California Large Group Annual Aggregate Rate Data Report Form

Version 3, September 7, 2017

(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) Other Comments

1) Company Name:

Aetna Life Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2017 .[1]

3) Weighted average annual rate increase (unadjusted)[2]

- All large group benefit designs 9.5%
- Most commonly sold large group benefit design 9.6%

Weighted average annual rate increase (adjusted)[3]

- All large group benefit designs 11.4%
- Most commonly sold large group benefit design[4] 11.5%

[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.

[10] Per prescription.

[11] Laboratory and Radiology measured on a per-service basis.

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	283	44.2%	89,563	0	$526.95	8.5%
February	23	3.6%	1,652	0	$812.83	5.9%
March	24	3.8%	2,609	0	$558.59	3.7%
April	34	5.3%	2,661	0	$690.08	17.7%
May	30	4.7%	2,583	0	$572.18	12.3%
June	44	6.9%	4,437	0	$587.06	10.3%
July	53	8.3%	7,144	0	$595.12	10.6%
August	34	5.3%	4,357	0	$556.24	5.2%
September	29	4.5%	3,000	0	$531.70	7.9%
October	16	2.5%	2,115	0	$662.63	22.4%
November	26	4.1%	2,972	0	$547.10	15.7%
December	44	6.9%	2,957	0	$638.11	19.5%
Overall	640	100%	126,050	0	$548.19	9.4%

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.

[10] Per prescription.

[11] Laboratory and Radiology measured on a per-service basis.

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 common plan design is a PPO plan with $1,000 deductible and 80% coinsurance (2) Approximations are derived from rating factors and underwriting reports.

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)	185	28.9%	39,002	0	$533.25	11.0%
Blended (in part)	357	55.8%	31,207	0	$585.87	8.1%
100% Experience Rated	98	15.3%	55,841	0	$537.56	9.0%
Overall	640	100%	126,050	0	$548.19	9.4%

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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 products types are offered for each segment.
Membership distribution is as follows:

Segment	PPO	EPO	Other-Indemnity
100% Community	31%	42%	4%
Blended	25%	18%	8%
100% Experience	44%	40%	88%

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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	639	99.8%	122,422	0	$547.81	9.6%
EPO	25	3.9%	3,499	0	$538.25	2.1%
POS						
HDHP						
Other (describe)	12	1.9%	129	0	$1,172.55	17.5%
Overall	640	100%	126,050	0	$548.19	9.4%

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.

Under the Aetna Traditional Choice (Indemnity) plan, members have the freedom to choose any recognized provider for covered services without a referral. The plan coinsurance percent is the same, regardless of whether a provider is contracted with Aetna or not. Plan sponsors save if a member obtains services from network providers who we reimburse based on their contracted fee schedule.

HDHP is included in the other product categories.

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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

PPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	726	33,825	27.6%	Deduct $50, OOP $500, Coinsurance 90%, PCP Copay $5, SPC Copay $5
0.8 to 0.899	2,285	79,367	64.8%	Deduct $200, OOP $800, Coinsurance 80%, PCP $5, SPC Copay $10
0.7 to 0.799	313	9,222	7.5%	Deduct $500, OOP $1400, Coinsurance 80%, PCP Copay $5, SPC Copay $10
0.6 to 0.699	2	8	0.0%	Deduct $3200, OOP $3200, Coinsurance 70%, PCP
0.0 to 0.599	0	0	0.0%	N/A
Total	3,326	122,422	100%	N/A

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	59	1,907	54.5%	Deduct $0, OOP $600, Coinsurance 95%, PCP Copay $5, SPC Copay $10
0.8 to 0.899	37	1,592	45.5%	Deduct $200, OOP $900, Coinsurance 90%, PCP Copay $10, SPC Copay $15
0.7 to 0.799	0	0	0.0%	N/A
0.6 to 0.699	0	0	0.0%	N/A
0.0 to 0.599	0	0	0.0%	N/A
Total	96	3,499	100%	N/A

[10] Per prescription.

[11] Laboratory and Radiology measured on a per-service basis.

POS

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

HDHP - ***Included within other product categories***

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%	

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	4	12	9.0%	Deduct $150, OOP $1250, Coinsurance 90%, PCP Copay $5, SPC Copay $10
0.8 to 0.899	12	89	69.2%	Deduct $700, OOP $2500, Coinsurance 80%, PCP Copay $0, PCP Copay $0
0.7 to 0.799	3	28	21.8%	Deduct $750, OOP $2700, PCP Copay $0, SPC Copay $0
0.6 to 0.699	0	0	0.0%	
0.0 to 0.599	0	0	0.0%	
Total	19	129	100%	

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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:

Standard plans and number of groups sold are listed below.

Standard Plans	Groups Sold
OAMC Ded $0/500, OOP $2000/$4000, Coins 90%/70%, PCP $10, SPC $20	4
OAMC Ded $0/500, OOP $2000/$4000, Coins 90%/70%, PCP $15, SPC $25	2
OAMC Ded $0/500, OOP $2000/$4000, Coins 90%/70%, PCP $20, SPC $40	8
OAMC Ded $0/500, OOP $2000/$4000, Coins 80%/60%, PCP $15, SPC $30	4
OAMC Ded $0/500, OOP $2000/$4000, Coins 80%/60%, PCP $20, SPC $40	26
OAMC Ded $0/750, OOP $2500/$5000, Coins 80%/60%, PCP $25, SPC $50	10
OAMC Ded $0/750, OOP $2500/$5000, Coins 70%/N/A, PCP $70, SPC $50	14
OAMC Ded $250/500, OOP $2500/$5000, Coins 90%/70%, PCP $10, SPC $20	16
OAMC Ded $250/500, OOP $2500/$5000, Coins 90%/70%, PCP $20, SPC $20	11
OAMC Ded $500/1000, OOP $3000/$6000, Coins 90%/70%, PCP $15, SPC $25	9
OAMC Ded $500/1000, OOP $3000/$6000, Coins 80%/60%, PCP $10, SPC $20	1
OAMC Ded $500/1000, OOP $3000/$6000, Coins 80%/60%, PCP $15, SPC $30	9
OAMC Ded $500/1000, OOP $3000/$6000, Coins 80%/60%, PCP $20, SPC $20	13
OAMC Ded $750/1500, OOP $3000/$6000, Coins 90%/70%, PCP $20, SPC $40	9
OAMC Ded $750/1500, OOP $3000/$6000, Coins 80%/60%, PCP $20, SPC $40	13
OAMC Ded $1000/2000, OOP $4000/$8000, Coins 80%/60%, PCP $25, SPC $50	30
OAMC Ded $1500/3000, OOP $3500/$7000, Coins 70%/N/A, PCP $30, SPC $50	7
OAMC Ded $2000/4000, OOP $4500/$9000, Coins 70%/N/A, PCP $30, SPC $50	6
OAMC Ded $2600/3000, OOP $3000/$7500, Coins 90%/70%, PCP $0, SPC $0	18
OAMC Ded $2600/3000, OOP $3000/$7500, Coins 80%/60%, PCP $0, SPC $0	19
OAMC Ded $3000/6000, OOP $5000/$10000, Coins 80%/60%, PCP $20, SPC $40	10
OAMC Ded $4000/8000, OOP $5500/$11000, Coins 70%/N/A, PCP $0, SPC $0	10
OAMC Ded $5000/10000, OOP $6550/$13000, Coins 80%/60%, PCP $0, SPC $0	3
OAMC Ded $6000/12000, OOP $6550/$13100, Coins 90%/70%, PCP $0, SPC $0	3

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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)	Geographic regions are based on counties and cost differences between regions. Area factors are developed using Aetna's book of business data. Area factors have not changed during the 12-month period covered by this rate review.
Age, including age rating factors (describe definition, such as age bands)	Age rating factors vary by age and gender, and are developed using Aetna's book of business data. Age rating factors have not changed during the 12-month period covered by this rate review.
Occupation	Occupation rating factors are considered under the same umbrella as industry factors.
Industry	Industry factors vary by SIC code, and are developed using Aetna's book of business data. Industry factors have not changed during the 12-month period covered by this rate review.
Health Status Factors, including but not limited to experience and utilization	Member-level prospective risk scores used in manual rating are derived from claims history and diagnosis data. Risk score methodology has not changed during the 12-month period covered by this rate review.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	Premium tiers are as follows: Employee Only, Employee + Spouse, Employee + Children, and Employee + Family Premium tiers have not changed during the 12-month period covered by this rate review.
Enrollees' share of premiums	There are no rating factors based on enrollees' share of premiums.
Enrollees' cost sharing	Benefit pricing factors based on enrollee cost sharing vary according to plan design. The majority of business is under custom plans.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Custom benefit riders are offered on a case by case basis.
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	All large group market segments use a credibility table based on number of covered lives to determine whether the group is fully experience rated or partially community rated.

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	Network factor decisions are informed by contracting and cost analysis. Network factors have not changed during the 12-month period covered by this rate review.

[7] i.e. premium tier ratios

[10] Per prescription.
[11] Laboratory and Radiology measured on a per-service basis.

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)

9.4%

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]	10.3%
Hospital Outpatient (including ER)	10.4%
Physician/other professional services[9]	6.9%
Prescription Drug[10]	11.7%
Laboratory (other than inpatient) [11]	10.4%
Radiology (other than inpatient)	10.4%
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

Allowed Trend: (Current Year + 1) / (Current Year)		Trend attributable to:			
	Aggregate Dollars (PMPM)	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	106.67	4.24%	5.63%	0%	10.1%
Hospital Outpatient (including ER)	85.27	4.64%	4.9%	0%	9.7%
Physician/other professional services[13]	167.69	3.51%	2.97%	0%	6.6%
Prescription Drug[14]	89.83	2.66%	7.7%	0%	10.5%
Laboratory (other than inpatient)[15]	Rolled up in above categories	4.64%	4.9%	0%	9.7%
Radiology (other than inpatient)	Rolled up in above categories	4.64%	4.9%	0%	9.7%
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	449.47	3.73%	4.91%	N/A	8.8%

[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, (iv) Taxes and Fees, and (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).

Any cost-sharing changes are initiated by the client, and therefore vary on a case by case basis.

(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 change in enrollee cost share is -2%

[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)***

Affordable Care Act Updates

• Updates were made to the bariatric surgery general exclusion and the routine cancer screening colonoscopy benefit.

• A correction was made to the breast pump benefit description.

Behavioral Health Benefits

• Updates were made to the mental disorders and substance abuse benefits to add telemedicine services and a new other outpatient services category. These changes are in alignment with the ongoing changes in response to our small group filings.

Other Changes

• Place of service cost sharing -- clarifying the times when cost-sharing for a covered benefit is based on the place where benefit is provided and by what kind of provider

• Foot care – clarifying when and what type of benefits are covered

• Non-preventive care tobacco cessation – clarifying that this optional benefit may be included in addition to benefits required under the Affordable Care Act

• Prosthetics – clarifying that cranial prosthesis (medical wigs) are covered and the benefit limits that may apply

Pharmacy Benefits

• Utilization Review -- This language has been updated to better reflect how a review could result in limiting quantities and supplies based on the results of the review.

• Personal Care Pharmacy Savings / Disease Management Program -- The program has not been operational to date. A new list of conditions has been added and upon approval the program may be available in the future.

• Partial Fill Dispensing Program -- This program would go hand in hand with the utilization review process noted above. With potential abuse of prescription drugs on the rise, Aetna would like to clarify the ability of pharmacies to partially fill prescriptions for drugs that have been shown to have higher abuse histories. The cost sharing would be adjusted to account for only the partial fill.

• Sexual Dysfunction/Enhancement Drugs -- This benefit is being updated to accommodate new forms of drugs either entering the market or currently in testing. With the release of these new methods, Aetna's forms will need to include clear information on dosing and delivery methods. The new general language outlines what a member would need to do to find out more on their specific coverage levels for these drugs.

• Exclusions -- Various updates have been made to the exclusion section.

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:"

1.1 Coordination and Cooperation
1.2 Ensuring Networks are Based on Value
1.3 Demonstrating Action on High Cost Providers
1.4 Demonstrating Action on High Cost Pharmaceuticals
1.5 Quality Improvement Strategy
1.6 Participation in Collaborative Quality Initiatives
1.7 Data Exchange with Providers
1.8 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

	Cost Containment	Quality
Value Based P4P (Integrated Healthcare Association): Applicable to HMO products. Rewards IPAs for cost efficiency and quality.	Yes	Yes
Pay for Performance Program – Physician/Hospital: Rewards physician groups or hospitals for meeting performance metrics based on both efficiency and quality.	Yes	Yes
Patient Centered Medical Home Program: Rewards physician groups for effectively managing the health of a population based on measurement of both cost efficiency and quality metrics.	Yes	Yes
High Performance Network/ACO Program model: Rewards health systems for effectively managing the health of a population based on measurement of both overall medical costs and quality metrics.	Yes	Yes
Institutes of Quality/Institutes of Excellence – Organ transplant, Bone Marrow Transplant; Bariatric; Orthopedic, Cardiac: Providers are selected for participation in these networks based on volume/outcomes and cost criteria.	Yes	Yes
Oncology Cost/Quality Improvement: Shared savings model in use with oncology groups, rewards providers for following clinical guidelines/evidence based medicine.	Yes	Yes

In-Network Behavioral Health Cost/Quality: Focused on managing costs and quality associated with Autism, Substance Abuse and Inpatient Behavioral Health confinement.	Yes	Yes
Out of Network ASC and Behavioral Health Costs: Cost containment program focuses on over-billing. Involves special claims oversight, network review and litigation.	Yes	Yes
Health Improvement for High Risk Members: This program identifies members with higher morbidity and engages them with their health care provider through outreach and a health assessment.	No	No
Other Cost Containment Initiatives: Aetna defines multiple additional market level and national cost reduction actions annually or more frequently as needed.	Yes	Yes

15) Excise tax incurred by the health plan

Describe for each segment the number of products covered by the information that incurred the excise tax paid by the health plan - applicable to year 2020 and later. ***See Health and Safety Code section 1385.045(c)(3)(G) and Insurance Code section 10181.45(c)(3)(G)***

Not applicable.

16) Other Comments

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

In the CA Large Group Historical Data Spreadsheet, we are unable to split out SG and LG for 2012.