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:

Health Net Life Insurance Company

2) This report summarizes rate activity for the 12 months ending reporting year 2021 [1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 5.3 %

[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 4.8 %

Weighted average annual rate increase (adjusted)[3]

- All large group benefit designs 5.4% %
- Most commonly sold large group benefit design[4] 4.8 %

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	67	29.6%	4,630	76	$659	5.2%
February	6	2.7%	56	77	$679	2.6%
March	10	4.4%	225	0	$633	7.1%
April	13	5.8%	176	12	$1,119	5.9%
May	6	2.7%	69	0	$1,000	8.5%
June	12	5.3%	241	0	$876	6.6%
July	34	15.0%	1,357	41	$969	7.0%
August	6	2.7%	50	0	$1,106	7.6%
September	12	5.3%	8,292	0	$498	4.9%
October	13	5.8%	100	2	$826	6.0%
November	14	6.2%	261	0	$694	6.1%
December	33	14.6%	383	0	$785	7.2%
Overall	226	100.0%	15,840	208	$618	5.3%

[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)	0	0.0%	0	0	$0	0.0%
Blended (in part)	26	11.5%	1,722	54	$903	5.6%
100% Experience Rated	200	88.5%	14,118	154	$583	5.3%
Overall	226	100.0%	15,840	208	$618	5.3%

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: 0% of covered lives are 100% community rated
83% of covered lives are 100% experience rated
17% of covered lives are blended

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

HDHP: 0% of covered lives are 100% community rated
76% of covered lives are 100% experience rated
24% of covered lives are blended

FlexNet: 0% of covered lives are 100% community rated
5% of covered lives are 100% experience rated
95% 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	177	72.2%	6,377	101	$721	5.8%
EPO	5	2.0%	7,990	0	$490	4.8%
POS						
HDHP	58	23.7%	1,059	91	$792	6.5%
Other (Flex Net)	5	2.0%	414	16	$1,000	4.1%
Overall	245	100.0%	15,840	208	$618	5.3%

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.

Flex Net is a managed indemnity product offered to large groups. It is an alternative benefit option for a small number of employees (never more than 10% of a California-based employer) who live outside the Health Net service area and cannot enroll in one of Health Net's core medical plans, or for California-based retirees who reside outside of the Health Net service area. Members may obtain services from any licensed provider.

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			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	97	10,613	91.1%	$300 deductible; $2,000 OOPM; $25 office visit; 0 per admit inpatient; 0 outpatient surgery; $250 ER
0.8 to 0.899	29	780	6.7%	$2000 deductible; $5,000 OOPM; $30 office visit; 30% per admit inpatient; 30% outpatient surgery; $100 ER
0.7 to 0.799	14	258	2.2%	$3000 deductible; $6,000 OOPM; $30 office visit; 30% per admit inpatient; 30% outpatient surgery; $100 ER
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	140	11,651	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	35	0.5%	$0 deductible; $1,500 OOPM; $10 office visit; 0 per admit inpatient; 0 outpatient surgery; $0 ER
0.8 to 0.899	2	7,627	99.5%	$100 deductible; $2,000 OOPM; $35 office visit; 500 per admit inpatient; 500 outpatient surgery; $0 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	10	7,663	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			100.0%	

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	5	66	3.8%	$2000 deductible; $2,000 OOPM; $0 office visit; 0 per admit inpatient; 0 outpatient surgery; $0 ER
0.8 to 0.899	52	1,429	81.4%	$3000 deductible; $4,000 OOPM; $0 office visit; 0.2 per admit inpatient; 0.2 outpatient surgery; $0 ER
0.7 to 0.799	16	261	14.8%	$2800 deductible; $5,000 OOPM; $0 office visit; 0.3 per admit inpatient; 0.3 outpatient surgery; $100 ER
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	73	1,756	100.0%	

Other (Flex)

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	433	100.0%	$0 deductible; $5,600 OOPM; $0 office visit; 0 per admit inpatient; 0 outpatient surgery; $0 ER
0.8 to 0.899	0	-	0.0%	
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	10	433	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:

Health Net Life currently has 103 standard plans with enrolled membership.

83% of members are enrolled in plans with deductible <=$500.
87% of members are enrolled in plans with an office visit copayment <=$30.

Health Net Life has 61 groups enrolled in custom PPO/EPO plans.
Health Net Life has 264 groups enrolled in standard PPO/EPO plans.

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The number of groups enrolled in standard plans in item #7 is higher than the number of groups renewing in items #4 and #5. 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 2021.

For the 2021 filing, we used the third party Milliman Health Care Cost model to compute Actuarial Value - a Paid/Allowed valuation. This represents a change from prior years where we used an internally developed model.

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 0.768 while the highest adjustment is 1.288. The average adjustment is 0.972. See section 17 for more background regarding the basis for regional adjustments to premium.
Age, including age rating factors (describe definition, such as age bands)	Age/sex factors are applied on the basis of the following bands (0, 1, 2-4, 5-9,10-14,15-19,20-24,25-29,30-34,35-39, 40-44, 45-49, 50-54,55-59,60-64, and 65+). They range in value from 0.401 to 3.365, with an average of about 1.163. See section 17.

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,[3] 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 17.
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 17.
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. For groups of up to 250 members, we block rate based on quarterly effective dates– the combined experience of all the groups in a given quarter of this size band are aggregated and experience rated. Groups in block rating receive the same renewal increase. For groups between 250 and 600 members, we use a blend of manual and experience rating. For groups with 600 or more members, we use experience rating entirely.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	N/A

[3] 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)

9.5%

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[4]	11.1%
Hospital Outpatient (including ER)	10.0%
Physician/other professional services[5]	7.0%
Prescription Drug[6]	9.0%
Laboratory (other than inpatient) [7]	9.6%
Radiology (other than inpatient)	9.6%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	N/A

[4] Measured as inpatient days, not by number of inpatient admissions.
[5] Measured as visits.
[6] Per prescription.
[7] 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.

Our PPO products are not capitated.

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[8]	$170	5.9%	4.5%	0.5%	11.3%
Hospital Outpatient (including ER)	$242	5.0%	4.5%	0.5%	10.3%
Physician/other professional services[9]	$142	1.6%	4.2%	0.5%	6.5%
Prescription Drug[10]	$181	0.0%	9.0%	0.0%	9.0%
Laboratory (other than inpatient)[11]	$11	4.1%	2.8%	0.5%	7.6%
Radiology (other than inpatient)	$12	4.1%	2.8%	0.5%	7.6%
Capitation (professional)	$0	N/A	N/A	N/A	N/A
Capitation (institutional)	$0	N/A	N/A	N/A	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.

Capitation (other)	$0	N/A	N/A	N/A	N/A
Other (describe)	$0	N/A	N/A	N/A	N/A
Overall	$759	3.3%	5.5%	0.4%	9.5%

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

Our PPO products are not capitated.

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 increased from 2020 ($23) to 2021 ($26) when weighting by enrollment.

Average coinsurance decreased from 2020 (14%) to 2021 (8%)

Average Deductible decreased by approximately 18% from 2020 ($608) to 2021 ($498) when weighting by enrollment.

Out of Pocket Maximum decreased by approximately 36% from 2020 ($3842) to 2021 ($2466) when weighting by enrollment.

Generic prescription drug copayments remained consistent from 2020 ($9) to 2021 ($9)

Brand prescription drug copayments decreased 23% from 2020 ($38) to 2021 ($30)

(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.[12]

As measured by actuarial value, aggregate enrollee cost sharing decreased by 0.2% from 2020 (Average AV 0.941) to 2021 (Average AV 0.939).

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 Plan's large group PPO, EPO and Flex offerings, benefits offered are consistent with coverage requirements for Basic Health Care Services as listed in Health and Safety Code §1345, as supported by California Code of Regulations Title 28, §1300.67, and there are no changes in these benefits for enrollees over the prior year.

[12] 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.

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

Improve Preventive Health for Commercial Members: Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, appropriate antibiotic prescribing for ages 18-64 and Flu Vaccination for Adults Ages 18-64 (BCS, CCS, COL, URI, AAB & FVA))

Goals: Reduce costly medical care and mortality of Commercial and Marketplace members from breast cancer, cervical cancer, colorectal cancer, and the flu by improving preventive health screening rates. Support the appropriate treatment of secondary infections during flu and asthma seasons, and appropriate use of antibiotics in general.

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. In 2020, the COVID-19 greatly impacted outreach for preventive screenings due to regional stay-at-home orders and with members discouraged from scheduling non-urgent/routine visits at the outset of the pandemic. Therefore, it is critical to ensure members understand the importance of preventive health screenings and complete all necessary visits in 2021.

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. Additionally, regular visits ensure that children are up-to-date on their immunizations and protected against preventable diseases. The California Department of Public Health reported that California immunization rates dropped 40% immediately following the governor's stay-a-home order, compared to the same month the previous year. Parents' fear of exposing their children to COVID-19 has had a concerning effect on the rates of well child visits, especially for infants[7].

Improve Office of the Patient Advocate (OPA) Star Ratings

Goals: The overall goal for PPO is to meet or exceed the 4 Star OPA rating, and/or achieve directional improvement on all Star ratings from the 2020-2021 report card

Rationale: As a result of the Centene merger, Health Net of California (HNCA) must meet certain quality performance requirements, known as the "Undertakings (UT)." CDI UT#13(i) (PPO) specifies that HNCA must "use best efforts to improve Star rating for each topic and measure on the OPA PPO Report Card."

Improve Behavioral Health (Mental Health and Substance Use) Outcomes for CA Market Members

Goals: The goals are to improve behavioral health (BH) outcomes and access to high quality behavioral health care services and programs, by achieving 4+ Star (or equivalent) quality ratings across all products in the CA Market. For Commercial, this includes directional improvement toward the National Quality Compass 75th percentile. For HNCA Marketplace/Exchange product lines, goals include directional improvement to increase the BH measures included in Quality Rating System (QRS) Star Rating (i.e., ADD, AMM, FUH, and IET). For Medicare, the goal is to achieve directional improvement for the quality metrics that are STARS display measures (i.e., AMM, FUH, and IET) is critical. For Medi-Cal, the goal is to achieve directional improvement or meet or exceed the minimum performance level (MPL) for Managed Care Accountability Set (MCAS) measures (i.e., AMM, ADD, APM, and SSD).

Rationale: According to the National Committee on Quality Assurance, the importance and focus on behavioral health grows exponentially, emphasizing that behavioral health quality is a priority for all CA Market members. Behavioral and mental health conditions are substantially undertreated and associated with higher overall utilization and cost. Many behavioral health treatments also have significant side effects that require careful monitoring and further treatment. Moreover, according to Mental Health America (MHA), the COVID-19 pandemic has caused detrimental effects on the mental health of the nation, including increasing the prevalence of anxiety and depression and increasing the morbidity of existing behavioral health conditions (i.e., more moderate to severe symptoms of depression and anxiety) (source: https://mhanational.org/covid19). BH as a critical priority is reflected in the large set of behavioral health quality measures that are included for NCQA Accreditation Scoring, the Marketplace (Exchange products) Quality Rating System, Medicare STARS Display Measures, and Medi-Cal MCAS.

Improve Medication Adherence to Bronchodilators and Systemic Corticosteroids for Members with COPD Exacerbations (PCE)

Goals:

1) To improve the rates for the Pharmacotherapy Management of chronic obstructive pulmonary disease (COPD) Exacerbation (PCE) HEDIS measure:
    - To improve the medication adherence to bronchodilators for members who have experienced a COPD exacerbation.
    - To improve the medication adherence to systemic corticosteroids for members who have experienced a COPD exacerbation.
2) To improve the percentage of members, age 40 and older, who have a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. Hospice members are excluded.

Rationale: Chronic lower respiratory disease, of which COPD is the primary contributor, is a major cause of disability, and the fourth leading cause of death in the United States. Currently 16 million people are diagnosed with COPD.[1] COPD is a chronic, progressive lung disease that makes it hard to breathe. The condition can cause coughing that produces large amounts of mucus, wheezing, shortness of breath, chest tightness and other symptoms. In accordance with the GOLD Guidelines[2], a global strategy for COPD care, spirometry is required to confirm a COPD diagnosis, in combination with clinical symptoms and assessment of comorbidities. Clinical confirmation with spirometry helps to reduce misdiagnosis and over-treatment. Working-age patients with COPD are costly, incurring roughly two-times the costs as employees without COPD.[3] In addition, the loss in productivity is greater in patients with COPD with an average of 5 more days/year of absence from work.[3] COPD exacerbations are associated with increased COPD costs related to the health care resources used to mitigate the exacerbation event. Pharmacotherapy management of COPD through use of systemic corticosteroids and bronchodilators is crucial to reducing exacerbations. Learned coping behaviors through pulmonary rehabilitation may also help to improve quality of life indicators. These treatment options are supported in the 2021 GOLD Guidelines, which further state, "The importance of long-

term behavior change to improve physical functionality, and reduce the psychological impact of COPD, should be emphasized to the patient."[2]

Reducing COPD exacerbations will lead to improved patient outcomes, including reduced hospitalizations and emergency room (ER) visits, and increased work productivity. Health Net can help members manage this chronic condition by ensuring that appropriate medications are dispensed after a COPD exacerbation requiring hospitalization or an ED visit. RY 2020 HEDIS Pharmacotherapy Management of COPD Exacerbation (PCE) data were analyzed for both Bronchodilators and Systemic Corticosteroids. The 75th percentile was not met for either sub-measure by line of business, however directional improvement was achieved for HMO/POS members for both medications.

Improve Satisfaction with Quality of Care

Goals: Implement initiatives and partner with operational stakeholders to improve CAHPS survey results and overall Health Net member experience.

Rationale: The CAHPS survey results are part of Quality Plan Rating Programs including Medicare Stars, Exchange Quality Rating System, and Commercial Office of the Patient Advocate. There are quality bonus payments received (or penalties accrued) based on CAHPS results. The CAHPS survey is also required for accreditation for all LOBs, including Medi-Cal. The CAHPS survey captures member experience on various topics including:

- Access to Care
- Customer Service
- Getting Prescription Drugs
- Claims and Plan Administration
- Doctor Communication
- Care Coordination
- Overall Rating Measures (Health Plan, Drug Plan, Health Care Quality, Provider, Specialist)

The Quality team has CAHPS-dedicated Program Managers to focus on CAHPS measure improvement, increase CAHPS exposure throughout the organization and with our external partners, conduct root cause analysis on member pain points, and create initiatives with operational stakeholders and identified measure owners.

These Program Managers partner with various department stakeholders to identify and track progress on various member experience initiatives taking place within the organization, which ultimately can have an impact on CAHPS.

During CAHPS fielding, the CAHPS team partners with Corporate CAHPS team and the NCQA-approved CAHPS survey vendor to administer the survey and partners with QIRA to distribute the internally-developed CAHPS tracker to identified leadership.

Due to COVID-19, CAHPS Survey Outreach halted early April 2020. As a result, NCQA and CMS announced they would not use RY 2020 CAHPS Rates for any of the applicable Rating Scores. Ratings from RY 2019 would be carried over instead, with the one exception of QHP (Covered California, the State-Based Exchange)CAHPS results which were submitted for the Final QRS Scoring (Plan Year 2021). Final RY 2020 CAHPS Rates were still calculated and made available to health plans, which are used to reflect the rate of improvement from the year prior.

Hospital Quality: Increase Transparency through Public Reporting

Goals: Increase transparency of hospital quality performance through public reporting on patient safety and other key measures among network hospitals.

Rationale: In 1999, the Institute of Medicine (IOM) released the report "To Err is Human" which estimated that 98,000 deaths a year in the U.S. were attributed to preventable hospital error based on data from 1984.[1] In 2016, Johns Hopkins University School of Medicine published an analysis of four large studies summarizing that if medical error was a disease, it would rank as the third leading cause of death in the U.S., behind Heart Disease and Cancer.[2] The study estimates that 9.5% of all deaths are due to medical error, or nearly 700 deaths a day and over 250,000 annually.[3]

Hospital public reporting is key to holding hospitals accountable for their quality performance and to provide guidance to key stakeholders, including health plans and consumers, about how well individual facilities provide care. It is important to help consumers become aware of quality information that is available to them, through tools like Health Net's *Hospital Advisor* online tool. Health Net promotes appropriate hospital quality

performance on patient safety and other priority areas, and urges network hospitals to participate in the annual The Leapfrog Group Hospital Survey, to report in to CMS Care 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 and other sites of care like ambulatory surgery centers.

The benchmark used for this initiative has been included in past versions of The Leapfrog Group's *Health Plan Users Group (HPUG) Scorecard ("Scorecard").* One of the Scorecard goals was to achieve a targeted level of hospital participation in the annual Leapfrog Hospital Survey. While Leapfrog will not be fielding the HPUG Scorecard in 2021, the most recent associated reference values are 75% (to fully meet) and 50% (to partially meet). For the 2019 period (4/1/19-1/31/20), Health Net had a rate of 66.9% (194/290 eligible network hospitals). Improving the proportion of hospitals reporting to Leapfrog may also help improve the share of hospital admissions to facilities meeting Leapfrog's top quartile rank, given that hospitals not reporting to Leapfrog do not count toward this measure, which is also included in the Scorecard. Health Net will continue to encourage network hospitals to participate in the annual Leapfrog survey.

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: In 1999, the Institute of Medicine (IOM) released the report "To Err is Human" which estimated that 98,000 deaths a year in the U.S. were attributed to preventable hospital error based on data from 1984.[1] In 2016, Johns Hopkins University School of Medicine published an analysis of four large studies summarizing that if medical error was a disease, it would rank as the third leading cause of death in the U.S., behind Heart Disease and Cancer.[2] The study estimates that 9.5% of all deaths are due to medical error, or nearly 700 deaths a day and 250,000 annually.[3]

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 quarterly 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 case review and take any necessary action to prevent future occurrences of the HAC. Notified hospitals are asked to respond within 30 days (or when possible, given the COVID-19 environment) 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. Potential Quality Issue referrals are made for cases that fall into one of these categories: Never events; confirmed preventable HACs; HACs identified as confirmed but "not reasonably preventable"; and potential HAC cases about which hospitals fail to respond.

This intervention is necessary given that HACs and Never Events are safety concerns that warrant monitoring and outreach. 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 case review.

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, industry factors as well as tailored network status. Adjustments are based on Health Net specific experience and provider reimbursement.