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 2022 [1]
3) Weighted average annual rate increase (unadjusted)[2]
   - All large group benefit designs 10.0 %

[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.

- Most commonly sold large group benefit design 12.4 %

Weighted average annual rate increase (adjusted)[3]

- All large group benefit designs 10.1% %
- Most commonly sold large group benefit design[4] 12.5 %

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	64	29.6%	4,579	434	$703	8.5%
February	7	3.2%	152	0	$703	5.4%
March	9	4.2%	56	2	$857	7.2%
April	11	5.1%	148	21	$1,205	4.6%
May	7	3.2%	85	0	$1,083	12.2%
June	12	5.6%	179	0	$879	4.1%
July	31	14.4%	1,163	54	$1,030	4.8%
August	6	2.8%	42	0	$647	5.2%
September	12	5.6%	9,156	23	$557	12.3%
October	16	7.4%	250	0	$786	5.8%
November	16	7.4%	136	0	$718	4.1%
December	25	11.6%	302	0	$841	4.4%
Overall	216	100.0%	16,248	534	$660	10.0%

[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)	23	10.6%	1,342	141	$913	3.0%
100% Experience Rated	193	89.4%	14,906	393	$635	10.7%
Overall	216	100.0%	16,248	534	$660	10.0%

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
86% of covered lives are 100% experience rated
14% 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
85% of covered lives are 100% experience rated
15% 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	167	70.8%	6,474	159	$755	8.2%
EPO	5	2.1%	8,787	23	$550	12.3%
POS						
HDHP	59	25.0%	576	331	$858	3.4%
Other (Flex Net)	5	2.1%	411	21	$1,020	4.0%
Overall	236	100.0%	16,248	534	$660	10.0%

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	89	7,251	86.0%	$0 deductible; $1,500 OOPM; $20 office visit; 0.2 per admit inpatient; 0.2 outpatient surgery; $0 ER
0.8 to 0.899	24	931	11.0%	$2000 deductible; $5,000 OOPM; $30 office visit; 0.3 per admit inpatient; 0.3 outpatient surgery; $0 ER
0.7 to 0.799	15	250	3.0%	$3000 deductible; $6,000 OOPM; $30 office visit; 0.3 per admit inpatient; 0.3 outpatient surgery; $0 ER
0.6 to 0.699	0	-	0.0%	
0.0 to 0.599	0	-	0.0%	
Total	128	8,431	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	11	8,410	100.0%	$100 deductible; $2,000 OOPM; $35 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	11	8,410	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	2	40	3.0%	$2000 deductible; $2,000 OOPM; $0 office visit; 0 per admit inpatient; 0 outpatient surgery; $0 ER
0.8 to 0.899	36	842	64.5%	$2800 deductible; $3,275 OOPM; $0 office visit; 0.2 per admit inpatient; 0.2 outpatient surgery; $0 ER
0.7 to 0.799	17	320	24.5%	$3000 deductible; $4,000 OOPM; $0 office visit; 0.2 per admit inpatient; 0.2 outpatient surgery; $0 ER
0.6 to 0.699	9	104	7.9%	$5500 deductible; $6,650 OOPM; $0 office visit; 0.2 per admit inpatient; 0.2 outpatient surgery; $150 ER
0.0 to 0.599	0	-	0.0%	
Total	64	1,306	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	430	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	430	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 75 standard plans with enrolled membership.

85% of members are enrolled in plans with deductible <=$500.

88% of members are enrolled in plans with an office visit copayment <=$35.

Health Net Life has 111 groups enrolled in custom PPO/EPO plans.

Health Net Life has 207 groups enrolled in standard PPO/EPO plans.

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 2022.

For the 2022 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 1.229. 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 1.005.
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.

[3] i.e. premium tier ratios

Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated	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

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]	11.3%
Hospital Outpatient (including ER)	10.7%

[4] Measured as inpatient days, not by number of inpatient admissions.

Physician/other professional services[5]	5.7%
Prescription Drug[6]	9.0%
Laboratory (other than inpatient)[7]	6.0%
Radiology (other than inpatient)	6.0%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	N/A

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)

[5] Measured as visits.
[6] Per prescription.
[7] Laboratory and Radiology measured on a per-service basis.

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]	$223	5.9%	4.3%	0.6%	11.1%
Hospital Outpatient (including ER)	$329	5.0%	4.5%	0.6%	10.3%
Physician/other professional services[9]	$167	1.6%	3.9%	0.6%	6.2%
Prescription Drug[10]	$77	0.0%	9.0%	0.0%	9.0%
Laboratory (other than inpatient)[11]	$11	4.1%	4.0%	0.6%	8.9%
Radiology (other than inpatient)	$9	4.1%	4.0%	0.6%	8.9%
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	$818	4.0%	4.7%	0.5%	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

[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.

(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 2022 to 2022. The average office visit copayment stayed at approximately $26 per visit. Average coinsurance increased from 2021 (8%) to 2022 (9%) Average Deductible decreased by approximately 4% from 2021 ($477) to 2022 ($458) when weighting by enrollment. Out of Pocket Maximum increased marginally from 2021 ($2436) to 2022 ($2450) when weighting by enrollment. Generic prescription drug copayments decreased 20% from 2021 ($9) to 2022 ($7) Brand prescription drug copayments decreased 29% from 2021 ($30) to 2022 ($21)

(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 1.9% from 2021 (Average AV 0.950) to 2022 (Average AV 0.933).

[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.

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.

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 influenza (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. For all product lines and measures, the goal is to increase our overall accreditation score and/or achieve directional improvement towards the national QC 75th percentile.

Rationale: It is important for members to stay up-to-date on the recommended screening schedules to stay healthy and detect diseases early, when they are easier to treat, and to receive an annual flu shot. COVID-19 greatly impacted outreach for preventive screenings, with the regional stay-at-home orders in early 2020 and members discouraged from scheduling non-urgent/routine visits. This may have impacted how members interact with health care in 2021, which noted a similar downward trend in preventive care screening rates. Therefore, it is critical to ensure members understand the importance of preventive health screenings and complete all necessary visits in 2022.

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. For HNCA Commercial plans, HNCA must meet or exceed at least the National Accreditation and/or Quality Compass 75th percentile for accreditation, Performance Guarantees, and Office of the Patient Advocate (OPA) public reporting on the "Treating Children: Getting the Right Care" Composite. For the Exchange population, childhood immunizations, well-child visits, and weight assessment and counseling for nutrition and physical activity, are included in the Covered California Quality Rating System (QRS). 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.

Improve Office of the Patient Advocate (OPA) Star Ratings

Goals: The goal for our HNCA HMO Commercial products is to meet or exceed the 4 Star OPA rating for all performance metrics and/or composites included on the OPA Report Card. 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 2021-2022 Report Card.

Rationale: As a result of the Centene merger, Health Net of California (HNCA) met certain quality performance requirements, known as the "Undertakings (UT)." DMHC UT#23 (HMO/POS) and CDI UT#13(i) (PPO) pertained to improving ratings on the publicly reported Office of the Patient Advocate Report Cards. While 2020 was the final year for the Undertakings reporting. Health Net continues to monitor OPA Report Cards, with a continued focus on preventive screenings, chronic care (diabetes and heart care), behavioral and mental healthcare, maternity care, and member experience.

Improve Chronic Care and Disease Management – Hypertension, Diabetes, Cardiovascular Disease and COPD

Goals: The overall goal is to improve the management of chronic conditions, including cardiometabolic and COPD, to prevent heart attacks, strokes, complications from diabetes, and prevent COPD exacerbations. The goal for HNCA Commercial and Exchanges products is to meet the 75th Quality Compass (QC) national percentile on chronic care metrics. Part of these metrics are part of the Right Care Initiative (RCI) (blood pressure control, HbA1c control, and cholesterol therapy). In addition, Health Net aims to meet the 75th Quality Compass (QC) national percentile for diabetic retinal eye exam (CDC-DRE), kidney health evaluation for patients with diabetes (KED), persistence of Beta blocker treatment after a heart attack (PBH) and Pharmacotherapy Management of COPD Exacerbation (PCE). *[RCI is a joint initiative between UC Berkeley, DMHC, and Stanford University to prevent heart attacks, strokes, and diabetic complications in California.]*

Rationale: Health Net aims to accomplish these goals by improving the control and management of these targeted conditions through provider and member outreach, aligned with current science and best practices. Our work is focused in these high-leverage areas of better management of cardiovascular disease and diabetes, with particular emphasis on control of blood pressure, cholesterol, blood sugar, care following a

heart attack and reducing COPD exacerbations. These conditions are some of the most significant drivers of death and disability. Best practices, anchored in well-documented science, are often inconsistently implemented in clinical care. Consistent application could prevent much unnecessary death and disability and associated medical costs for Commercial and Marketplace members.

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) and preparing to meet the new requirements with the Quality Transformation Initiative (QTI). 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 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 external partners, conduct root cause analysis on member pain points, and collaborate on initiatives with operational stakeholders and identified measure owners. These Program Managers also partner with various stakeholder departments to 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 the Corporate CAHPS Team and SPH Analytics (the NCQA-approved CAHPS survey vendor) to administer the survey each year. Final results are shared with leadership, as well as cascaded out to all stakeholder department within the organization. The CAHPS Team also conducts an off-cycle Mock CAHPS Survey as a way to get a pulse on member experience throughout the year. This also allows the opportunity to capture results and tie to them back to the member's PPG. Results from the Mock CAHPS Survey are a critical tool to shaping future CAHPS improvement initiatives that can be tailored to a specific PPG's strengths and weaknesses within member experience.

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 groundbreaking report "To Err is Human", which estimated that 44,000 to 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 A Johns Hopkins Armstrong Institute for Patient Safety and Quality report prepared for The Leapfrog Group estimated in a 2019 report that 160,000 deaths occurred due to medical errors the previous year.4 A 2020 article reported on a meta-analysis by researchers at the Yale School of Medicine estimating that the figure was less than 23,000 deaths per year, however this analysis relies on extrapolation from studies conducted in Canada and Europe.5 There has been considerable disagreement in the academic and medical communities about the true toll of medical errors, but there is consensus about the fact that the numbers are too high.

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 into 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.

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 A Johns Hopkins Armstrong Institute for Patient Safety and Quality report prepared for The Leapfrog Group estimated in a 2019 report that 160,000 deaths occurred due to medical errors the previous year.4 A 2020 article reported on a meta-analysis by researchers at the Yale School of Medicine estimating that the figure was less than 23,000 deaths per year, however this analysis relies on extrapolation from studies conducted in Canada and Europe.5 There has been considerable disagreement in the academic and medical communities about the true toll of medical errors, but there is consensus about the fact that the numbers are too high.

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.