California Large Group Annual Aggregate Rate Data Report Form
Version 2, August 31, 2016

(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 "SB 546 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
10) Projected Medical Trend
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) 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 _2016_.[1]

3) Weighted average annual rate increase (unadjusted)[2]:
   - All large group benefit designs: __4.7_%
   - Most commonly sold large group benefit design: __4.0_%

   Weighted average annual rate increase (adjusted)[3]:
   - All large group benefit designs: __7.5_%
   - Most commonly sold large group benefit design[4] _7.4__%

[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.
[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.

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

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	260	50.6%	77,055	2,857	$387.70	4.5%
February	20	3.9%	875	0	$421.73	10.7%
March	21	4.1%	6,849	0	$499.17	13.4%
April	17	3.3%	1,193	1	$570.97	7.7%
May	24	4.7%	1,847	0	$490.26	4.9%
June	19	3.7%	876	0	$430.00	5.9%
July	41	8.0%	48,070	12	$486.41	4.9%
August	16	3.1%	1,144	0	$431.56	3.0%
September	24	4.7%	1,377	0	$484.81	8.4%
October	23	4.5%	1,302	682	$553.65	2.3%
November	14	2.7%	444	0	$552.70	4.3%
December	35	6.8%	10,402	38	$361.65	-1.3%
Overall	***514***	***100.0%***	***151,434***	***3,590***	***$428.33***	***4.7%***

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

[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).*

- PPO is the most popular product.
- For outstanding renewals, the proposed rate change less the historical negotiation impact and benefit buy-down is used as a proxy for the unadjusted sold rate change.
- Groups may offer coverage option through other plans and the number of affected enrollees may be less than 100.

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 month 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)	399	77.6%	22,746	1,687	$438.92	9.3%
Blended (in part)	36	7.0%	6,080	255	$457.39	2.4%
100% Experience Rated	79	15.4%	122,608	1,648	$424.77	3.9%
Overall	***514***	***100.0%***	***151,434***	***3,590***	***$428.33***	***4.7%***

Comments: Describe differences between the products in each of the segment types listed in the above table, including which product types (PPO, EPO, HMO, POS, HDHP) 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 the three rating methodologies are available for all the products.
- Distribution of covered lives
  - 100% Community Rated

HMO	0.0%
PPO	62.2%
EPO	1.7%
POS	0.0%
HDHP	36.1%

  - Blended

HMO	0.0%
PPO	61.6%
EPO	4.0%
POS	0.0%
HDHP	34.4%

  - 100% Experience Rated

HMO	0.0%
PPO	70.5%
EPO	2.2%
POS	0.0%
HDHP	27.3%

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 month 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	443	75.5%	106,623	2,738	$464.65	4.0%
EPO	11	1.9%	3,443	0	$313.41	3.8%
POS						
HDHP	133	22.7%	41,368	852	$343.64	6.5%
Other (describe)						
Overall	***587***	***100.0%***	***151,434***	***3,590***	***$428.33***	***4.7%***

HMO – Health Maintenance Organization PPO – Preferred Provider Organization
EPO – Exclusive Provider Organization POS – Point-of-Service
HDHP – High Deductible Health Plan with or without Savings Options (HRA, HSA)

Describe "Other" Product Types, and any needed comments here.

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	72	24,572	21.5%	Most popular cost sharing: Deductible=$500, OOPM=$2,000
0.8 to 0.899	165	60,326	54.4%	Most popular cost sharing: Deductible=$1,500, OOPM=$4,500
0.7 to 0.799	91	21,468	21.5%	Most popular cost sharing: Deductible=$2,500, OOPM=$8,850
0.6 to 0.699	28	2,995	2.6%	Most popular cost sharing: Deductible=$3,500, OOPM=$9,850
0.0 to 0.599				
Total	356	109,361	100.0%	

EPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	10	3,434	99.7%	Most popular cost sharing: Deductible=$0, OOPM=$2,000
0.8 to 0.899	1	9	0.3%	Most popular cost sharing: Deductible=$0, OOPM=$5,000
0.7 to 0.799				
0.6 to 0.699				
0.0 to 0.599				
Total	11	3,443	100.0%	

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	79	13,124	31.1%	Most popular cost sharing: Deductible=$1,500, OOPM=$3,000
0.7 to 0.799	46	27,867	66.0%	Most popular cost sharing: Deductible=$2,500, OOPM=$3,425
0.6 to 0.699	12	1,229	2.9%	Most popular cost sharing: Deductible=$6,350, OOPM=$6,350
0.0 to 0.599				
Total	137	42,220	100.0%	

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:

- 141 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.
- 330 groups with standard plans; 192 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 • Eight geographic regions in CA: Bay Area / Central Valley / Sacramento / Los Angeles / Orange / Riverside / San Diego / Santa Barbara. • Overall factor was reduced. • This impacts 191,206 members months
Age, including age rating factors (describe definition, such as age bands)	No change
Occupation	N/A
Industry	No change
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
Enrollees' share of premiums	N/A
Enrollees' cost sharing	N/A
Covered benefits in addition to basic health care services and any other benefits mandated under this article	N/A

[7] i.e. premium tier ratios

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

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

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)

8.0%

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]	6.3%
Hospital Outpatient (including ER)	6.3%
Physician/other professional services[9]	6.3%
Prescription Drug[10]	17.5%
Laboratory (other than inpatient) [11]	6.3%
Radiology (other than inpatient)	6.3%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	N/A

[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.

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

Pricing Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	N/A	4.0%	3.5%	N/A	7.7%
Hospital Outpatient (including ER)	N/A	4.0%	3.5%	N/A	7.7%
Physician/other professional services[13]	N/A	4.0%	3.5%	N/A	7.7%
Prescription Drug[14]	N/A	0.8%	7.7%	N/A	8.5%
Laboratory (other than inpatient)[15]	N/A	4.0%	3.5%	N/A	7.7%
Radiology (other than inpatient)	N/A	4.0%	3.5%	N/A	7.7%
Capitation (professional)	N/A	N/A	N/A	N/A	N/A
Capitation (institutional)	N/A	N/A	N/A	N/A	N/A
Capitation (other)	N/A	N/A	N/A	N/A	N/A
Other (describe)	N/A	N/A	N/A	N/A	N/A
Overall	N/A	3.5%	4.1%	N/A	7.8%

[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, and (iv) Taxes and fees. *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. Describe these changes at the plan level (see definition of "plan" in the document "SB546-Additional Information.") Please include 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

- Any $ limit on benefit category has been removed.
- Rx benefit changed from $10/$25/$50/30% $250 Deductible with Tier 4 copay maximum = $150 to $15/$40/$60/30% with Tier 4 copay maximum = $250.

Custom plans

- With exception of federal/state mandates, cost-sharing changes are initiated by clients and 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]

N/A

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. Describe these changes at the product level (see definition of "product" in the document "SB546-Additional Information.") Please 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)***

[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.

Standard / Custom plans

- For PPO, CDH and HDHP,
    - Expand Blue Distinction network inside CA in addition to Centers of Medical Excellence for transplants.
    - Implement Blue Distinction Centers/Centers of Medical Excellence steerage for outpatient bariatric services.
- Flu Shot and preventive incentives added to Healthy Support plans
- Essential Formulary is made available.
- Coverage for contraceptive drugs expanded to Over the counter (OTC) FDA-approved contraceptives (SB1053)
- For non-HDHP, pharmacy coverage is extended to cover immunization at retail pharmacy stores.
- For specialty pharmacy drugs, 2 courtesy fills at retail pharmacy store is reduced to only 1 fill. After the 1st fill, prescription has to be filled through participating specialty pharmacy provider.
- Compound drugs covered only if *all* ingredients, not one or more ingredient, are FDA approved prescription drugs and a commercially available dosage form of a medically necessary medication is not available.
- First fill for certain specialty drug is limited to a 10-day or 15 day supply, instead of a 30 day supply for any subsequent fills.
- If a member is suspected of abusing prescription drug, the member will be required to fill all future prescriptions through a single participating pharmacy of member's choice.

14) Cost containment and quality improvement efforts

Describe any cost containment and quality improvement efforts since prior year for the same category of health benefit plan (for this purpose, "category of health benefit plan" means product type, such as HMO, PPO, EPO, etc.). To the extent possible, describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period. Companies are encouraged to structure their response with reference to the cost containment and quality improvement components of "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract:"

1.01 Coordination and Cooperation
1.02 Ensuring Networks are Based on Value
1.03 Demonstrating Action on High Cost Providers
1.04 Demonstrating Action on High Cost Pharmaceuticals
1.05 Quality Improvement Strategy
1.06 Participation in Collaborative Quality Initiatives
1.07 Data Exchange with Providers
1.08 Data Aggregation across Health Plans

See Health and Safety Code section 1385.045(c)(3)(F) and Insurance Code section 10181.45(c)(3)(F), see also California Health Benefit Exchange, April 7, 2016 Board Meeting materials: http://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

Response for item 14, Cost containment and quality improvement efforts:

CA Care Management Response: The activities/initiatives described below were implemented over the course of 2015-2016 and have been monitored closely for outcomes and opportunities for further refinement. All of these proactive efforts combined have provided significant contributions to quality improvement and driving the positive utilization trends we are seeing today. Please note that some activities meet more than one category.

a) **Total Population Health Multidisciplinary Care Team**
This Care Team model is focused on improving consumer health and helping to control health care costs, with an emphasis on enhanced technology to personalize the member experience. Staff are assigned based on the geographic location of each member. Our staff members, which are organized in regional Care Teams, not only understand the needs of our members, but are also knowledgeable about the local facilities, physicians and community resources in the member's area. This insight allows us to deliver both personalized care to members and an improved rapport with the physicians and hospital staff that surround them in their communities. Each Care Team consists of geographically-based Utilization Management and designated Nurse Care Managers (Case Management/Disease Management) who are aligned with designated medical directors, Behavioral Health clinicians and other health professionals. The multi-functional and interdisciplinary Care Team:
- Works collaboratively to improve each member's health care experience.
- Enables member continuity and coordination of care.
- Nurtures relationships with hospitals and their Utilization Management staff and physicians.
- Includes closely-aligned Case Management teams and Utilization Management teams that support members with discharge plans and post-discharge follow-ups as needed.
- Focuses on evidenced-based, coordinated care likely to result in fewer unplanned readmissions, greater medication compliance and improved follow-up care, all of which reduce cost of care.
- Focuses on identifying provider issues that may need to be addressed outside of Care Management.

b) **Primary Nurse Clinical Model**
Our primary nurse clinical model supports our total management approach. Through this model, we focus on members' overall health needs to achieve improved outcomes. We address all conditions and comorbidities as they relate to and affect members' ability to manage their overall health. We assign a primary nurse care manager for each participant we identify as likely to benefit from telephonic management. Our nurse care managers work one-on-one with members to help reduce or stabilize clinical severity and increase management control over their conditions. This continuity and consistency in relationship with a single primary nurse is an essential component of creating genuine change. We

provide members with a specific toll-free telephone number to reach their primary nurses. If a nurse is not available at the time of the call, another nurse provides the caller with the assistance they need. Our nurses are also generalists who are trained to handle all conditions and existing comorbidities. These primary nurse care managers also have access to a staff of health professionals including pharmacists, registered dietitians, licensed social workers and medical directors. This team assists in managing all conditions that members may have. The team shares their expertise on a member-specific basis, working together to help members overcome barriers to improve their health and adhere to their treating physician's plan of care.

c) **Complex Discharge Planning Enhancements**
The role of the Complex Discharge Planner (CDC) was enhanced to focus efforts on cases with specific referral criteria, acting as a bridge between Utilization Management and Case Management. CDC case referrals were enhanced to include (but not limited to) cases involving air ambulance transfers, non-par to par redirection, benefit substitutions, high dollar cases, complicated cases identified in Case Rounds, cases involving rate negotiations, and cases at risk for readmission. These enhancements allow for improved management of cases within Utilization Management and prior to referring to Case Management.

d) **Acute Rehab Management**
The program has two dedicated physiatrists who review all rehabilitation requests. The physiatrists provide direction and input to explore appropriate alterative care settings with providers. Cases are verbally discussed during Multidisciplinary Care Team Clinical Rounds (see below) and with our physiatrists. This assures a clear plan of management and appropriate movement along the continuum of recovery including community based neuro rehabilitation.

e) **Total Population Health Multidisciplinary Care Team**
This Care Team model is focused on improving consumer health and helping to control health care costs, with an emphasis on enhanced technology to personalize the member experience. Staff are assigned based on the geographic location of each member. Our staff members, which are organized in regional Care Teams, not only understand the needs of our members, but are also knowledgeable about the local facilities, physicians and community resources in the member's area. This insight allows us to deliver both personalized care to members and an improved rapport with the physicians and hospital staff that surround them in their communities. Each Care Team consists of geographically-based Utilization Management and designated Nurse Care Managers (Case Management/Disease Management) who are aligned with designated medical directors, Behavioral Health clinicians and other health professionals. The multi-functional and interdisciplinary Care Team:
- Works collaboratively to improve each member's health care experience.
- Enables member continuity and coordination of care.
- Nurtures relationships with hospitals and their Utilization Management staff and

physicians.
- Includes closely-aligned Case Management teams and Utilization Management teams that support members with discharge plans and post-discharge follow-ups as needed.
- Focuses on evidenced-based, coordinated care likely to result in fewer unplanned readmissions, greater medication compliance and improved follow-up care, all of which reduce cost of care.
- Focuses on identifying provider issues that may need to be addressed outside of Care Management.

f) **Multidisciplinary Care Team Clinical Rounds**
Based on data, we first began by focusing on 5 targeted facilities with the most opportunity to decrease length of stay. Clinical Rounds are supported by a multi-disciplinary clinical team consisting of nurses from UM, CM, DM, and Behavioral Health, plus a designated Medical Director. Our Clinical Social Worker and Pharmacist joined on an ad hoc basis. The Clinical rounds include verbal exchange of information and are held 2-4 times per week, depending on the facility census and contractual arrangement with the Hospital. We determined that there would be more of an impact if the teams focused on all facilities, discussing any member with complex discharge planning needs, gaps in care, social issues, and were at risk for readmission. Job aids were developed and nurse training was given to assist in the identification of members who were most appropriate for rounds presentation.
The rounds have positively impacted length of stay, early discharge planning activities, and consistency in referrals to Case Management and Behavioral Health.

g) **NICU Focused Review / Approval Enhancements**
The NICU Care Team implemented enhancements to their NICU case review and discharge planning process as well as their initial authorization for the first 2 days in the NICU, drawing upon the support of their NICU Complex Discharge Planner to facilitate earlier, safe discharges home.

h) **Multiple Redirection / Steerage Focused Initiatives**
The Care Management team has worked with identified members to facilitate potential opportunities for alternate setting / alternate options / In-Network transitions related to ~~Coram~~ home infusion therapy, frequent non-emergent ambulance utilization, ERT (enzyme replacement therapy), dialysis, hemophilia drug therapy and IVIG (intravenous immunoglobulin therapy).

i) **Focused Review of Total Hip/Knee Replacement, Arthroscopy and Cervical Spine Fusion**
Focused clinical medical necessity reviews initiated on selected high volume ortho-surgery cases to positively impact utilization trends.

j) **Frequent Emergency Room Visits**
Focused outreach to members with frequent Emergency Room utilization to

educate, facilitate member/primary care physician relationship, and offer alternative options for routine, non-emergency care.

k) **Enhanced Personal Health Care**
This program provides information and resources to Primary Care providers to assist with the identification of high-risk and complex patients, including alerts when their patients are admitted to the hospital or visit the ER. The information allows providers to proactively and effectively manage their patients with the support of our experienced care management nurses who can work as an extension of their practice.

l) **Alternative Site of Care**
This is a partnership between Anthem Blue Cross and Coram CVS/Specialty Infusion Services. The goal of the program is to reduce hospital length of stay through early identification of members appropriate for outpatient infusion. Anthem and Coram CVS clinical staff work with hospital discharge planners to create a discharge plan for safe and effective outpatient care. There are now 104 CA hospitals engaged in this program. Average per patient days saved since inception of program is approximately 2 days.

m) **Facility Electronic Medical Records Access (EMR)**
Remote access to facility Electronic Medical Records by nurses performing inpatient review improves communication and collaboration between Anthem and hospital clinical staff. Remote access is provided by a facility to individual Anthem UM Nurses via a secure sign in connection into their EMR portal. It also allows for timely inpatient review, earlier discharge planning activities, decreases lack of information denials and reduces the need for post service. Expansion to our goal of 50 facilities with EMR access will continue throughout 2016.

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) Other Comments

Provide any additional comments on factors that affect rates and the weighted average rate changes included in this filing.

N/A