy Services to Preventive Sterilization Benefit

In 2017, KP Program Office Legal clarified that Affordable Care Act (ACA) guidelines on coverage for FDA-approved contraceptive methods state that if a member requires a specific female sterilization procedure (e.g. salpingectomy) for contraceptive purposes, the service should be covered as a preventive service.

Based on KP Legal and ACA guidance, certain coding combinations for laparoscopy and salpingectomy services should be mapped to the preventive benefit for female sterilization.

(6) Update to Women's Preventive Services Benefit

On December 29, 2017, the Health Resources and Services Administration (HRSA) updated the Women's Preventive Services Guidelines that address health needs specific to women based on clinical recommendations from the Women's Preventive Services Initiative. This 2017 update adds two additional services to the nine preventive services included in the 2016 update.

1. Women's Screening for Diabetes Mellitus after Pregnancy
2. Women's Screening for Urinary Incontinence

(7) Additional tool for KP Care team to prevent or delay the onset of diabetes in the Commercial population

KP's Health Education department will assist members with available prediabetes resources in the region and connect members to the virtual DPP (diabetes prevention program). The program is not part of the medical plan benefit package and is a value added program available to commercial HMO members. The DPP program is provided to members at $0 which aligns with competitor health plans in CA and KP's existing in person DPP program available in SCAL.

(8) CA Law AB 1048 - Prorated cost shares for partial fill of Schedule II Drugs

To comply with AB 1048, Kaiser Permanente (KP) will prorate cost sharing for prescriptions for schedule II drugs when dispensed by a pharmacist at the request of a

patient or prescribing provider for up to 30 days after the original written prescription.

Effective 1/1/2019 KP pharmacists will be able to partially fill prescriptions for schedule II drugs at a patient or providers request. After the initial partial fill is dispensed the remainder of the quantity can be subsequently filled for up to 30 days from when the prescription was written. After 30 days the prescription will no longer be valid and members will be required to obtain a new prescription for schedule II drugs. For partially filled prescriptions, KP will prorate copay prescriptions using the current Medicare Part D proration methodology. Schedule II drugs are dispensed under the Brand and Generic benefit services. All subsequent fills must be dispensed by the original pharmacy where the prescription was filled.

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only
The changes described below apply to non-Grandfathered plans only.
If a 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.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (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 Tier have been expanded to include coverage for the following:
      i. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus.
      ii. Urinary incontinence screening in women.
      iii. Counseling of parents of young children, adolescents, and young adults who have fair skin about minimizing the child's exposure to ultraviolet radiation to reduce risk for skin cancer has been expanded to include children as young as 6 months (up to 24 years of age).

   b) Vitamin D for falls prevention in community-dwelling adults age 65 or older
      - Vitamin D for falls prevention in community-dwelling adults age 65 or older under the Preventive Care Services benefit will be covered only through December 31, 2019 regardless of your group's renewal date. Beginning January 1, 2020, Vitamin D will no longer be covered. The USPSTF (United States Preventive Service Taskforce) has downgraded this preventive service from a "B" recommendation to a "D" recommendation. Therefore, it will no longer be a mandated benefit under the Affordable Care Act.

Grandfathered (GF) Plans
If a 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, 2018.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (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 Tier have been expanded to include coverage for the following:

i. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus.

ii. Urinary incontinence screening in women.

iii. Counseling of parents of young children, adolescents, and young adults who have fair skin about minimizing the child's exposure to ultraviolet radiation to reduce risk for skin cancer has been expanded to include children as young as 6 months (up to 24 years of age).

b) Vitamin D for falls prevention in community-dwelling adults age 65 or older

- Vitamin D for falls prevention in community-dwelling adults age 65 or older under the Preventive Care Services benefit will be covered only through December 31, 2019 regardless of your group's renewal date. Beginning January 1, 2020, Vitamin D will no longer be covered. The USPSTF (United States Preventive Service Taskforce) has downgraded this preventive service from a "B" recommendation to a "D" recommendation. Therefore, it will no longer be a mandated benefit under the Affordable Care Act.

** 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.*

(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 1.1% from 75.7% in 2018 to 74.6% in 2019

[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)

Point of Service (POS) * In-Network Tier

(1) Behavioral Health Treatment (BHT) & Applied Behavioral Analysis (ABA) Benefit Change

Pursuant to guidance provided by the California Department of Managed Healthcare (DMHC), given that Kaiser Foundation Health Plan (KFHP) views Behavioral Health Treatment (BHT) and Applied Behavior Analysis (ABA) services as a treatment program usually delivered in a member's home or location other than an office, KP will reclassify such services more appropriately as "other items and services."

To ensure continued compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), KFHP has changed cost sharing for BHT/ABA Services from outpatient office visit (currently aligns with primary care office visit in most cases) to outpatient other items and services at NO charge ($0) for all 2018 Covered California plan designs that may not have a determinable "substantially all" cost share type. Such impacted plans that may not have a "substantially all" cost share type include those plans where services with the highest utilization may have hybrid cost share types (e.g., complex imaging coinsurance and outpatient surgery copayment).

Based on the financial requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) quantitative treatment limits (QTLs), the deductible applicability for the outpatient mental health and substance use disorder (MH/SUD) other items and services need to be modified on certain DHMO accumulation type plans.

Based on the financial requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) quantitative treatment limits (QTLs), the cost share type and cost share value for the substantially all medical/surgical benefits and MH/SUD will be modified on certain DHMO plans.

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

(2) Tobacco Cessation Medication Without Cost Share for all KPCA Commercial Members

Clinical evidence and cost studies show that quitting smoking is beneficial to health at any age. Tobacco cessation medication is a highly cost-effective preventive service, and

comprehensive coverage at no cost share increases the use of tobacco cessation medication and increases quit rates.

KPCA will extend coverage of tobacco cessation medication without cost share to the 11% of KP California Commercial members who do not already have this coverage.

- The cost impact is $0.10 PMPM.

(3) Direct Admit Observation Benefit Service Hierarchy

To align the member experience for direct admit observation with admit to observation through the emergency department (ED), the cost share for ancillary services such as lab, x-ray, etc. received while in observation status will be $0. Before this benefit change, members who were admitted directly (not through ED) into observation status were charged a separate copay for each of these ancillary services.

Effective 01/01/2019, a new benefit service (EMRGHANC) will bundle ancillary services received when admitted directly into in observation status.

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

(4) Add Rx Safety Glasses to Optical hardware benefit

Effective 1/1/19, allow members in commercial plans to use their optical hardware allowance to purchase prescription safety glasses for personal (not employment-related) use. For example, a carpentry hobbyist who uses prescription safety glasses for wood-working.

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

(5) Addition of Laparoscopy and Salpingectomy Services to Preventive Sterilization Benefit

In 2017, KP Program Office Legal clarified that Affordable Care Act (ACA) guidelines on coverage for FDA-approved contraceptive methods state that if a member requires a specific female sterilization procedure (e.g. salpingectomy) for contraceptive purposes, the service should be covered as a preventive service.

Based on KP Legal and ACA guidance, certain coding combinations for laparoscopy and salpingectomy services should be mapped to the preventive benefit for female sterilization.

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

(6) Update to Women's Preventive Services Benefit

On December 29, 2017, the Health Resources and Services Administration (HRSA) updated the Women’s Preventive Services Guidelines that address health needs specific to women based on clinical recommendations from the Women’s Preventive Services Initiative. This 2017 update adds two additional services to the nine preventive services included in the 2016 update.

3. Women's Screening for Diabetes Mellitus after Pregnancy

4. Women's Screening for Urinary Incontinence

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

(7) Additional tool for KP Care team to prevent or delay the onset of diabetes in the Commercial population

KP's Health Education department will assist members with available prediabetes resources in the region and connect members to the virtual DPP (diabetes prevention program). The program is not part of the medical plan benefit package and is a value added program available to commercial HMO members. The DPP program is provided to members at $0 which aligns with competitor health plans in CA and KP's existing in person DPP program available in SCAL.

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

(8) CA Law AB 1048 - Prorated cost shares for partial fill of Schedule II Drugs

To comply with AB 1048, Kaiser Permanente (KP) will prorate cost sharing for prescriptions for schedule II drugs when dispensed by a pharmacist at the request of a patient or prescribing provider for up to 30 days after the original written prescription.

Effective 1/1/2019 KP pharmacists will be able to partially fill prescriptions for schedule II drugs at a patient or providers request. After the initial partial fill is dispensed the remainder of the quantity can be subsequently filled for up to 30 days from when the prescription was written. After 30 days the prescription will no longer be valid and members will be required to obtain a new prescription for schedule II drugs. For partially filled prescriptions, KP will prorate copay prescriptions using the current Medicare Part D proration methodology. Schedule II drugs are dispensed under the Brand and Generic benefit services. All subsequent fills must be dispensed by the original pharmacy where the prescription was filled.

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

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only
The changes described below apply to non-Grandfathered plans only.
If a 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.

(2) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements:
   c) The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:
      i. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus.
      ii. Urinary incontinence screening in women.
      iii. Counseling of parents of young children, adolescents, and young

adults who have fair skin about minimizing the child's exposure to ultraviolet radiation to reduce risk for skin cancer has been expanded to include children as young as 6 months (up to 24 years of age).

d) Vitamin D for falls prevention in community-dwelling adults age 65 or older
   - Vitamin D for falls prevention in community-dwelling adults age 65 or older under the Preventive Care Services benefit will be covered only through December 31, 2019 regardless of your group's renewal date. Beginning January 1, 2020, Vitamin D will no longer be covered. The USPSTF (United States Preventive Service Taskforce) has downgraded this preventive service from a "B" recommendation to a "D" recommendation. Therefore, it will no longer be a mandated benefit under the Affordable Care Act.

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

Grandfathered (GF) Plans

If a 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, 2018.

(2) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements:

c) The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:

i. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus.

ii. Urinary incontinence screening in women.

iii. Counseling of parents of young children, adolescents, and young adults who have fair skin about minimizing the child's exposure to ultraviolet radiation to reduce risk for skin cancer has been expanded to include children as young as 6 months (up to 24 years of age).

d) Vitamin D for falls prevention in community-dwelling adults age 65 or older
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- This change has little to no impact on 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.*

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

POS In-Network Tier and EPO

1.01 Coordination and Cooperation

Kaiser Permanente is structured differently than most health plans. The most important differentiator is our integrated system. Having an integrated system means that our health plan function, our network of health facilities, and our health care providers are all effectively part of one organization. Most decisions on the day- to-day management are made at the regional and local level by three separate but cooperating entities, the Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Hospitals (KFH) and the Northern and Southern Permanente Medical Groups (Permanente providers). KFHP contracts with individuals and group customers to arrange to provide comprehensive health care services under the range of KFHP benefit plans. KFHP also contracts exclusively with KFH and the Permanente providers to provide the hospital and professional medical services under these benefit plans to meet the health care needs of KFHP members.

Our integrated system brings together physicians, nurses and other health care providers to provide covered health care services to KFHP members. The integrated system supports high quality by centering on the patient. These services are provided by physician-led delivery systems, supported by cutting edge technology and an extensive care management infrastructure in order to provide superior care in the most appropriate setting for a lower overall cost, and at a better value for KFHP members.

1.02 Ensuring Networks are Based on Value

The vast majority of hospital care is provided to Kaiser Permanente members in Kaiser Foundation Hospitals. There are circumstances due to geographic considerations, particularly in Southern California where there are large regions of low population density, when it is necessary to have contracted plan hospitals. Geographic access and quality are the primary considerations in the development of these contracts. Kaiser Permanente considers the same quality priorities for Plan hospitals that are measured for Kaiser Foundation Hospitals and include quality metrics such as rates of hospital acquired infections and performance on other quality indicators, measures of patient experience, electronic health record interoperability and others. Moreover, whenever possible, Permanente physicians provide care to Kaiser Permanente members and drive change and provide Medical Staff leadership in non-KFH plan hospitals, thereby improving care to all patients in these hospitals.

In addition to establishing expectations around quality, service, and efficiency in non-KFH Plan hospitals with the goal of delivering the same level of care as in our owned and operated facilities, Kaiser Permanente subject matter experts and leaders collaborate with leaders and staff at our Plan hospitals to share best practices and strategies to improve care. This shared expertise accelerates change and improves care for all California patients.

Medical Center leaders in the Medical Center geography adjacent to or including the Plan Hospital meet with the Plan Hospital leadership on an ongoing basis (usually quarterly) to monitor performance, collaborate to provide expertise, and create action plans to approach KFH performance on the following metrics:

Hospital Utilization:

- Average daily census
- Average length of stay

- Readmission rates: observed /expected

Quality:

- C. Diff rates converted to SIR
- CAUTI rates converted to SIR
- CLABSI rates converted to SIR
- Leapfrog Hospital Safety Grade
- Core SEP 1 Early management, bundle, severe sepsis/septic shock
- Maintenance of TJC Stroke certification

Care Experience: Data from HCAHPS

- Overall rating
- Care Transitions
- Cleanliness
- Communication about Medications
- Discharge information
- Doctor Communication/Nurse Communication
- Pain Management
- Quietness of hospital
- Willingness to recommend
- Staff responsiveness
- Overall stars

1.03 Demonstrating Action on High Cost Providers

Kaiser Foundation Health Plan (KFHP) contracts exclusively with The Permanente Medical Group (TPMG) in Northern California and Southern California Permanente Medical Group (SCPMG) in a mutually exclusive relationship to provide comprehensive medical services to our California members. Most of the compensation KFHP pays is an annually negotiated per member per month amount (capitation rate). The remaining compensation is generally for actual costs, or a percentage thereof, for specific items, such as leased equipment. This arrangement provides limitations on the potential gain or loss of each medical group.

Because KP is an integrated system, we manage cost variation with much more transparency of data than fee-for-service health plans. We compare cost and underlying drivers of cost, such as productivity, wage rates, and supply costs/patient day. We work to understand variation, eliminate inappropriate variation, spread best practices, and tightly manage expenses. Furthermore, as a prepaid delivery system, our is incented to be as efficient as possible — both from ensuring quality is high (since high quality is the most cost-effective care in the long run) to being operationally efficient.

We remain committed to direct cost-lowering initiatives. We're targeting three key areas to deliver cost reductions:

- Enhance care quality and efficiency: With our coordinated, team-based approach, we have the unique ability to analyze and improve how care is delivered across the entire treatment continuum, leading to better outcomes, appropriate care, and management of long-term expenses. For example, we are:

- Reducing unnecessary variations in care through predictive modeling and new protocols
- Continuing to lead the industry in prevention and disease management
- Leveraging Kaiser Permanente HealthConnect® to prevent errors and duplication
- Maximizing pharmacy savings through generics, formularies, and purchasing

- Streamlined operations and expense management: We've designed our cost structure to make care more affordable for our more than 12 million members without compromising safety and quality. We do this by:

  - Restructuring workforce needs without impacting care quality or service
  - Reviewing systems to ensure the best use of resources
  - Benchmarking operations against industrywide standards
  - Using renewable energy sources to protect against future price escalation
  - Improving inventory management and strategic purchasing opportunities

- Transforming care through innovation: Today's consumers expect to access mobile technology where and when they get their care, and they now expect partnership in pursuit of their health goals. We have kept pace with that change and currently deliver care that supports better health using every site, technology, and digital mobile device available, all connected to KP HealthConnect. We use advanced health information technology to improve quality, accessibility and timeliness of care, while also providing more cost-effective alternatives to traditional office visits. We are moving health care forward and expanding avenues to care through:

  - Secure email messaging
  - Phone specialty consultations
  - Video visits
  - Telehealth services
  - Nurse advice line
  - Retail clinics
  - Mobile health vehicle

1.04 Demonstrating Action on High Cost Pharmaceuticals

Kaiser Permanente has pharmacy programs in place to support quality, cost, and value to our members. Our physicians and pharmacists collaborate and share information to prevent medication errors, improve prescription adherence, and lower costs. In other health plans, physician practices and retail pharmacies are separate, and pharmacists rarely work alongside physicians to coordinate member care. If members visit multiple pharmacies, pharmacists are unaware of the other medications members are taking, and physicians have no way of knowing whether members filled their prescriptions. At Kaiser Permanente, pharmacists are part of the same organization and coordinate members' drug treatment plans and health care alongside our physicians. Pharmacists have access to a member's electronic medical record, and can view prescription lists, allergies, diagnosed conditions, and many other important pieces of information used to manage pharmaceutical treatment. We electronically track whether members have filled their new prescriptions as well as adherence to their chronic medications.

- Our pharmacy program successfully manages prescription costs and medication compliance in the following ways:

  - Higher rate of generic prescribing saves money - We prescribe less-expensive

generics more frequently than industry average, resulting in significant savings in prescription costs for Exchange members.

- Better medication adherence saves time and money — 96% of our members fill their prescriptions. Members who take their medications as prescribed are absent from work seven fewer days per year (including absenteeism and short-term disability) than those who aren't current with their medications.
- No pharmaceutical sales reps on our campuses — We ban pharmaceutical sales representatives from our medical offices and hospitals, so our doctors aren't prescribing based on marketing pressure.
- High rate of e-prescribing leads to better information — Electronic prescription orders can't be duplicated or altered and are easily monitored to track adherence and prevent potentially dangerous interactions. Every one of our doctors prescribes electronically — and 99% of all our prescriptions are electronically transmitted to the pharmacy. All this information resides within KP HealthConnect, so every caregiver can view a member's complete prescription list at any time.
- Standardized formulary — We have a safe, standard formulary of more than 850 preferred pharmaceuticals. Each region's Pharmacy and Therapeutics Committee selects drugs for the formulary based on clinical evidence, recommendations from our pharmacists and physicians. Drugs are regularly added or removed based on evaluations of safety, efficacy, and cost-effectiveness.

We own and operate inpatient, outpatient, and mail-order pharmacy services, and our integrated system gives us a distinct advantage when purchasing drugs because we can systematically shift market share to contracted, cost-effective alternatives within therapeutic drug classes. This enables us to negotiate advantageous pricing for select drugs, which helps to offset pharmacy cost increases overall and maintain competitively priced pharmacy benefits. In addition, our national warehousing capabilities allow us to purchase large quantities of drugs before price increases take effect, resulting in documented annual savings of millions of dollars. We also generate significant savings by operating our own centralized repackaging and processing facilities.

Our formulary is determined by our doctors, who decide which drugs to include, relying on clinical research and recommendations from pharmacists, rather than on pharmaceutical company marketing. Unlike many health care plans with formularies not maintained at the clinical level, our physicians and pharmacists work together to implement brand-to-generic conversions. In addition to the FDA process for approving generic medications, we have an extensive approval process to ensure that our preferred generic drugs are of high quality. With input from our pharmacists, pharmacy committees at each of our medical facilities, and individual physicians, our regional pharmacy and therapeutics committees decide on all inclusions and changes to the formulary. Clinical efficacy, cost, safety, and inactive ingredients are evaluated. Member acceptance of, and compliance with, the use of medications is also considered, so medications are also evaluated for their product labeling, ease of handling and use, and even product flavor and texture.

Members taking brand name medications that are being transitioned to generic receive notifications by mail and at point-of-purchase describing the change and gives information on the safety and efficacy of generics. Members are always encouraged to talk with their physician and pharmacist about any of the medications they are using. Members who refill their prescriptions by mail are provided a toll-free number to call if they have questions or concerns about converting to generics. We use academic detailing and have prescriber-level reports that are transparent, which results in appropriate prescribing. Hence, we have not needed point-of-care support tools.

In terms of our strategy for specialty pharmacy, Kaiser Permanente has initiated an emerging therapeutics pharmacy program focused on the proactive evaluation of new and pipeline specialty drugs and new pharmaceutical technologies. The strategy is designed to for the optimal use of new and pipeline specialty drugs and new pharmaceutical technologies, in order to provide high-quality and affordable health care services to improve the health of our members and the communities we serve. Development of these strategies involves an evidence-based review process as well as expert recommendations from our physician specialists. Inter-regional collaboration serves to create a community of peers to develop consensus clinical practice.

1.05 Quality Improvement Strategy

100% of care is delivered in an integrated health model and no anticipated barriers to care. Kaiser Permanente patients all benefit from our integrated system, in which health conditions are managed in a robust and comprehensive delivery system. Members need not actively enroll in special programs to manage their health, as they are proactively identified using up-to-date clinical information, after which they automatically receive outreach and preventive care. Our focus is to ensure members have their conditions under control before they present harmful and costly acute issues. Kaiser Permanente relies on our clinical experts to implement current evidence-based care recommendations, and individual care is always designed to deliver the greatest benefit and lowest risk to each member. Cases are managed on an individual basis, and as such, incur costs associated with the most appropriate care for each member. Our integrated design offers advantages to help ensure members are diagnosed early, treated appropriately, and have access to the care they need. These advantages include:

- **Team-based approach**

Physicians and pharmacists can view each other's notes, monitor lab results, coordinate care plans, and resolve benefits issues to align treatment at every point of care — and they work together to assess the clinical evidence behind each new drug.

- **Evidence-based care**

Our clinical teams evaluate the most up-to-date recommendations to help ensure treatment is grounded in evidence-based guidelines. And through outcomes management we aim to improve the effectiveness and value of treatments.

- **Efficient purchasing and distribution**

Kaiser Permanente's approach to population care is a proven model that improves the health of our members. We consistently score among the best in the nation on publicly reported quality measures related to population health, and we are dedicated to continuously improving our care delivery.

Kaiser Permanente's program seamlessly weaves comprehensive disease management into our care delivery model which, supported by our integrated system, technology, and dedicated care teams, ensures that patients with complex chronic conditions and multiple health issues receive proactive coordinated care to maintain optimal health with maximum convenience.

1.06 Participation in Collaborative Quality

The following table (extracted from Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract) includes a list of the Plan's participation in collaborative quality initiatives.

	Describe the nature of engagement	**Engaged in this market**	**Other markets in which engaged**
The health plan is not engaged in any of the below programs	Not applicable		
Leapfrog Hospital Rewards Program	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Hospital Assessment and Reporting Taskforce (CHART)	Kaiser Permanente submits data to the Collaborative.	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Health Performance Information System (CHPI)	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Integrated Healthcare Association (IHA) Pay for Performance Program	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC)	We report on a number of measures to decrease maternal morbidity and mortality related to obstetric hemorrhage and preeclampsia. Kaiser Permanente is also a CMQCC partner organization; we have physicians on the CMQCC Executive Committee, which determines policy and direction for the collaborative.	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Appropriate use of C-sections: multi-stakeholder collaborative sponsored by the California Health and Human Services Agency (CHHS) and other	Kaiser Permanente representatives serve as advisory members and provide feedback on initiatives and projects.	1: Engaged (Single, Radio group Options:	Not applicable

statewide agencies and organizations		1: Engaged, 2: Not Engaged)	
California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Immunization Registry sponsored by the California Department of Public Health	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
National Neurosurgery Quality and Outcomes Database (N2QOD) of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
IHA Payment Bundling demonstration	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)	Not engaged	2: Not Engaged (Single, Radio group Options:	Not applicable

		1: Engaged, 2: Not Engaged)	
CMMI Comprehensive Primary Care initiative (CPC)	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
CMMI Transforming Clinical Practice Initiative	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged	Not applicable
CMMI Partnership for Patients Hospital Safety Initiative	Kaiser Permanente representatives provide feedback on initiatives and projects.	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Health plan-sponsored accountable care programs	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Perinatal Quality Care Collaborative	Kaiser Permanente physicians are members of the CPQCC Executive Committee, which meets regularly to debate, review, prioritize, and plan the direction of the Collaborative. CPQCC includes 136 member hospitals, 20 of which are Kaiser Permanente hospitals. Our hospitals submit data to the CPQCC Data Center.	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
California Quality Collaborative	Not engaged	2: Not Engaged (Single, Radio group Options:	Not applicable

		1: Engaged, 2: Not Engaged)	
Statewide Workgroup on Overuse	Engaged	1: Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable
Other (described in detail box)	Not engaged	2: Not Engaged (Single, Radio group Options: 1: Engaged, 2: Not Engaged)	Not applicable

1.07 Data Exchange with Providers

As the largest, most comprehensive civilian electronic health record (EHR) system in America, KP HealthConnect securely links Kaiser Permanente facilities across the nation, making each member's current medical record securely available when and where it is needed. KP HealthConnect enhances member safety by linking members and authorized caregivers with electronic medical records (EMR) and online resources with just the click of a mouse. KP HealthConnect's Care Everywhere functionality permits providers to obtain information about procedures, labs and care completed in other KP regions. With fast and easy collaboration, critical data such as the patient's allergies, current medications, and recent medical history may be accessed by a member's entire care team in real time.

Pharmacy records and lab results, among other data, are accessible around the clock by members and their providers, mitigating the possibility of error that can develop with handwritten documentation. Physicians and pharmacists see drug alerts, which warn them of adverse reactions that might occur if patients receive certain combinations of medications simultaneously. As a result, potential miscommunication can be circumvented, and clinicians are assisted in providing the proper protocols and treatment.

In addition, kp.org, the member-accessible view of KP HealthConnect, is a user-friendly tool for members. When logging into kp.org from their computers or smartphones, KP HealthConnect gives our more than 12.2 million members across the nation password-protected access to their health care teams and their personal health information when and where it is convenient for them. Unlike many personal health records that only allow users to view and enter claims information, kp.org connects members to convenient health services, relevant health information, and their entire team of doctors, nurses, pharmacists, and other caregivers. When health professionals enter information into KP HealthConnect at each point of service, that data is immediately updated across the system.

Kp.org allows members to request doctors' appointments, view most test results, refill prescriptions, securely exchange emails with their health care team, and more. KP HealthConnect strengthens the integration of our health care delivery system — which encompasses physicians, hospitals, pharmacies, research labs, and knowledge databases —

by connecting every Kaiser Permanente facility in the nation. KP HealthConnect has also helped to minimize wait times, improving members' experience at the doctor's office.

Kp.org and all its online services are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA), ensuring the privacy of our members and the security of their health records.

KP utilizes externally-reported HEDIS metrics to track provider performance in the care that is provided to patients. Internally created reports are communicated to providers on a regular basis to enable identification of improvement areas that drive enhanced care models and better patient outcomes. Reports include current HEDIS quality performance, disparity rates and member satisfaction, among others.

1.08 Data Aggregation across Health Plans

To support aggregation of claims or other information across payers, Kaiser Permanente is engaged in the following data aggregation initiatives:

- Integrated Health Association (IHA)Align Measure Perform (AMP) Commercial HMO program (formerly known as Value Based P4P)
- IHA Encounter Data Initiative
- IHA Cost and Quality Atlas
- CalHospitalCompare
- CMQCC

For POS, PPO and OOA Contracted Network Tier and Out-of-Network Tier:

This response applies to Kaiser Permanente Insurance Company's (KPIC's) PPO and OOA products and tiers 2 and 3 of the POS product. Since 2017, KPIC's Pharmacy Benefit Manager (PBM) has continued full administration of KPIC's outpatient prescription drug benefit. This includes maintenance of the formulary, utilization of the PBM's Pharmacy & Therapeutics and Formulary Committee (P&T Committee), and adoption of its cost containment processes. KPIC formularies, pharmacy utilization management edits and supporting medication treatment guidelines are reviewed and approved by PBM's P&T Committee and are based upon a thorough review of the medical literature reflecting published treatment guidelines recommended by national medical organizations. The P&T Committee reviews key therapeutic drug categories on a continuous basis to ensure they reflect the most up to date medication treatment recommendations.

Drugs presented to the P&T Committee for consideration are reviewed on the following evidence-based criteria:

1. Safety, including concurrent drug utilization review (cDUR) when applicable,
2. Efficacy: the potential outcome of treatment under optimal circumstances,

3. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary,
4. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available,
5. Relevant benefits of current formulary agents of similar use,
6. Condition of potential duplication of similar drugs currently on formulary,
7. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

KPIC's PBM monitors the ability of the utilization management programs applied at point of sale to ensure that KPIC delivers a highly efficient cost effective pharmacy benefit program to our membership.

KPIC's PBM also received NCQA Utilization Management (UM) Accreditation in 2017. This accreditation demonstrates that KPIC's PBM has the systems, processes and personnel to conduct utilization management in accordance with the strictest quality standards with focus on quality through consumer protection and improvement in service to customers with emphasis that organizations continually work on quality improvement. Some areas of focus:

- The PBM has the quality improvement infrastructure needed to improve the UM functions and services provided to its members.
- The PBM has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.
- The PBM applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.
- The PBM continually assesses member and practitioner experience with its UM process to identify areas in need of improvement.

Drugs requiring prior authorization:
Prior authorization is generally applied to drugs that have multiple indications, qualify as Specialty medications per our protocol (cost >$600/month, requires complex monitoring and/or administration, complex clinical condition/disease state), are high in cost, have a high abuse potential (topical testosterone) or have a significant safety concern.

Drugs requiring step therapy:
Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Under step therapy, KPIC insureds may first need to try a proven, cost-effective medication before using a more costly treatment.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the insured's drug history, prior to the use of another drug (2nd line agent). If the licensed prescribing provider determines that a first-line drug is not appropriate or effective, a second-line drug, may be covered after meeting certain conditions.

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.

None