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:

Anthem Blue Cross Life and Health Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2019.[1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 4.0 %
   - Most commonly sold large group benefit design 2.4 %

   Weighted average annual rate increase (adjusted)[3]
   - All large group benefit designs 5.9 %

[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.

- Most commonly sold large group benefit design[4] 4.2 %

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

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

1	2	3	4	5	6	7
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups *(number for each month in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected by Rate Change[5]	Number of Enrollees/ Covered Lives Offered Renewal During Month Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted[6]
January	156	38.9%	41,020	661	$472.95	5.8%
February	10	2.5%	235	26	$585.14	6.1%
March	21	5.2%	5,838	17	$579.95	4.4%
April	18	4.5%	1,237	0	$524.89	0.3%
May	19	4.7%	979	0	$575.55	2.3%
June	21	5.2%	1,536	105	$441.13	3.7%
July	44	11.0%	18,788	0	$595.06	0.1%
August	11	2.7%	693	0	$475.24	3.8%
September	29	7.2%	1,227	0	$538.36	6.4%
October	24	6.0%	1,437	0	$482.03	5.2%
November	9	2.2%	283	0	$595.26	2.9%
December	39	9.7%	1,904	0	$497.16	4.7%
Overall	401	100.0%	75,177	809	$515.56	4.0%

[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 product is PPO.
(2) The projected rate change for groups where the renewal process has not started is assumed to be the year-to-date average rate change.

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)	335	80.7%	15,445	471	$528.99	5.1%
Blended (in part)	21	5.1%	3,025	0	$485.51	2.8%
100% Experience Rated	59	14.2%	56,707	338	$513.41	3.8%
Overall	415	100.0%	75,177	809	$515.56	4.0%

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.

All three rating methodologies are available for all products.

Distribution of covered lives:

- 100% Community Rated

HMO	0.0%
PPO	98.7%
EPO	0.5%
POS	0.0%
HDHP	0.8%

- Blended

HMO	0.0%
PPO	100.0%
EPO	0.0%
POS	0.0%
HDHP	0.0%

- 100% Experience Rated

HMO	0.0%
PPO	72.0%
EPO	0.3%
POS	0.0%
HDHP	27.6%

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						
PPO	398	95.9%	59,019	809	$537.38	2.4%
EPO	6	1.4%	261	0	$721.45	9.6%
POS						
HDHP	11	2.7%	15,897	0	$430.07	10.1%
Other (describe)						
Overall	415	100.0%	75,177	809	$515.56	4.0%

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.

N/A

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				

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	69	32,203	54%	Most popular cost sharing: Deductible=$250, OOPM=$1,500
0.8 to 0.899	153	26,704	45%	Most popular cost sharing: Deductible=$1,500, OOPM=$3,500
0.7 to 0.799	13	921	2%	Most popular cost sharing: Deductible=$5,500, OOPM=$7,350
0.6 to 0.699				
0.0 to 0.599				
Total	235	59,828	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	6	261	100%	Most popular cost sharing: Deductible=$0, OOPM=$750
0.8 to 0.899				
0.7 to 0.799				

0.6 to 0.699				
0.0 to 0.599				
Total	6	261	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				

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				
0.8 to 0.899	3	53	0%	Most popular cost sharing: Deductible=$2,500, OOPM=$3,500
0.7 to 0.799	6	15,844	100%	Most popular cost sharing: Deductible=$2,700, OOPM=$3,425
0.6 to 0.699				
0.0 to 0.599				
Total	9	15,897	100%	

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:

- 69 standard plans (including grand-fathered plans) offered
  - PPO, EPO and HDHP are offered.
  - All products provide major medical/pharmacy coverage
    - PPO - provides 2 tier benefits; namely, in-network/out-of-network benefits, with variety of deductible/coinsurance combination
    - EPO - provides coverage only for in-network providers.
    - HDHP - provides 2 tier benefits; namely, in-network/out-of-network benefits, with a high deductible and Health Savings Account, Health Reimbursement Account, or Health Incentive Account.
- 312 groups with standard plans; 89 groups with custom 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)	• The objective is to set one of the rating variables so that manual claims cost equals to actual experience for each product, plan design, and market combination. Therefore, area factors which account for geographic and network differences are adjusted according to our manual rate study • 33 rating areas over 8 geographic regions in CA: Bay Area / Central Valley / Sacramento / Los Angeles / Orange / Riverside / San Diego / Santa Barbara. • 381 rating areas outside of CA. • Overall factor was decreased. • This impacts 58,412 member months
Age, including age rating factors (describe definition, such as age bands)	• No change • Factors assigned to each subscriber according to the subscriber's quinquennial attained age rating band. • The age rating bands are 0-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+. • These factors reflect claims cost due to age make-up of insureds for contracts under each age rating band.
Occupation	N/A
Industry	• Factors assigned to each employer group per industry classification based on the Standard Industrial Classification (SIC) Code. • These factors recognize that some industries tend to experience higher claim levels due to greater risk of accident or due to riskier lifestyles of typical industry employees. • Factors for some industry classifications are recalibrated and overall factor was increased. • This impacts 10,037 member months.
Health Status Factors, including but not limited to experience and utilization	N/A

Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	• No change • Factors assigned to each family tier reflecting expected age distribution by family composition tier. • Each employer group can choose from two tiers, three tiers, four tiers and five tiers for family composition tiers.
Enrollees' share of premiums	N/A
Enrollees' cost sharing, including cost sharing for prescription drugs	N/A
Covered benefits in addition to basic health care services and any other benefits mandated under this article	N/A
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	N/A
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	N/A

[7] 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)

8.9%

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[8]	8.8%
Hospital Outpatient (including ER)	8.8%
Physician/other professional services[9]	8.8%
Prescription Drug[10]	9.2%
Laboratory (other than inpatient) [11]	8.8%
Radiology (other than inpatient)	8.8%
Capitation (professional)	
Capitation (institutional)	
Capitation (other)	
Other (describe)	

[8] Measured as inpatient days, not by number of inpatient admissions.
[9] Measured as visits.
[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

Please provide an explanation if any of the categories under 9(b) are zero or have no value.

Capitation (professional), Capitation (institutional), Capitation (other):

- Not applicable to CDI plans.

Other (describer):

- No other major benefits than the categories listed in the table.

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]	$139.30	2.7%	5.8%	0.8%	9.5%
Hospital Outpatient (including ER)	$143.30	2.7%	5.8%	0.8%	9.5%
Physician/other professional services[13]	$186.46	2.7%	5.8%	0.8%	9.5%
Prescription Drug[14]	$112.32	4.8%	5.2%	0.8%	11.1%
Laboratory (other than inpatient)[15]	$18.24	2.7%	5.8%	0.8%	9.5%
Radiology (other than inpatient)	$27.60	2.7%	5.8%	0.8%	9.5%
Capitation (professional)					
Capitation (institutional)					
Capitation (other)					
Other (describe)					
Overall	$627.23	3.1%	5.7%	0.8%	9.8%

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

Capitation (professional), Capitation (institutional), Capitation (other):

- Not applicable to CDI plans.

Other (describer):

- No other major benefits than the categories listed in the table.

[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).

Standard Plans

- State mandate impacting all standard plans
  - Prorating an enrollee or insured's cost sharing for a partial fill of an oral or solid dosage form.

Custom Plans

- With exception of state mandates, cost-sharing changes are initiated by clients and the resulting changes vary widely by clients.

(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]

Aggregate AV has decreased by 0.1% over 2018 renewal.

[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)

N/A

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%207Individual_4-6-2016_CLEAN.pdf

1.01: Coordination and Cooperation

1. Remote Facility Electronic Medical Record (EMR Access)

- Upon admission to a facility and throughout the inpatient stay, Anthem Utilization Management (UM) nurses review the medical necessity for each inpatient day. Anthem requests clinical information from the facility in order to determine whether or not the member meets medical necessity criteria per MCG™ guidelines. In order to meet California's strict regulatory and accreditation case decision turnaround times, timely information must be provided by the facility via fax, phone or the Interactive Care Reviewer (ICR) portal. If the clinical information is not received within established timeframes, cases are sent for physician review and denied for Lack of Clinical Information (LOI). This results in delays for discharge planning and increased administrative costs for both the facility and Anthem due to multiple case touch points.
- To mitigate these issues with obtaining clinical information Anthem has established real-time, remote access to 68 high volume California facilities. Of our total inpatient admission volume, 39% of our hospital admissions are reviewed via Electronic Medical Records (EMR) access through facility-provided web portals. EMR access allows Anthem nurses to review current inpatient records for clinical status, history, medications, and consultations, discharge planning and lab/x-ray results - a comprehensive view of each admission. This decreases

multiple case touch points, reduces the need for the facility to provide clinical information to Anthem, decreases lack of information denials, decreases facility accounts receivables, decreases G&A overturns of previous LOI denials, provides more timely UM decisions and decreases post-service review with provision of hard copy medical records. Anthem benefits by meeting regulatory and accreditation timeframes, thus avoiding regulatory penalties related to turnaround time. Medical costs are lowered because we are performing earlier discharge planning and identifying opportunities to transition members to a lower level of care or transition home. EMR access has been identified as a best practice among other Anthem markets and divisions. Additional facilities are planned for future implementation in 2020 and beyond.

2. Future Moms

- Digital Maternity Program support enhanced as a new Future Moms 2.0 comprehensive UM and CM delivery model for low, moderate and high risk pregnant mothers.
- Implemented 1/1/2019
- Mothers are identified at the beginning of their pregnancy by their OBGYN via Availity portal connectivity with Anthem Future Moms, i.e., systematic case creation and low/moderate/high risk pregnancy identification to support individualized CM collaboration.
- Specialty UM/CM Anthem RNs offer mothers and baby single point of UM and CM contact support throughout pregnancy and delivery within one contained specialty team, i.e., based on primary nurse model.
- Provides personalized maternity support including:
    - OB screener assessments,
    - Earlier UM/CM interventions and multiple ways to engage, i.e., phone app*, computer, telephonic, mail, text, interactive voice (IVR), etc.
        - *Phone App includes personalized Calendar/Countdowns, Kick counter, Contraction timer, Pregnancy checklist, library, geographically relevant alerts, Resource links, i.e., March of Dimes, Anthem Engage, etc.
    - Individualized education and resources
    - Routine educational communications and books,
    - Breast feeding support via LiveHealth Online

4. Diabetes Prevention Program Expansion

- Enrollment with weight loss milestone attainment in Anthem CA Diabetes Prevention Program has increased 79% from year 2 (7/2017-7/2018) to Year 3 (8/2018-7/2019).

5. Palliative Care Program

- Anthem has deployed an intensive palliative care case management approach in partnership with Aspire which began 2018 and has expanded in 2019.
- The program includes claims based identification of eligible members, multi-channel engagement outreach to both member and their physician, and implementation of palliative support appropriate for the member's needs. Both telephonic and home based palliative care are offered depending on the situation.

1.02: Ensuring Networks are Based on Value:

- Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers. Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from "unit price" or volume-based payment models to payment models that involve a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver. Driven by that strategy, Anthem Blue Cross ("Anthem") supports value based provider networks to achieve the most value for members. This strategy is implemented in part through our on-going efforts in the following areas:

  <u>Hospitals:</u>

  - Anthem's Quality-In-Sights®' Hospital Incentive Program (Q-HIP®) is designed to recognize facilities for practicing evidence-based

medicine and implementing nationally endorsed best practices in patient safety, health outcomes and member satisfaction from standard setting organizations such as The Joint Commission (TJC), the National Quality Forum (NQF) and other respected authorities. Hospitals enter into a written agreement with Anthem Blue Cross in order to participate in the program. The better a hospital performs on the selected indicators, the greater the Q-HIP Adjustment to contract compensation the hospital may receive. More than 48% of member admissions to Anthem's State-wide hospital network are to a hospital that participates in QHIP.

1.03: Demonstrating Action on High Cost Providers

1. Converting NPAR to PAR:

- Using data that showed non-par providers driving allowed pmpm and high unit cost trend, the CA provider solutions team intensified its efforts to convert non-par to par providers. In this initiative, BH hospitals and professional were recruited to par status with savings.

2. Standardizing Fee Schedule:

- Another significant effort to reduce high cost providers was to build standardized fee schedules for complex surgeries.
- Local Commercial also implemented standard PPO fee schedule.

3. Other:

- CA Contract Compliance Unit designed to ensure compliance and claims provider payment accuracy.
- Increased diligence in Chargemaster violations.

1.04: Demonstrating Action on High Cost Pharmaceuticals

- Pharmacy migration to Ingenio Rx, an independent internal Anthem company is projected to reduce prescription drug cost.
- Medical rebates and ESI discounts.

1.05: Quality Improvement Strategy

- Anthem's vision is committed to excellence in the quality of care and services provided to members, and to the competence of provider networks. There is dedication to member satisfaction, improving the health status and quality of care for members and the public, providing

value-added services, improving member safety, and promoting member access to medical services.

- The goals, objectives, and structure of the QI Program are responsive to the changing needs of members, providers, and the health care community; evolving and building upon the culture to focus on being a valued health partner across the health care continuum.
- The Commercial/Exchange Quality Improvement Committee (CEQIC) has been designated by the Board of Directors as the responsible committee to oversee the Quality Improvement Program and all related quality activities. The CEQIC provides routine reports on updates to the program, the annual work plan, and the evaluation of the annual work plan to the Board of Directors. The CEQIC has designated the day to day management of quality including quality management projects and activities to the business areas that support quality. As designated by the quality leadership, the Medical Director who chairs the Commercial/Exchange Quality Improvement Committee is responsible to help ensure that cross-disciplinary collaboration occurs to improve the quality of member care and services. The CEQIC Chair engages with the leadership of various CEQIC sub-committees and other areas of the organization to help ensure quality goals and accreditation standards are being met and members are receiving the benefit of programs that are interconnected, non-duplicative and value-added in nature.
- The Senior Vice President, Health Care Management: has overall responsibility for the quality improvement program aligning the goals/objectives of the Quality Improvement program with business objectives, and setting quality program strategy. In addition, is responsible for implementation and maintenance of the quality program priorities that will demonstrate improved provider and member outcomes.
- The Quality Improvement Program Description (QIPD) is an ongoing, comprehensive, and integrated system which defines how departments support quality, objectively and systematically monitors and evaluates the quality, safety, and appropriateness of medical and BH care and services offered by the health network, and to identify and act on opportunities for continuous improvement. These values provide an overall foundation for success, helping define what is done and how it's done. Quality activities are often interdepartmental and collaborative in nature, and are offered through several business units. The pursuit of excellence guided by Anthem's four strategic pillars – *Provider Collaboration, Consumer Centricity, Quality, and Managing the Total Cost of Care* – is the foundation for many programs and initiatives across the company to deliver meaningful and measurable quality outcomes for members. The five Quality dimensions that make up the quality pillars are clinical quality, service quality, quality compliance, clinical programs, and wellness.

- To enable comprehensive assessment of the system and meaningful prioritization of initiatives, critical monitors are selected from CM, DM, provider services, pharmacy management, utilization medical management, and customer service to develop the annual Anthem Blue Cross Commercial/Marketplace Quality Improvement Work Plan. The annual work plan includes multiple interventions to improve the quality of care and safety to Anthem members.
- The QI Plan addresses medical and behavioral health quality programs and activities many of which are delivered from an enterprise perspective. Our quality programs include HEDIS measures for Prevention, Health Management, Behavioral Health, and Pharmacy, Patient Safety, Continuity and Coordination of Care, Utilization Management (UM) and Case Management (CM), Disease Management, CAHPS, and Service Operations. Quality activities are often interdepartmental and collaborative in nature and are offered through several business units. Products in scope include Commercial PPO (EPO is included) and Marketplace PPO. The Work Plan identifies and tracks priority metrics for quality activities that can be impacted with initiatives. The work plan contains priority metrics previously noted by business owners as not meeting goal and/or performance is to be maintained at goal level

1.06: Participation in Collaborative Quality Initiatives

- Anthem Blue Cross and Blue Shield of California have joined together to share health data and improve patient care by launching the California Information Data Exchange (Cal INDEX). Cal INDEX, a next generation Health Information Exchange, was created through a joint investment of $80 million and will allow health care providers to share health data and improve patient care. Utilizing the records of nine million people, more than 25% of the state's population, Cal INDEX will be one of the largest health information exchanges in the country. Cal INDEX houses a comprehensive collection of patient records on a secure, electronic platform. It includes clinical data from multiple health care providers and insurers and allow physicians and hospitals throughout the state to share patients' health information to help them give their patients the best care possible. Cal INDEX has been set up as a not-for-profit organization that will be open to all doctors, hospitals and health plans that contribute data.
- Anthem is engaged with Integrated Health Association (IHA), CMS Physician Quality Reporting System and fund California HealthCare Performance Information System (CHPI), and CalHospital Compare.
- Anthem has provider collaboration as a key focus and data integration is a critical component. Anthem currently has electronic admission and

ER notification from over 300 hospitals that is shared with the members' medical groups and physicians for ACO PPO.

- In addition, Anthem, with Blue Shield of California was a founding partner of Cal Index, a not-for-profit organization developing a statewide, next-generation health information exchange. This comprehensive collection of electronic patient records will include clinical data from healthcare providers and health insurers like Anthem Blue Cross. Cal INDEX provides the underlying data and technology platform to improve quality of care by providing doctors with a unified statewide source of integrated patient information, as well as improve efficiency and reduce the cost of healthcare. Cal INDEX is designed to improve the inefficiency and complexity of the current system by: 1) Collecting and integrating clinical data from multiple healthcare providers and health insurers; 2) Centralizing and storing that data; 3) Allowing doctors, nurses and hospitals to share vital patient information easily, reliably and securely.
- Population Health Management and Care Delivery Transformation
  At Anthem, we support our providers with tools and resources to practice patient-centered care and maximize the value of the data we provide. Anthem takes claims data feeds through our analytics engines to deliver actionable reports in real-time, through a multi-payor platform. In contrast, even though other plans provide claims data, they fall short of translating raw claims into actionable insights that providers can use to determine which patients need attention and why. Anthem analytics engines deliver actionable reports in real time through a multi-payer platform, facilitating seamless care coordination. Anthem is the only payer offering innovative transformation assistance to the extent that we do and our population health technology and consulting services are second to none in the market.
- Multiple resources and programs available on Anthem's site such as My Health Coach, Healthy lifestyles, Future Moms, Behavioral Health and Employee Assistance Program, Care Management programs that are available to all members. Also, available are resources for cancer prevention program specifically related to Colon Cancer, Cervical cancer and Breast cancer. Additional resources are available on Anthem's website to help all members with understanding on basics of health insurance, customer service topics such as how to get the most out of your health plan, what to do when you get a bill form your doctor, what to do when you get a new ID card, planning ahead for your next doctor’s visit, tools to help with cost and quality, claims, find a doctor and Health Record etc.
- Participation in multiple statewide programs as listed: State Health Report, Journey Forward Program for cancer survivors, Better Choices, Better Health Diabetes, National MS Society, LLS Night the Light, Conejo Valley Senior Concerns/Love Run, Susan G. Komen

Race for the Cure, AIDS Walk LA, Diabetes program for Downtown Women's Center, ADA Step out walk, Diabetes Prevention Youth Camp, CA Equality Institute. Participation in many state wide programs to support non-health related activities such as finding for Jessie Rees Foundation, Santa Barbara County/Salute to Teachers, ADA/Diabetes Prevention Youth Camp, MEND, Santa Barbara County/Salute to Teachers

- Community health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative. Patient Safety First Launched in 2010, Patient Safety First (HQInstitute.org/PSF) united key stakeholders from different geographic regions within the state to improve quality of care provided to Californians, save lives by targeting zero avoidable medical errors, and reduce healthcare costs to allow for reinvestment into the system.
- Anthem Corporate Scholars Program for college students. Each year 15 students will participate in an 8-week internship in different markets over the term of the grant.
- Convergence Center for Policy: This grant will help fund the building and testing "Smart Receipts" to influence and encourage a shoppers-behavior towards more healthful purchases. Participation in geographic disaster relief efforts (e.g., weather, fire, environmental) American Red Cross: Provide Appropriate disaster relief as needed. Americares: Support Ebola Relief Efforts, Portlight Strategies: Disaster Response Program.

1.07: Data Aggregation across Health Plans

Cost Atlas

- Anthem is an active participant in the IHA Cost Atlas initiative which aggregates data across 11 plans to illustrate the cost of care, resource use and clinical quality measures in all 19 regions of the Covered California health benefits exchange and examines the variation in these measures across regions and payer types and for particulate sub-populations. The atlas uses claims, encounters, eligibility, and cost data for both HMO and non-HMO products form three payer types: commercial, Medicare, and Medi-Cal, as well as data previously submitted by Plan and Other Plan/Insurers to Data Aggregator or IHA for other IHA performance measurement initiatives.

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.

N/A