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 _2020_.[1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs _5.7_ %
   - Most commonly sold large group benefit design _6.5_ %

   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 _4.7_ %
- Most commonly sold large group benefit design[4] _4.0_ %

4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month

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

1	2	3	4	5	6	7
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups *(number for each month in column 2 divided by the 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
January	84	41%	903	0	$946.89	4.5%
February	8	4%	258	0	$908.68	7.9%
March	5	2%	24	0	$843.12	4.6%
April	10	5%	73	0	$963.17	2.6%
May	7	3%	47	0	$740.73	7.2%
June	17	8%	2,444	0	$445.90	6.9%
July	16	8%	100	0	$1,266.09	7.6%
August	8	4%	80	0	$1,021.31	2.3%
September	18	9%	168	0	$1,212.67	4.3%
October	10	5%	103	0	$1,099.77	3.6%
November	10	5%	84	0	$1,167.43	7.0%
December	13	6%	49	0	$1,183.43	3.7%
Overall	206	100%	4,333	0	$689.13	5.7%

[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 2020 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)	173	84%	1,599	0	$1,035.47	4.3%
Blended (in part)	27	13%	295	0	$838.96	10.0%
100% Experience Rated	6	3%	2,439	0	$443.95	6.9%
Overall	**206**	**100%**	**4,333**	**0**	**$689.13**	**5.7%**

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)	26%	0%	11%	0%	**37%**
Blended (in part)	0%	0%	7%	0%	**7%**
100% Experience Rated	0%	55%	2%	0%	**56%**
Overall	**26%**	**55%**	**19%**	**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	114	55%	1,121	0	$1,086.32	**3.8%**
EPO	2	1%	2,368	0	$430.38	**6.5%**
POS	88	43%	840	0	$886.96	**7.7%**
HDHP	0	0%	0	0	N/A	N/A
Other (describe)	2	1%	4	0	$1,009.66	**13.2%**
Overall	**206**	**100%**	**4,333**	**0**	**$689.13**	**5.7%**

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	9	209	19%	$250/$750 DED; $15/30% OV; 10% IP, $15/$40 RX
0.8 to 0.899	18	692	62%	$500/$1000 DED; $25/30% OV; 10% IP, $15/$40 RX
0.7 to 0.799	7	220	20%	$1500/$3000 DED; $40/50% OV; 30% IP, $15/$40 RX
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**34**	**1,121**	**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%	N/A
0.8 to 0.899	2	2,368	100%	$1400 DED; 20% OV; 20% IP
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**2**	**2,368**	**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	29	840	100%	$500/$1000 DED; $20/$30/40% OV; 20% IP, $20/$40 RX
0.8 to 0.899	-	-	0%	N/A
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**29**	**840**	**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%	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	1	1	25%	$300/$600 DED; 20% OV; 20% IP
0.8 to 0.899	1	3	75%	$500/$1000 DED; $20/20% OV; 20% IP
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	2	4	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:

(1) All of the plans are custom plans.
(2) There are 206 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 2020. PPO/OOA - Rates are area-adjusted and area factors are based on zip code. The factors did not change in 2020.
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 2020.
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 2020.
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 - 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 factors did not change in 2020. PPO/OOA and EPO – 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)

4.8%

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]	4.6%
Hospital Outpatient (including ER)	4.6%
Physician/other professional services[3]	4.6%
Prescription Drug[4]	6.0%
Laboratory (other than inpatient) [5]	4.6%
Radiology (other than inpatient)	4.6%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	4.6% (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]	$154	3.3%	0.8%	0.0%	4.1%
Hospital Outpatient (including ER)	$129	2.6%	1.5%	0.0%	4.1%
Physician/other professional services[13]	$121	-2.6%	6.9%	0.0%	4.1%
Prescription Drug[14]	$51	0.0%	6.0%	0.0%	6.0%
Laboratory (other than inpatient)[15]	$31	-1.9%	6.2%	0.0%	4.1%
Radiology (other than inpatient)	$44	-2.5%	6.9%	0.0%	4.1%
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)	$5	4.3%	-0.2%	0.0%	4.1%
Overall	**$536**	**0.7%**	**3.6%**	**0.0%**	**4.3%**

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) Removal of Vitamin D for Falls Prevention from Preventive Care Package

Due to its downgrade by the USPSTF from a B to a D grade recommendation, coverage of Vitamin D for Falls Prevention in a Community-Dwelling for Older Adults will be removed from the Kaiser Permanente (KPCA) ACA preventive package. The KP Inter-regional Benefit Design Group (IBDG) approved this coverage change.

2) New USPSTF Preventive Service: Perinatal Depression Counseling

In February 2019, the United States Preventive Service Task Force (USPSTF) released new guidelines recommending that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.

Coding combinations for perinatal depression counseling interventions will be added to the preventive provider visit benefit (PROVPHYS), and to PROVFRST for telephone and video visits.

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. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.
      ii. Pre exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This change is effective for plan years beginning on or after July 1, 2020.

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. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

ii. Pre exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This change is effective for plan years beginning on or after July 1, 2020.

(2) Prescribed tobacco-cessation medications – As an enhancement to your preventive benefits, prescribed over-the-counter and FDA-approved prescription tobacco-cessation medications that are listed in your KPIC drug formulary will now be covered at no charge and not subject to any Deductible when obtained at a Participating Pharmacy. Previously, this coverage was only available at no cost share for those enrolled in grandfathered plans issued to groups who elected to include ACA preventive care benefits under their grandfathered plan. This change is effective on January 1, 2020, regardless of your group's renewal date.

** 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 increased by 1.6% from 86.6% in 2019 to 88.3% in 2020

[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) Removal of Vitamin D for Falls Prevention from Preventive Care Package

Due to its downgrade by the USPSTF from a B to a D grade recommendation, coverage of Vitamin D for Falls Prevention in a Community-Dwelling for Older Adults will be removed from the Kaiser Permanente (KPCA) ACA preventive package. The KP Inter-regional Benefit Design Group (IBDG) approved this coverage change.

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

2) New USPSTF Preventive Service: Perinatal Depression Counseling

In February 2019, the United States Preventive Service Task Force (USPSTF) released new guidelines recommending that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.

Coding combinations for perinatal depression counseling interventions will be added to the preventive provider visit benefit (PROVPHYS), and to PROVFRST for telephone and video visits.

- 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
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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. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

ii. Pre exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This change is effective for plan years beginning on or after July 1, 2020.

- The cost was covered in our Pharmacy trend.

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.

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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:

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- The cost was covered in our Pharmacy trend.

(2) Prescribed tobacco-cessation medications – As an enhancement to your preventive benefits, prescribed over-the-counter and FDA-approved prescription tobacco-cessation medications that are listed in your KPIC drug formulary will now be covered at no charge and not subject to any Deductible when obtained at a Participating Pharmacy. Previously, this coverage was only available at no cost share for those enrolled in grandfathered plans issued to groups who elected to include ACA preventive care benefits under their grandfathered plan. This change is effective on January 1, 2020, regardless of your group's renewal date.

- The cost impact is $0.10 PMPM.

** 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 (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/2016/407/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

POS In-Network Tier and EPO

1.01 Coordination and Cooperation

We bring our entire health plan, physicians, facilities and pharmacies together in a continuous effort to provide care that is clinically appropriate, safe and cost-effective. At any point in time, Kaiser Permanente has many initiatives we are piloting, implementing and managing throughout our health care delivery system.
In the traditional United States health care model, physicians are incentivized to treat more rather than to treat better and health insurance companies mitigate risk through costly premiums and high deductibles. Kaiser Permanente's model was designed precisely to remove these negative incentives and replace them instead with an unavoidable path to high-value and high-quality care. We accomplish this by unifying the three principal components of health care delivery into a single system – physicians, health plan, and facilities:

1. Health plan. Pre-paid health coverage means our system bears the risk of inefficiencies and there is no room for waste. When our patients thrive, our business thrives.
2. Physicians. Our physicians represent expertise from every major specialty and provide care exclusively for Kaiser Permanente members.

- Primary care physicians work at the top of their scope and receive unparalleled access to specialists, ensuring patients receive the expert care they need when they need it.
- Rather than compensating physicians for each individual service provided, our physicians are salaried. Severing compensation from a system that rewards inefficiencies enables physicians to focus on evidence-based medicine and rewards them for providing the right care at the right time.

3. Facilities. Hospitals and medical office buildings are thoughtfully planned, designed and operated by the people who use them, promoting geographic access to care and an agility to innovate space planning.

By merging care and coverage together as a fully integrated care delivery system, high-quality, coordinated care becomes the premise of our model. Our care model not only obviates the need to create sophisticated communication solutions amongst many fragmented providers or to solve data interoperability issues, but makes coordination of care amongst the care team a standard part of our work.

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

IT Healthcare Information Exchange (interoperability)

- eHealth
- Direct Messaging to KP
- Image exchange KP import/KP view
- Image exchange Plan import/Plan view

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

Quality and service are top priorities for Permanente physicians. Our physicians practice evidence-based medicine regardless of the setting in which they provide care. Our physicians bring this evidence-based care, team approach, and best practices into non-Kaiser hospitals and work collaboratively with our non-Kaiser partners to assure that our patients receive the best care possible.

In addition, Permanente Medical Group (PMG) physicians actively participate in medical staff activities in our plan hospitals, often serving as Department Chairs and even as the Chief of Staff. By providing this leadership, our PMG physicians promote a culture of safety, quality and service.

All hospitals in the KP network are expected to maintain a high standard of care – per regulatory requirements (NCQA, DMHC), policies and procedures, and hospital contract quality language.

- Credentialing process which includes an initial on-site visit to review quality standards of the providers and their facilities.
- Focused site reviews are conducted, as needed.
- KP quality leads maintain line of sight to quality metrics that may indicate a need to address issues, improve practices, reduce variation, spread success.
- Ongoing monitoring of member complaints and response, significant events, accreditation status, and regulatory sanctions.
- Should a contracted provider fail to meet KP criteria, an action plan is developed and progress is reported, until all issues have been resolved.

We have a council that is responsible for presenting a set of core quality metrics and a standardized annual quality plan template to KP's governing body over quality assurance for KP facilities and contracted plan hospitals. Once the standard template and core metrics are approved by the quality committee, the plans to achieve the goal metrics are jointly developed by quality leads that have a contracted plan hospital and the quality lead at the contracted plan hospital. These jointly developed annual quality plans are presented to the quality committee for approval. Implementation of the approved quality plans and monitoring of the core metrics are done through the joint operating committees that govern the health services agreement between KP and the Plan Hospitals. KP

Northern California and Southern California are both represented.

Additionally, each KP service area with a contracted plan hospital has a governance structure comprised of KP and contracted plan hospital leadership (administration, physician, quality):

- An executive oversight committee: scope includes strategic focus and process improvement
- A joint operations committee: scope includes sharing of operations best practices and ensuring common goal quality metrics are achieved

Kaiser Foundation Health Plan contracts with Kaiser Foundation Hospitals in a mutually exclusive arrangement, providing or arranging for hospital services. Within our integrated delivery system, a majority of the care we provide is delivered at our own facilities. As much as possible, we provide care as part of our integrated system - health plan, medical group, and hospital network. Only when a specific highly-specialized method of care is not available within our network do we contract with external Centers of Excellence.

To improve the clinical outcomes and health status of our members and to help ensure a high-quality care experience, Kaiser Permanente has stringent selection criteria for choosing Centers of Excellence. All our hospitals are licensed by the California Department of Health Services, Division of Licensing and Certification; accredited by The Joint Commission; and certified to receive federal funds for Medicare and Medi-Cal. Our medical center leadership continues to meet periodically with Plan hospital leaders to discuss common quality goals with our contracted partners.

Agreements between Kaiser Foundation Health Plan, the Permanente Medical Groups, and Kaiser Foundation Hospitals are perpetually renewed. All providers are expected to contribute to a culture of continuously improving care by taking responsibility for a variety of quality metrics. Clinical areas include inpatient quality measures such as sepsis and stroke care; outpatient quality measures such as cancer screening and cardiovascular health; and patient safety measures such as surgical safety and hospital-acquired infections. Our philosophy, structure, and incentives enable our providers to work collaboratively to deliver comprehensive care, achieve superior clinical outcomes, and help members maximize their total health. We do not anticipate any barriers in continuing this work.

1.06 Participation in Collaborative Quality

Kaiser Permanente participates in all industry collaboratives outlined below, with varying levels of participation. For example, KP participates by contributing data to several of IHA's Align. Measure. Perform. (AMP) programs, including the AMP Commercial HMO, AMP Medicare Advantage, and Cost & Quality Atlas programs. William Caswell, KFHP SVP Ops & COO, is the Board Chair and sits on the Executive Committee of IHA. KP has representation on each of IHA's three governing committees - Suketu Sanghvi, AED, TPMG, participates in the Governance Committee, Dave Schweppe, KFHP, and Ralph Vogel, SCPMG, sit on the Technical Measurement Committee, and Andrew See, KFHP, sits on the Technical Payment Committee.

1. Smart Care California
2. Partnership for Patients

3. CMQCC
4. Integrated Healthcare Association (IHA)
5. California Quality Collaborative (CQC)
6. Cal Hospital Compare

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 and Commercial ACO program
- 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.

I. Administration of Outpatient Prescription Drug Benefit by KPIC's Pharmacy Benefit Manager (PBM)

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.

II. Quality Management, Utilization Management, and Case Management by KPIC's TPA

KPIC's TPA, Permanente Advantage (PA), provides quality management, utilization management, and case management of care and services provided to KPIC's insureds.

1) **Quality Management Program.** The purpose of the Quality Management Program Description (QMPD) for Permanente Advantage (PA) is to assess and oversee the quality of care and services provided to Kaiser Permanente Insurance Company (KPIC) members throughout the continuum of care by non-KP practitioners and providers.

The scope of the PA QMPD is limited to Preferred Provider Organization (PPO) or Point of Service (POS) members receiving care by non-KP practitioners and providers. POS members must be utilizing their tier 2 or tier 3 benefits to fall under the PA QMPD, otherwise the oversight of their care will be performed by the KP Regional Quality Program.

The Program's activities are developed and implemented in compliance with state and federal
regulations and are approved by the PA Quality Management Committee (QMC).

Permanente Advantage (PA) Board of Managers (PBAM) has granted authority to the QMC for oversight of the Quality Management Program. The QMC is responsible for oversight and direction of the Permanente Advantage QM Program. The QMC recommends policy decisions, reviews and evaluates the results of all QM activities, oversees implementation of action plans and ensures follow-up as appropriate. The QMC meets at least quarterly and may meet more frequently if deemed necessary by the Committee Chair or the PABM.

a) The functions of the QMC include, but are not limited to:
    1. Monitoring of clinical cases by peer review.
    2. Approve the Quality Management Program Description and work plan annually.
    3. Review of clinical decision-making processes for resource utilization and quality of care referred from UM Committee (UMC).
    4. Monitors key clinical quality indicators and benchmarks and identifies areas requiring focused review.
    5. Monitor data and outcomes of member and provider satisfaction, complaints, grievances and appeals.
    6. Reviewing, approving, or facilitating physician and/or provider education.
    7. As appropriate, providing feedback to Regional and National Network management regarding provider network quality and/or access issues and/or education (Network is contracted with KPIC).

b) Maintain a clearly defined Quality Management (QM) Program structure.
    1. Involve physicians in the QM Program through participation in the Quality Management Committee (QMC).
    2. Ensure adequate staff and resources are available for implementation and maintenance of the QM Program.
    3. Ensure that all appropriate quality issues are reported to the QMC.
    4. Ensure issues addressed by the QMC are communicated to the Permanente Advantage Board of Managers (PABM) to facilitate its oversight of the Program.

c) Integrate the QM Program.
    1. Promote a quality improvement approach to issue resolution and

process enhancement.

2. Communicate the results of studies, audits, and surveys to all staff.

d) Continuously improve the quality of care and services.

1. Maintain no less than two (2) quality improvement projects per accreditation program that address performance improvement and/or opportunities to reduce errors.
2. Ensure accurate and valid data collected for QM activities.
3. Monitor adverse outcomes for trends and implement action plans as appropriate.
4. Encourage the use of clinical practice guidelines (nationally recognized) as appropriate.

e) The members of the QM Committee include the following persons/representatives:

1. PA Medical Director and QM Chairperson
2. Federation Associate Medical Director for Quality
3. PA Director of Care Management
4. KFHP Resource Stewardship
5. Behavioral Health Practitioner
6. Physician representatives from KP regions

The Quality Management Program will be reviewed, revised and updated annually. The evaluation process includes a summary of activities accomplished over the year and the impact of the activities on the provision of patient care and service. The QM Program may be amended by a majority vote of the PA Board of Managers, QM Committee or upon recommendation of the PA Care Management Director and the Medical Director.

2. **Utilization Management.** The purpose of the PA Utilization Management (UM) Program Description is to identify components of the UM Program, roles and responsibilities of the UM staff, and to provide the framework for activities scheduled for the current year. PA has established a formal process for the oversight of resource utilization as defined in the UM Program Description and measured in the work plan and annual UM Program evaluation.

   The PA UM Program will be applied equitably, and in compliance with existing Kaiser Permanente (KP) governance and administrative policies. Health care will be based on quality and appropriateness of care. Care will not be restricted on a cost basis and clinical review is not a guarantee of payment. Payment is always subject to member eligibility and available benefits at the date of service.

   PA does not use financial incentives to encourage barriers to care or service and does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, or to promote under-utilization.

   The UM Program Description will be updated, reviewed, and approved by the PA UM Committee, Medical Director, and Director of Care Management, annually or more frequently as necessary.

The purpose of the UM Program is to provide a comprehensive process in which reviews of inpatient and outpatient services are performed in accordance with the requirements of the Kaiser Permanente Insurance Company (KPIC) Group Policy (Certificate of Insurance and Schedule of Coverage). While the optimal scenario is for all Preferred Provider Organization (PPO) and Point of Service (POS) members to receive care within the KP delivery system, the PPO/POS environment is structured to allow such members to obtain care outside of that system from either a KP-contracted provider network, or a provider of the member's choice. The UM Program is designed to assure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner. The focus of the Program is to ensure efficiency and continuity by identifying, evaluating, monitoring, and correcting matters that affect the overall efficacy of the UM process. The Program's activities are developed and implemented in compliance with state and federal regulations and are approved by the PA Board of Managers (PABM) and the PA UM/QM Committee.

Permanente Advantage is URAC accredited in Health Utilization Management.

This Program provides for fair and consistent evaluation of medical necessity and appropriateness of care through the use of KP and nationally accepted clinical practice standards.KP practitioners are included in the UM processes through participation in the various UM/QM Committees, which are functional components of the Program.

A. Maintain a clearly defined Utilization Management Program structure.
   1. Involve providers in the UM Program through participation in the UM Committee, and through regular written communication with providers about the program.
   2. Ensure adequate staff and resources are available for implementation and maintenance of the UM Program.
   3. Ensure issues addressed by the UM/QM Committees are communicated to the PABM, Quality of Care Committee, and the KPIC Board of Directors to facilitate Program oversight.
   4. Coordinate with Regional and National Network Management to educate contracted providers on policies, procedures, goals, and objectives of the UM/QM Program, and to ensure compliance

B. Provide ongoing monitoring and evaluation to address and correct inefficient coordination of health care.
   1. Perform prospective review of specific health care services to ensure services are provided within established guidelines and benefits of the member's plan.
   2. Monitor, evaluate, and optimize health care resource utilization by applying evidence-based criteria for medical necessity review.
   3. Perform medical management for acute inpatient hospitalizations and skilled nursing facility care to include:

i. Pre-admission, admission, concurrent review, and discharge planning to ensure medical necessity, appropriate level of care, and timely services.
ii. Follow-up communication with patient, physician, and provider to ensure adherence to discharge plan, and avoidance of post discharge complications.

4. Medical Director review of all potential or actual clinical denials, excluding denials due to non-eligibility and non-benefit coverage.
5. Perform retrospective review of health care services rendered to validate appropriateness of service.

C. Identify members through screening criteria appropriate for case or disease management and develop interventions that ensure efficient delivery of care.
1. Identify and manage members with catastrophic, complex, or chronic illnesses.
2. Refer members with targeted diagnoses to disease management programs.

D. Integrate the UM Program within the QM Program, where appropriate.
1. Monitor both inpatient and outpatient care for possible quality of care deficiencies, utilizing referral indicator screening criteria, and report to the QM department.
2. Respond to member or provider complaints or Level 1 appeals after comprehensive and timely investigations associated with utilization issues.
3. Perform peer review in conjunction with QM Program, when necessary.

E. Monitor for over and under-utilization trends that may lead to quality of care concerns and implement appropriate interventions when indicated.
1. Analyze utilization, readmission, pharmacy, appeals and grievance, and claims data to identify adverse trends or recurrent patterns indicating over or under utilization.
2. Measure effectiveness of interventions implemented to address over or under utilization, as indicated.

F. Promote legislative and regulatory compliance as applicable to the organizational structure and care delivery model.
1. Utilize a continuous quality improvement approach in the development, implementation, and evaluation of the UM Program.
2. Assure governmental and other regulatory guidelines, standards, and criteria are adhered to, and submit required documentation to demonstrate compliance.

3. **Case Management.** The purpose of the PA Case Management (CM) Program is to provide and ensure the necessary tools are available to the Case Manager from the initial assessment, development of treatment plan and ongoing management of the case managed member. The goal is to achieve the desired outcomes by providing quality care across a continuum enhancing quality of life and containing costs.

Case Management is defined by the Commission for Case Manager Certification (CCMC) as a collaborative process that assesses, plans, implements,

coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Case Management will be performed on specifically identified members who have experienced a critical event or diagnosis requiring extensive use of resources and requires assistance in navigating the healthcare system to facilitate appropriate delivery of care and services.

Case Management is a service available to all Kaiser Permanente Insurance Company (KPIC) members. Members have the right to decline participation or dis-enroll from the Case Management Program.

Permanente Advantage is URAC accredited in Case Management.

a) **Member Identification -** Members are identified for referrals to the Case Management Program via several data and personnel sources. This includes but is not limited to:
   i. Claims data
   ii. Auth data
   iii. Physicians, providers, discharge planners, vendors
   iv. PA Care Management staff
   v. Other Kaiser staff
   vi. Disease Management program
   vii. Member

b) **Assessment**
   Members who are enrolled in the Case Management Program are engaged in a detailed documented assessment of overall health status and condition specific issues pertaining to:
   i. Clinical history
   ii. Activities of daily living (ADL)
   iii. Mental Health status
   iv. Life planning
   v. Cultural and linguistic needs, preferences or limitations
   vi. Caregiver resources
   vii. Benefits

c) **Problem Identification**
   Member, family and the healthcare team are essential participants in problem identification
   Problems identified for Case Management intervention where members outcomes can be positively influenced includes but is not limited to:
   i. Lack of established or ineffective treatment plan
   ii. compromised patient safety
   iii. inappropriate utilization of services
   iv. alterations in function
   v. non-adherence to medication or treatment
   vi. lack of social or financial resources
   Identification of referrals to Regional Kaiser Permanente (KP) Disease Management program

d) **Planning**
   Collaboration with member, family and healthcare team results in

development of a Case Management plan with ensuing follow-up dates determined by evidence-based algorithms utilized in the Case Management Documentation system to include:

i. Development of a Case Management plan including short and long term goals
ii. Identification of barriers to meeting or complying with plan
iii. Development of follow-up schedule and communication with member and physician
iv. Development and communication of self management plans for members
v. Process to assess progress against the case management plans

e) Monitoring

Develops a process of ongoing assessment and documentation to monitor the quality of care, services and products delivered to the member. Assesses if the goals of the Case Management plan are achieved, remain appropriate and realistic and revise if appropriate.

f) Evaluation/Measurement

Employs a methodology designed to measure healthcare and case management process focusing on the client's response to the case management plan. The evaluation process occurs over specific time frames and is a continuous process. The evaluation process encourages in-put from the member, family and healthcare team to appropriately determine the impact of case management and healthcare interventions.

g) Outcomes

Case Management is a goal-directed process. Identification and implementation of changes in the Care Management plan to produce outcomes that are positive, measurable and goal-oriented.

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