

## 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:

National Health Insurance Company
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2) This report summarizes rate activity for the 12 months ending reporting year 2019.<sup>1</sup>

3) Weighted average annual rate increase (unadjusted)<sup>2</sup>

- All large group benefit designs 11.31 %
- Most commonly sold large group benefit design 11.31 %

Weighted average annual rate increase (adjusted)<sup>3</sup>

- All large group benefit designs 11.31 %

<sup>1</sup> Provide information for January 1-December 31 of the reporting year.

<sup>2</sup> 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.

<sup>3</sup> "Adjusted" means normalized for aggregate changes in benefits, cost sharing, provider network, geographic rating area, and average age.

- Most commonly sold large group benefit design<sup>4</sup> 11.31 %

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 <i>(number for each month in column 2 divided by overall total)</i>	Number of Enrollees/ Covered Lives Affected by Rate Change <sup>5</sup>	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted <sup>6</sup>
January	35	43.75%	434	16	953.53	14.61%
February	2	2.50%	3	0	980.82	37.57%
March	5	6.25%	128	0	735.79	12.09%
April	4	5.00%	11	0	1,060.24	3.32%
May	4	5.00%	16	0	850.47	5.65%
June	7	8.75%	78	0	732.20	0.70%
July	10	12.50%	92	0	703.74	4.24%
August	3	3.75%	25	0	654.11	5.26%
September	3	3.75%	74	0	1,197.63	7.97%
October	0	0.00%	0	0	0.00	0.00%
November	4	5.00%	25	0	1,052.06	3.97%
December	3	3.75%	16	0	977.96	50.06%
<b>Overall</b>	<b>80</b>	<b>100%</b>	<b>902</b>	<b>16</b>	<b>893.53</b>	<b>11.31%</b>

<sup>4</sup> 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.

<sup>5</sup> The total number of enrollees/covered lives (employee plus dependents) affected by, or subject to, the rate change.

<sup>6</sup> 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).

MCO 1:

- The most common sold benefit plan is a lower deductible PPO plan with copay structures that try to mirror an HMO like plan.
- No estimations were needed since all renewals were final.

5) Segment type: Including whether the rate is community rated, in whole or in part

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

1	2	3	4	5	6	7
Rating Method	Number of Renewing Groups	Percent of Renewing Groups <i>(number for each rating method in column 2 divided by overall total)</i>	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)	<b>31</b>	<b>38.75%</b>	<b>405</b>	<b>16</b>	<b>1,124.80</b>	<b>16.86%</b>
Blended (in part)	<b>49</b>	<b>61.25%</b>	<b>497</b>	<b>0</b>	<b>697.63</b>	<b>4.54%</b>
100% Experience Rated						
Overall	<b>80</b>	<b>100%</b>	<b>902</b>	<b>16</b>	<b>893.53</b>	<b>11.31%</b>

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.

MCO 1: Most employers have a small number of enrollees and therefore all 100% community rated. This represents 45.9% of enrollment all of which is in PPO plans.

MCO 2: Uses a blended methodology. This represents 54.1% of enrollment. In this case, 94% of plans are PPO and 6% are HDHP.

Summary:

Plan	Rating Method	Members	% Distribution
PPO	Community Rating	421	45.9%
	Blended Methodology	467	50.9%
HDHP	Blended Methodology	30	3.2%

6) Product Type:

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

1	2	3	4	5	6	7
Product Type	Number of Renewing Groups	Percent of Renewing Groups <i>(number for each product type in column 2 divided by overall total)</i>	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						
PPO	76	95%	872	16	903.96	11.36%
EPO						
POS						
HDHP	4	5%	30	0	584.79	9.48%
Other (describe)						
Overall	80	100%	902	16	893.53	11.31%

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.

Not Applicable

- 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				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

**PPO**

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	2	166	18.7%	Lower deductible and higher coinsurance plans.
0.8 to 0.899	10	458	51.6%	Lower deductible and higher coinsurance plans.
0.7 to 0.799	5	231	26.0%	Mid-level deductible and coinsurance
0.6 to 0.699	2	22	2.5%	High deductible plans
0.0 to 0.599	1	11	1.2%	High deductible plans
Total	20	888	100.0%	

**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				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

**POS**

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			100%	

**HDHP**

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	0	0	0.0%	Lower deductible and higher coinsurance plans.
0.8 to 0.899	0	0	0.0%	Lower deductible and higher coinsurance plans.
0.7 to 0.799	2	30	100.0%	Mid-level deductible and coinsurance
0.6 to 0.699	0	0	0.0%	High deductible plans
0.0 to 0.599	0	0	0.0%	High deductible plans
Total	2	30	100.0%	

**Other (describe)**

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000				
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total			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:

MCO 1: Only offer 8 standard plans.

MCO 2: Offers 14 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)**

<b>Factor</b>	<b>Provide actuarial basis, change in factors, and member months during 12-month period.</b>
Geographic Region (describe regions)	MCO 1: Rates are based on the employee's MSA.
Age, including age rating factors (describe definition, such as age bands)	MCO 1: See NHIC CA LARGE GROUP ANNUAL AGGREGATE RATE DATA - SUPPLEMENT
Occupation	Not applicable
Industry	Not applicable
Health Status Factors, including but not limited to experience and utilization	Not applicable
Employee, and employee and dependents, <sup>7</sup> including a description of the family composition used in each premium tier	MCO 1: See NHIC CA LARGE GROUP ANNUAL AGGREGATE RATE DATA - SUPPLEMENT
Enrollees' share of premiums	Not applicable
Enrollees' cost sharing, including cost sharing for prescription drugs	Pricing models that take deductibles, coinsurance, OOP, etc., into the calculations.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Not applicable
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	MCO 1: All segments are community rated. MCO 2: Part experience rated and part community rated
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	MCO 1: Provider discounts based on employee's MSA.

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<sup>7</sup> i.e. premium tier ratios

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

**a) Overall Medical Allowed Trend Factor**

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

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

7.0%

**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 <sup>8</sup>	10.5%
Hospital Outpatient (including ER)	6.3%
Physician/other professional services <sup>9</sup>	5.0%
Prescription Drug <sup>10</sup>	5.0%
Laboratory (other than inpatient) <sup>11</sup>	5.0%
Radiology (other than inpatient)	7.2%
Capitation (professional)	Not Applicable
Capitation (institutional)	Not Applicable
Capitation (other)	Not Applicable
Other (describe)	5.0%

<sup>8</sup> Measured as inpatient days, not by number of inpatient admissions.

<sup>9</sup> Measured as visits.

<sup>10</sup> Per prescription.

<sup>11</sup> 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.

NHIC does not have any capitation arrangements.

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 <sup>12</sup>	\$188.50	3.4%	6.8%	0.0%	10.5%
Hospital Outpatient (including ER)	\$184.66	2.0%	4.2%	0.0%	6.3%
Physician/other professional services <sup>13</sup>	\$89.89	1.6%	3.3%	0.0%	5.0%
Prescription Drug <sup>14</sup>	\$94.66	1.6%	3.3%	0.0%	5.0%
Laboratory (other than inpatient) <sup>15</sup>	\$12.32	1.6%	3.3%	0.0%	5.0%
Radiology (other than inpatient)	\$29.70	1.8%	5.3%	0.0%	7.2%
Capitation (professional)	N/A	N/A	N/A	N/A	N/A
Capitation (institutional)	N/A	N/A	N/A	N/A	N/A
Capitation (other)	N/A	N/A	N/A	N/A	N/A
Other (describe)	\$11.10	1.6%	3.3%	0.0%	5.0%
Overall	\$610.83	N/A	N/A	N/A	7.0%

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

No fees and risk charges are explicitly added to the trends. As mentioned above, NHIC does not have capitation arrangements.

<sup>12</sup> Measured as inpatient days, not by number of inpatient admissions.

<sup>13</sup> Measured as visits.

<sup>14</sup> Per prescription.

<sup>15</sup> 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).

MCO 1: Not Applicable  
MCO 2: Not Applicable

- (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.<sup>16</sup>

The weighted average actuarial value based on plan benefits using the company's plan relativity model, weighted by the number of enrollees is .008.

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<sup>16</sup> 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)**

MCO 1: Not Applicable  
MCO 2: Not Applicable

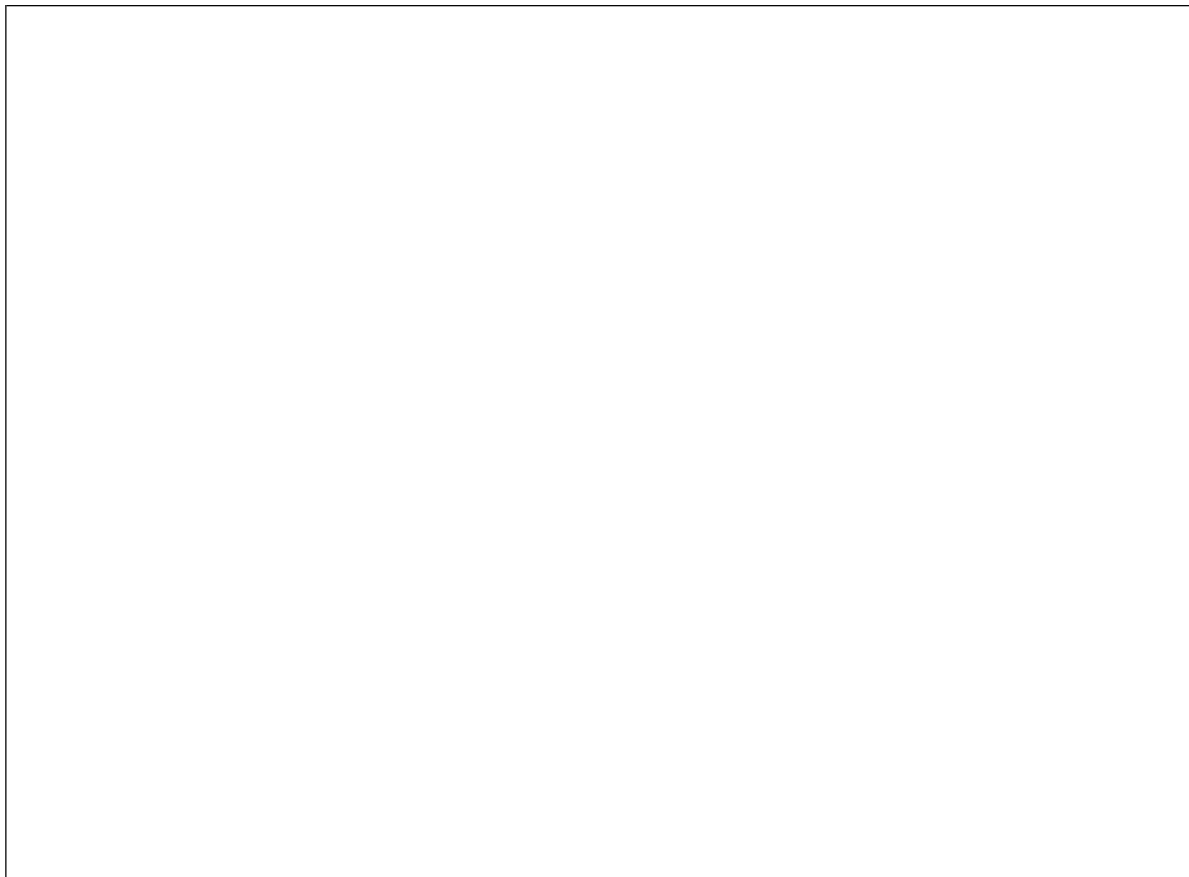
14) Cost containment and quality improvement efforts

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](http://board.coveredca.com/meetings/2016/407/2017%20QHP%20Issuer%20Contract_Attachment%207_Individual_4-6-2016_CLEAN.pdf)





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)**

Not Applicable

- 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.

The blank entries indicate that there was no data to report. This is consistent with the template from the DOI. NHIC does not have any administrative expenses, taxes, or fees for this business. These amounts are ceded to the MCOs mentioned above.

The explanation for the company's large group business model is similar to the explanation provided in the rate filings for the company's small group business model, where the company provides out of area coverage to contracted health plans.