California Large Group Annual Aggregate Rate Data Report Form

Version 4, July 16, 2018

(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:

Health Net Life Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2018.[1]

3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 6.9%
   - Most commonly sold large group benefit design 7.0%

   Weighted average annual rate increase (adjusted)[3]
   - All large group benefit designs 7.2%
   - Most commonly sold large group benefit design[4] 8.0%

[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) 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	104	30.0%	17,781	240	$555	6.0%
February	9	2.6%	213	0	$561	9.0%
March	19	5.5%	562	21	$543	7.2%
April	15	4.3%	256	188	$753	4.8%
May	9	2.6%	192	0	$807	7.2%
June	15	4.3%	303	0	$645	5.4%
July	37	10.7%	1,020	83	$899	9.0%
August	13	3.7%	381	0	$549	7.2%
September	21	6.1%	9,528	10	$421	7.7%
October	20	5.8%	403	8	$650	9.0%
November	22	6.3%	381	0	$679	10.9%
December	63	18.2%	792	38	$657	12.7%
Overall	347	100.0%	31,812	588	$537	6.9%

[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).*

The most commonly sold benefit design is the Vaden EPO (Student Plan).

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)	339	97.7%	6,177	588	$737	8.5%
Blended (in part)	4	1.2%	1,138	0	$811	10.4%
100% Experience Rated	4	1.2%	24,497	0	$469	6.3%
Overall	347	100.0%	31,812	588	$537	6.9%

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.

PPO: 27% of covered lives are 100% community rated
69% of covered lives are 100% experience rated
4% of covered lives are blended

EPO: 1% of covered lives are 100% community rated
99% of covered lives are 100% experience rated
0% of covered lives are blended

HDHP: 42% of covered lives are 100% community rated
47% of covered lives are 100% experience rated
10% of covered lives are blended

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	302	81.0%	20,293	560	$595	6.6%
EPO	5	1.3%	8,966	2	$407	7.1%
POS						
HDHP	66	17.7%	2,553	26	$521	8.1%
Other (describe)						
Overall	373	100.0%	31,812	588	$537	6.9%

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.

The total number of renewing groups in item #6 is higher than the total number of renewing groups in items #4 and #5. This is because groups with members in more than one product type are represented multiple times in item #6.

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	19	4,067	18.2%	$0 deductible; $1,500 OOPM; $20 office visit; $250 per admit inpatient; 20% outpatient surgery; 20% ER
0.8 to 0.899	103	16,011	71.5%	$300 deductible; $2,000 OOPM; $25 office visit; $200 per admit inpatient; 0% outpatient surgery; $250 ER
0.7 to 0.799	16	1,261	5.6%	$2,000 deductible; $4,000 OOPM; $30 office visit; 30% per admit inpatient; 30% outpatient surgery; $100 ER
0.6 to 0.699	13	1,042	4.7%	$3,000 deductible; $5,000 OOPM; $30 office visit; 30% per admit inpatient; 30% outpatient surgery; $100 ER
0.0 to 0.599	0	-	0.0%	
Total	151	22,380	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	8	54	0.6%	$0 deductible; $1,500 OOPM; $10 office visit; $0 per admit inpatient; $0 outpatient surgery; $50 ER
0.8 to 0.899	4	8,415	99.4%	$500 deductible; $4,000 OOPM; $25 office visit; 30% per admit inpatient; 30% outpatient surgery; $100 ER
0.7 to 0.799	0	-	0.0%	
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	12	8,470	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	-	0.0%	
0.8 to 0.899	0	-	0.0%	
0.7 to 0.799	37	1,961	61.0%	$1,500 deductible; $3,000 OOPM; 10% office visit; 10% per admit inpatient; 10% outpatient surgery; 10% ER
0.6 to 0.699	40	1,252	39.0%	$3,000 deductible; $3,000 OOPM; 0% office visit; 0% per admit inpatient; 0% outpatient surgery; 0% ER
0.0 to 0.599	0	-	0.0%	
Total	77	3,213	100.0%	

Other (describe)

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

In the comment section below, provide the following:

- Number and description of standard plans (non-custom) offered, if any. Include a description of the type of benefits and cost sharing levels.
- Number of large groups with (i) custom plans and (ii) standard plans.

Place comments here:

Health Net Life currently has 130 standard plans with enrolled membership.

76% of members are enrolled in plans with deductible <=$500.
85% of members are enrolled in plans with an office visit copayment <=$30.

Health Net Life has 80 groups enrolled in custom PPO/EPO plans.
Health Net Life has 412 groups enrolled in standard PPO/EPO plans.

The number of groups enrolled in standard plans in item #7 (412) is higher than the number of groups renewing in items #4 and #5 (347). This is because the group counts in item #7 include all groups enrolled during the 12 month experience period while items #4 and #5 only include groups who are renewing in 2018.

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)	Member county is used to identify geographical adjustments to premium. The lowest adjustment based on geographic region is 0.792 while the highest adjustment is 1.305. The average adjustment is 0.971. See section 16 for more background regarding the basis for regional adjustments to premium.
Age, including age rating factors (describe definition, such as age bands)	Demographic (age/sex) adjustments to premium are based on the following age bands: 0 to 1, 2 to 4, and each 5-year age band thereafter (5-9,10-14, etc.)
Occupation	N/A
Industry	Health Net adjusts premium based on member industry. Factors range from 0.84 to 1.18 with an average of about 1.00.
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	Most Health Net rating is provided on a 4-tier basis (single 1.0, employee and spouse 2.4, employee and children 1.75, and family at 3.05). In some cases, employers stipulate the tier ratios. See section 16.
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	See section 16.
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	Health Net uses credibility blending when determining premiums based on experience. Groups with over 600 average enrollees per month are fully credible. Groups with over 400 average enrollees per month are partially credible. Groups with fewer than 200 average enrollees per month are not credible for experience rating.
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:

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)

11.6%

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]	12.0%
Hospital Outpatient (including ER)	12.0%
Physician/other professional services[9]	11.4%
Prescription Drug[10]	14.9%
Laboratory (other than inpatient) [11]	10.2%
Radiology (other than inpatient)	10.2%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (Ambulance, DME, Home Health)	10.2%

[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]	$223	2.8%	6.3%	0.0%	9.3%
Hospital Outpatient (including ER)	$148	2.8%	6.1%	0.0%	9.1%
Physician/other professional services[13]	$274	2.8%	5.8%	0.0%	8.7%
Prescription Drug[14]	$103	1.2%	12.5%	0.0%	13.8%
Laboratory (other than inpatient)[15]	$12	2.8%	4.2%	0.0%	7.1%
Radiology (other than inpatient)	$15	2.8%	4.2%	0.0%	7.1%
Capitation (professional)	$0	N/A	N/A	N/A	N/A
Capitation (institutional)	$0	N/A	N/A	N/A	N/A
Capitation (other)	$0	N/A	N/A	N/A	N/A
Other (Ambulance, DME, Home Health)	$25	2.8%	4.2%	0.0%	7.1%
Overall	$799	2.6%	6.7%	0.0%	9.5%

[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).

Professional office visit copayments did not change from 2017 to 2018. The average office visit copayment stayed at approximately $22 per visit.

From 2017 to 2018, average coinsurance dropped by 2%. Coinsurance generally determines the cost share for inpatient hospital, outpatient surgery and ER.

From 2017 to 2018 generic prescription drug copayments decreased by 10% (or $1) while brand copayments per prescription increased by 1%.

(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]

As measured by actuarial value aggregate enrollee cost sharing has slightly increased from 2017 to 2018 by approximately 1%.

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)

At the product level in the Health Net Life Insurance Company Inc. large group PPO and EPO offerings, benefits offered are consistent with coverage requirements listed in Health and Safety Code §1345 as further defined in California Code of Regulations title 28 §1300.67. We acknowledge that the requirements set forth in these citations may not be adopted requirements by the CDI for Large Group PPO and EPO products. However they provide a framework to provide consistent comprehensive coverage that meets the needs of all our members. There are no changes in these benefits for enrollees over the prior year.

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:"

[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.

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

Improve Preventive Health for Commercial Members: Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Flu Vaccination for Adults Ages 18-64 (BCS, CCS, COL, & FVA)
Goals: Reduce costly medical care and mortality of commercial members from breast cancer, cervical cancer, colorectal cancer, and the flu by improving preventive health screening rates. For all product lines and measures, the goal is to increase our overall accreditation score and/or achieve directional improvement towards the QC 90th Percentile.
Rationale: It is important for members to stay up to date on the recommended screening schedules and flu immunizations to stay healthy and detect diseases early on when they are easier to treat.

Improve Immunizations & Well Child Visits Among the Pediatric Population
Goals: Improve pediatric health by ensuring Commercial children and adolescents receive timely age-appropriate vaccinations and attend all required well child visits.
Rationale: Bringing children in for their regular visits helps keep children healthy, especially during a time when they experience substantial growth and developmental changes.

Hospital Quality: Increase Transparency through Public Reporting
Goals: Increase health care transparency through Public Reporting of safety measures by participating hospitals.
Rationale: Hospital public reporting is key to ensuring that consumers make informed choices when selecting where to obtain care. Increasingly, consumers are becoming more aware of health care quality tools available to them, such as Health Net's Hospital Compare online tool. The Leapfrog Group reports that 97% of consumers choose hospitals that get an 'A' for safety, regardless of cost. Health Net promotes patient safety and performance measurement activities by encouraging network hospitals participate in the annual The Leapfrog Group Hospital Survey, and/or report in to CMS Hospital Compare, or other readily available consumer quality outlets. The Leapfrog Group is a nationwide collaborative effort to promote patient safety and improve quality of care in hospitals.

Increase Awareness of and Activities to Decrease Hospital Never Events & Hospital Acquired Conditions Among Contracted Hospitals
Goal: Increase awareness of, and activities to decrease, hospital never events and hospital acquired conditions among contracted hospitals.
Rationale: The main goal of Health Net's Hospital Acquired Conditions (HAC) and Never Events policy is to track and monitor the quality of care provided by hospitals and to encourage efforts to provide the safest care, thus limiting the occurrence of HACs and Never Events. Health Net's Quality Improvement (QI) Department tracks, monitors and notifies hospitals bi-annually if a member is discharged with one of the conditions identified by CMS as a potential HAC. If it is determined the HAC was not present on admission and was preventable, the QI Department asks the hospital to perform a root-cause analysis and take any necessary action to prevent future occurrences of the HAC. Notified hospitals are asked to respond within 30 days and are given the opportunity to describe extenuating circumstances and determine what, if any, actions are necessary. Specifically, the hospital is asked to implement Quality Improvement activities to ensure that evidence-based practices are in place to limit the risk of such conditions, and sign an attestation that these actions were taken.
The rational for continuing this intervention is that HACs and Never Events are important safety issues that require continuous monitoring. The objectives for this initiative are to meet or exceed an 80% response rate to HN's HAC notification letters; and for hospitals with a confirmed HAC to show a directional increase in the completion of a root cause analysis of the HAC.

15) Excise tax incurred by the health plan

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

Not applicable.

16) Complete the SB 17 - Large Group Prescription Drug Cost Reporting Form to provide the information on covered prescription drugs dispensed at a plan pharmacy, network pharmacy or mail order pharmacy for outpatient use for each of the following:

(i) Percent of Premium Attributable to Prescription Drug Costs
(ii) Year-Over-Year Increase, as Percentage, in Per Member Per Month, Total Health Plan Spending
(iii) Year-Over-Year Increase in Per Member Per Month Costs for Drug Prices Compared to Other Components of Health Care Premium
(iv) Specialty Tier Formulary List
(v) Percent of Premium Attributable To Drugs Administered in a Doctor's Office, if available
(vi) Health Plan/Insurer Use of a Prescription Drug (Pharmacy) Benefit Manager, if any

Complete SB 17 - Large Group Prescription Drug Cost Reporting Form - Excel
See Health and Safety Code section 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C) and Insurance Code section 1385.045(c)(4)(A), 1385.045(c)(4)(B), 1385.045(c)(4)(C)

17) Other Comments

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

Question 8 note: All Health Net pricing is adjusted based on geography, demographic factors and industry factors as well as tailored network status. Adjustments are based on Health Net specific experience and provider reimbursement.