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 2022 .[1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 4.4 %
   - Most commonly sold large group benefit design 4.3 %

Weighted average annual rate increase (adjusted)[3]
   - All large group benefit designs 6.2 %

[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] 6.8 %

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	181	47.8%	53,148	901	$585.53	3.6%
February	7	1.8%	515	17	$490.62	1.4%
March	12	3.2%	4,716	0	$589.85	0.2%
April	13	3.4%	788	2	$618.81	4.1%
May	11	2.9%	545	0	$725.66	6.7%
June	19	5.0%	947	0	$583.57	4.0%
July	35	9.2%	10,394	0	$516.04	8.9%
August	14	3.7%	1,524	0	$606.26	7.1%
September	24	6.3%	1,619	0	$539.94	6.1%
October	28	7.4%	1,774	0	$558.70	7.7%
November	7	1.8%	144	45	$701.29	2.8%
December	28	7.4%	1,394	0	$705.22	8.3%
Overall	***379***	***100.0%***	***77,507***	***965***	***$578.48***	***4.4%***

[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 determined by comparing the current premium to the required premium which equals to the trended claims divided by target loss ratio.

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)	308	81.3%	17,892	764	$617.86	6.5%
Blended (in part)	22	5.8%	3,588	52	$595.87	5.0%
100% Experience Rated	49	12.9%	56,027	149	$564.28	3.7%
Overall	***379***	***100.0%***	***77,507***	***965***	***$578.48***	***4.4%***

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	99.6%
EPO	0.4%
POS	0.0%
CDHP	0.0%

- Blended

HMO	0.0%
PPO	85.8%
EPO	14.2%
POS	0.0%
CDHP	0.0%

- 100% Experience Rated

HMO	0.0%
PPO	58.5%
EPO	0.6%
POS	0.0%
CDHP	40.9%

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	0	$0.00	0.0%
PPO	380	97.9%	53,579	965	$584.37	4.3%
EPO	6	1.5%	942	0	$693.40	4.7%
POS	0	0.0%	0	0	$0.00	0.0%
HDHP	2	0.5%	22,986	0	$559.80	4.8%
Other (describe)						
Overall	***388***	***100.0%***	***77,507***	***965***	***$578.48***	***4.4%***

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	34	15,139	28%	Most popular cost sharing: Deductible=$250, OOPM=$2500
0.8 to 0.899	69	19,052	35%	Most popular cost sharing: Deductible=$400, OOPM=$3500
0.7 to 0.799	76	20,353	37%	Most popular cost sharing: Deductible=$2,500, OOPM=$6,350
0.6 to 0.699				
0.0 to 0.599				
Total	179	54,544	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	942	100%	Most popular cost sharing: Deductible=$0, OOPM=$1500
0.8 to 0.899				
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total	6	942	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	1	412	2%	Most popular cost sharing: Deductible=$1,400, OOPM=$3,000
0.7 to 0.799	3	22,574	98%	Most popular cost sharing: Deductible=$2,800, OOPM=$3,425
0.6 to 0.699				
0.0 to 0.599				
Total	4	22,986	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				

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:

- 19 standard plans offered.
  - PPO, EPO, and HDHP are offered.
  - All products provide major medical/pharmacy coverage.
  - PPO - provide 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 - provide 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.
- 277 groups with standard plans; 102 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 claims study. • 75 rating areas over 9 geographic regions in CA: Rural / Sacramento / San Francisco Bay Area / Central Coast / Central Valley / Los Angeles / Inland Empire / Orange / San Diego. • 91 rating areas outside of CA. • Overall factor was decreased. • This impacts 71,267 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	• No Change • 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.
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)

9.4%

b) Medical Allowed Trend Factor by Aggregate Benefit Category

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

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

Hospital Inpatient[8]	9.5%
Hospital Outpatient (including ER)	9.5%
Physician/other professional services[9]	9.5%
Prescription Drug[10]	9.0%
Laboratory (other than inpatient) [11]	9.5%
Radiology (other than inpatient)	9.5%
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 (describe):
• 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]	$110.39	4.7%	3.3%	0.0%	8.2%
Hospital Outpatient (including ER)	$132.26	4.7%	3.3%	0.0%	8.2%
Physician/other professional services[13]	$162.35	4.7%	3.3%	0.0%	8.2%
Prescription Drug[14]	$98.41	7.0%	3.3%	0.0%	10.5%
Laboratory (other than inpatient)[15]	$20.58	4.7%	3.3%	0.0%	8.2%
Radiology (other than inpatient)	$24.16	4.7%	3.3%	0.0%	8.2%
Capitation (professional)					
Capitation (institutional)					
Capitation (other)					
Other (describe)					
Overall	$548.15	5.1%	3.3%	0.0%	8.6%

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 (describe):
• 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

i) Benefits changes that applied to all standard active PPO
   a. Live Health Online medical office visits are offered at no cost sharing.
   b. Office-based injection cost sharing is 30% coinsurance with up to $250 maximum copay after deductible.
   c. Decrease DME coinsurance from 50% plan coinsurance after deductible.
   d. Include embedded vision exam visit at no cost sharing for all plans.
   e. In-network specific medical services, drug types and devices (listed in IRS notice 2019-45) associated with chronic condition are covered in full at no cost sharing for all plans.

ii) Changes to a few Solution PPO Plans
   a. Increase PCP and Urgent Care copay from $15 to $20 and Specialty copay from $30 to $40
      i. Anthem Solution PPO 1500/15/30/20 to Anthem Solution PPO 1500/20/40/20

b. Increase in-network OOPM from $4000/$8000 (Individual/Family) to $5000/$10,000 and out-of-network OOPM from $12000/$24000 to $15000/$30000
    i. Anthem Solution PPO 1500/15/30/20
    ii. Anthem Solution PPO 2000/20/40/20

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

(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 2.1% over 2021 renewal, driven by the mix of plans (one large group with high AV moved).

[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%207_Individual_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 123 high volume California facilities. . 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 2022-2023 and beyond.

2. Future Moms
    - Digital Maternity Program support enhanced as a new Future Moms 2.0 comprehensive 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 CM Anthem RNs offer mothers and baby single point of 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
            - Post Partum assessment and support up to 12 weeks after birth

3. Enhanced Personal Health Care Expansion
    - Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs): Anthem's value-based payment initiative, Enhanced Personal Health Care (EPHC), is applicable to any provider organization with a foundation in primary care. EPHC, which is composed of both Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), uses a payment model that includes a support system of data, analytics and insights to help promote providers' success around prevention, disease management and population health improvement.
    - The EPHC payment model gives providers the opportunity to earn shared savings bonus payments when they successfully manage quality and overall health care costs. To qualify for shared savings, providers must first meet quality thresholds built on a scorecard of nationally recognized measures of clinical quality and, utilization. This scorecard not only determines eligibility for shared savings, but also calibrates the percent of shared savings for which providers are eligible. We also support participating providers through fixed per member per month clinical coordination payments, which support important clinical interventions that occur between patient visits.
    - EPHC further supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care

Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. Anthem couples this analytic support with a team of health care delivery transformation experts who help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem has a dedicated focus on physician practices serving rural/remote populations.

- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being. Currently we have 26 larger Medical Groups/IPAs/Integrated Systems participating in our ACOs while 27 smaller practices participate in our PCMH model. Our ACOs and PCMHs are responsible for coordinating the care of over 1 Million attributed Commercial PPO lives in California. Anthem continues to evaluate areas of opportunities and partnerships to expand the EPHC program.

5. Palliative Care Program
    - Anthem has a robust palliative care program for our commercial members that launched in 2018 and is monitored for continuous quality improvement. With our partner Aspire Health, palliative care services are provided to members with advanced illness with a life expectancy of 12 months or less.
    - Palliative care services are provided by palliative certified and experienced physicians, social workers and nurse practitioners
    - 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.
    - Additionally, direct referrals for these services are encouraged from Anthem case managers, Medical Directors as well as from treating providers. Clinical referral guidelines are available to identify members appropriate for these services.

6. Readmissions Reduction
    - Initiative is focused on reduction of avoidable hospital readmissions through improved multidisciplinary coordination and collaboration with hospitals, agencies, internal/external customers, and communities while ensuring cost effective, high quality, and appropriate level of care.
    - Members are included in program who are identified as meeting specific criteria related to frequent ER usage/hospital admissions and/or diagnoses.
    - Focused discharge planning includes UM/CM collaboration; MD name and phone number documented in case by UM (when able to obtain from facility) for follow-up by CM, ensuring member has/keeps post discharge appointment(s), treatment plan is in place and understood.
    - Case Management follow-up with member in hospital when possible, or post discharge and/or CM follow-up with provider if member is unable to engaged.

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:

  Hospitals:

  - 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.

  Physicians:

  - The goal of the Align.Measure.Perform (AMP) VBP4P Incentive Program is to provide a comprehensive pay for performance program for our capitated Participating Medical Groups (PMGs) that rewards efficient care coupled with quality. AMP VBP4P integrates quality, appropriate resource use ("ARU") and cost of services provided by Anthem's commercial health maintenance organization (HMO) Participating Medical Groups (PMGs). The Align.Measure.Perform (AMP) VBP4P Incentive Program was developed in collaboration with the Integrated Healthcare Association ("IHA"), health plans, and physician organizations participating in Pay for Performance ("P4P") as a strategic initiative to moderate HMO cost trend in California while continuing to improve quality of care and utilization of health care services.
  - The Align, Measure, Perform (AMP) VBP4P Incentive program evaluates participating Medical Groups for compliance with clinical guidelines and protocols, patient outcomes, member satisfaction, and advance care information. AMP's VBP4P is designed to share savings with participating

PMGs if the PMG achieves improvements on individual ARU measures. Performance on total cost of care trend serves as a gate, and performance on quality serves both as a gate and an adjustment to the incentive payout if savings are achieved. Two thirds or Anthem's State-wide HMO PMGs participate in the AMP VBP4P Incentive Program.

Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs):

- Anthem's value-based payment initiative, Enhanced Personal Health Care (EPHC), is applicable to any provider organization with a foundation in primary care. EPHC, which is composed of both Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), uses a payment model that includes a support system of data, analytics and insights to help promote providers' success around prevention, disease management and population health improvement.
- The EPHC payment model gives providers the opportunity to earn shared savings bonus payments when they successfully manage quality and overall health care costs. To qualify for shared savings, providers must first meet quality thresholds built on a scorecard of nationally recognized measures of clinical quality and utilization. This scorecard not only determines eligibility for shared savings, but also calibrates the percent of shared savings for which providers are eligible. We also support participating providers through fixed per member per month clinical coordination payments, which support important clinical interventions that occur between patient visits.
- EPHC further supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. Anthem couples this analytic support with a team of health care delivery transformation experts who help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem has a dedicated focus on physician practices serving rural/remote populations.
- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being.

1.03: Demonstrating Action on High Cost Providers

1. Securing contracts with non-participating providers.
    - The California Provider Solutions team employed a data-driven process to (i) identify high-cost, non-participating providers, (ii) develop a target outreach campaign and (iii) convert those high-cost, non-participating providers into participating providers with compensation rates that were in-line with market-acceptable compensation

rates. The targeted non-participating providers included Behavioral Health providers, Ambulatory Surgery Centers (ASCs), facility providers and Specialists and Emergency Room physicians.

2. Standardizing Fee Schedule:
    - The California Provider Solutions team undertook an in-depth analysis of the standard Professional fee schedules and implemented changes which helped generate significant savings across more than 70% of Anthem's Professional provider network, with a focus on complex surgeries and other high-cost Professional services.

3. Implementing Other Measures:
    - The California Provider Solutions team, in conjunction with the California Contract Compliance Unit and additional national resources, developed and implemented policies and procedures to (i) enhance contract compliance and improve claims adjudication accuracy compliance, (ii) continue its due-diligence and active management of hospital Chargemaster violations and (iii) reduce claims leakage and optimize performance of its capitated and delegated HMO entities.

1.04: Demonstrating Action on High Cost Pharmaceuticals

- Initiative #442473 – PPO Specialty Drug Utilization
    - For specialty drugs administered in a physician's office or outpatient setting, this project will require providers to use CVS Specialty (or designated vendor). Initiative targets 106 specialty drugs.
    - When providers administer drugs in the office or outpatient setting they are not required to obtain the medications from Anthem's preferred specialty pharmacy CVS Specialty. Anthem assumes financial risk for these medications. Providers authorize and acquire the medications then bill for the cost as part of a buy and bill model. Buy and bill methodology does not align with standard industry practices of requiring providers to obtain drugs through a specialty pharmacy that's designated by the insurer.
    - Annualized hard savings of $15.7M
- Initiative # 433340 – HMO Specialty Drug Utilization
    - For specialty drugs administered in a physician's office project will require Independent Physician Associations (IPAs) and Physician Management Groups (PMGs) to use CVS Specialty (or designated vendor) where risk carved out to Anthem for Commercial and MCD HMOs.
    - Obligate IPA's to use Ingenio Rx where risk carved out to Anthem.
    - Annualized hard savings of $8.5M

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 Vice President, Enterprise Quality Strategy and 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 HMO, POS, and PPO (EPO is included) and Marketplace HMO,

POS, and 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 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 both HMO and ACO PPO.
- In addition, Anthem, is supports and utilizes Manifest MedEx , 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. Manifest MedEx 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. Manifest MedEx 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.
- For HMO patients, Anthem provides the medical groups and physicians both the electronic hospital census as well as quality data feeds that are loaded into the medical groups' electronic health records. Anthem is working with the HMO medical groups through Joint Operating Meetings, delegation process and ongoing education and communication exchanges to improve the vertical integration of Anthem-hospitals and medical groups. In addition, Anthem is an active participant with IHA P4P and other statewide collaborative to improve data. In the last two years, Anthem has been working with the HMO medical groups to improve the encounter data. Anthem has improved the encounter data from 80% complete and accurate to closer to 85-90% and this is a top priority to continue to improve encounter data. Another area of data integration is with the HMO medical groups and hospitals that work from a full capitation arrangement.
- For PPO patients, the Anthem ACO program, the Enhanced Personal Health Care has data integration as a key component. Anthem works with the groups on providing reports via our online tool PCMS as well as monthly, quarterly and annual reports.
- <u>Population Health Management and Care Delivery Transformation</u>
  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: Foundation for CA Community Colleges, MAVEN Project, JDRF, LLS Night the Light, California Association of Food Banks, United Ways of California, Susan G. Komen Race for the Cure, AIDS Walk LA, Diabetes program for Downtown Women's Center, March of Dimes, Mental Health America, Boys & Girls Clubs of America, Jessie Rees Foundation, Easterseals. Participation in many state wide programs to support non-health related activities such as funding Santa Barbara County/Salute to Teacher, UNCF Corporate Scholarship Program & BioComm InstituteCommunity 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.

Disaster Relief efforts: Participation in geographic disaster relief efforts (e.g., COVID 19 response, weather, fire, environmental) American Red Cross Annual Disaster Giving Program, Americares, Portlight Strategies, and Direct Relief

1.07: Data Exchange with Providers

1. Vivity

- The partner hospitals and their affiliated medical groups do have access to Vivity's integrated private health information exchange with longitudinal patient records (LPRs) that are shared between Vivity partner entities. The clinical records are updated on a nightly basis for inpatient and ER encounters, as well pharmacy and lab. Outpatient records, care management progress notes and therapy notes are also updated daily if records are available.
- The private HIE provides high risk alerts, care gap reports, trend reports, for population health outreach and care management, and providers may also access the LPR to get current patient clinical history, discharge summaries, lab results, etc. for treatment and care coordination of the patient.
- The reporting from this HIE has been pivotal in the partners' efforts to manage cost of care. For example, using the AI-driven insights on rising risk populations, the medical groups have proactively outreached to those at risk and kept our medical inpatient admissions 18% lower than benchmark in 2020, and 35% lower in terms of medical inpatient days/K. .
- The private Vivity HIE offers a number of clinical management reports that can be filtered and extracted based on claims records to include condition based

high risk alert and care gap reports for care management and population health teams at Vivity medical groups/IPA to use in member outreach, provider alerts, and other quality improvement activities. These conditions include, but are not limited to CHF, diabetes, lipid disorder, COPD, hypertension, asthma, vulnerable elders, etc. These reports may be further filtered by co-morbidity and other risk factors (A1c poor control).

- In addition, partner hospitals are working to enhance more detailed exchanges of clinical data through their respective organizations' IT strategy in participation in national health information exchanges such as CareEverywhere, Carequality and CommonWell.

2. EPHC

- Anthem's EPHC program supports value-based payment with a robust suite of tools, support and resources that providers need to thrive in a value-based payment environment. Through alerts, dashboards, and reports, Provider Care Management Solutions (PCMS), Anthem's web-based application available to practices participating in EPHC, gives practices the tools they need to manage population health, and risk stratify their membership to identify the most vulnerable patients in need of intervention. In addition, providers will have access to Anthem's longitudinal health record, Patient360, a compliance tool that facilitates the sharing of a comprehensive range of patient data with our ACOs/PCMH. The robust reporting helps to promote providers' success around prevention, disease management and population health improvement. Anthem couples this analytic support with a team of health care delivery transformation experts who serve as an extension of the physician practice, providing transparent access to health and cost data and help EPHC providers succeed in improving quality, controlling the overall cost of care, and delivering the best possible care experience to our members. As part of this program Anthem has a dedicated focus on physician practices serving rural/remote populations.
- At its inception in 2010 the program initially served three regional markets in Southern California. Today, EPHC serves 19 regional markets across the State. As this program has evolved Anthem has observed evidence that EPHC is changing the way providers interact with members, resulting in significant improvements in member experience. EPHC members report better access to urgent care, improved communication with their PCPs and attention to mental as well as physical well-being. Currently we have 26 larger Medical Groups/IPAs/Integrated Systems participating in our ACOs while 27 smaller practices participate in our PCMH model. Our ACOs and PCMHs are responsible for coordinating the care of over 1 Million attributed PPO lives in California. Anthem continues to evaluate areas of opportunities and partnerships to expand the EPHC program.

1.08: Data Aggregation across Health Plans

<u>California's HMO Value Based Pay for Performance Program</u>

- Working with California health plans and physician organizations for nearly two decades, IHA's Align.Measure.Perform (AMP) Incentive Program, formerly known as Value Based Pay for Performance (VBP4P), has grown into one of the largest alternative payment models in the country. Today, participants include 14 statewide health plans and nearly 200 California physician organizations caring for over 13 million Californians enrolled in

commercial health maintenance organization (HMO) and point of service (POS) products.

- The program has four key components: a common set of measures and benchmarks; health plan incentive payments to physician organizations; public reporting of physician organization results; and public recognition awards. Adoption of common performance measures and benchmarks across health plans and physician organizations helps harness collective market forces to drive improvements in patient care. Additionally, aggregation of data across participating health plans significantly improves measurement reliability and validity and decreases reporting burden for physician organizations by eliminating competing and conflicting health plan rating systems

<u>California Regional Health Care Cost & Quality Atlas</u>

- Anthem is an active participant in the California Regional Health Care Cost & Quality 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