California Large Group Annual Aggregate Rate Data Report Form

Version 5, August 7, 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) Prescription Drug Costs
    - *submit SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans (Excel)*
18) Other Comments

1) Company Name:

Kaiser Permanente 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 7.1 %
   - Most commonly sold large group benefit design 9.0 %

   Weighted average annual rate increase (adjusted)[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.

- All large group benefit designs 7.1 %
- Most commonly sold large group benefit design[4] 8.0 %

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	92	35%	596	0	$955.75	6.2%
February	12	5%	279	0	$887.79	9.5%
March	10	4%	82	0	$900.55	7.8%
April	13	5%	47	0	$1,034.41	3.2%
May	9	3%	55	0	$888.41	10.6%
June	20	8%	3,393	0	$394.78	8.7%
July	27	10%	209	0	$1,055.89	1.2%
August	10	4%	137	0	$900.50	1.8%
September	24	9%	217	0	$1,061.69	6.6%
October	9	3%	65	0	$1,171.39	4.2%
November	14	5%	179	0	$1,063.92	8.4%
December	23	9%	85	0	$1,052.52	6.4%
Overall	**263**	**100%**	**5,344**	**0**	**$609.77**	**7.1%**

[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).*

(1) The most commonly sold benefit design is EPO (based on number of members).
(2) The 2018 rates for groups that are not yet quoted are estimated using KPIC's standard rating methodology.

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)	222	84%	1,687	0	$1,013.75	5.4%
Blended (in part)	32	12%	227	0	$833.04	11.3%
100% Experience Rated	9	3%	3,430	0	$396.30	8.7%
Overall	**263**	**100%**	**5,344**	**0**	**$609.77**	**7.1%**

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.

POS/EPO - Renewal rates for groups with more than 1,000 members is 100% experienced rated. For groups with less than 1,000 members - that is, groups whose utilization is not fully credible, we use a blend of experience and community rating. For groups with less than 300 members it is 100% community rating.

PPO/OOA - All groups are community-rated.

Distribution of Covered Lives

	Product			
Rating Method	PPO	EPO	POS	OOA
100% Community Rated (in whole)	22%	0%	9%	0%
Blended (in part)	0%	0%	4%	0%
100% Experience Rated	0%	62%	2%	0%
Overall	22%	62%	15%	0%

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	0	0%	0	0	N/A	N/A
PPO	136	52%	1,202	0	$1,060.14	5.3%
EPO	2	1%	3,329	0	$386.76	9.0%
POS	122	46%	798	0	$852.35	6.9%
HDHP	0	0%	0	0	N/A	N/A
Other (describe)	3	1%	15	0	$1,107.69	10.8%
Overall	**263**	**100%**	**5,344**	**0**	**$609.77**	**7.1%**

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 “Other” row includes the Out-of-Area (OOA) product, which is an employer group plan that offers health coverage for group enrollees who live and work outside Kaiser Permanente’s HMO service area and Private Healthcare Systems (PHCS) network of providers.

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	0	0%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**0**	**0**	**100%**	**N/A**

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	4	76	6%	$250/$750 DED; $15/30% OV; 10% IP; $15/$40 RX
0.8 to 0.899	39	921	77%	$500/$1000 DED; $25/30% OV; 10% IP; $15/$40 RX
0.7 to 0.799	8	184	15%	$1500/$3000 DED; $40/50% OV; 30% IP; $15/$40 RX
0.6 to 0.699	3	21	2%	$2700 DED; $20/50% OV; 20% IP; $15/$40 RX
0.0 to 0.599	0	0	0%	N/A
Total	**54**	**1,202**	**100%**	**N/A**

EPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	0	0	0%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	2	3,329	100%	$1500 DED; 20% OV; 20% IP
0.0 to 0.599	0	0	0%	N/A
Total	**2**	**3,329**	**100%**	**N/A**

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	36	732	92%	$500/$1000 DED; $20/20%/40% OV; 20%IP; $20/$40 RX
0.8 to 0.899	6	66	8%	$1500/$3000 DED; $35/30%/50% OV; 30% IP; $20/$40 RX
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**42**	**798**	**100%**	**N/A**

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%	N/A
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**0**	**0**	**100%**	**N/A**

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	3	15	100%	$300/$600 DED; 20% OV; 20% IP; $5/$15 RX
0.8 to 0.899	0	0	0%	N/A
0.7 to 0.799	0	0	0%	N/A
0.6 to 0.699	0	0	0%	N/A
0.0 to 0.599	0	0	0%	N/A
Total	**3**	**15**	**100%**	**N/A**

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:

(1) All of the plans are custom plans.
(2) There are 263 groups with custom plans and no group with standard plans.

8) Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

See Health and Safety Code section 1385.045(c)(2) and Insurance Code section 10181.45(c)(2)

Factor	**Provide actuarial basis, change in factors, and member months during 12-month period.**
Geographic Region (describe regions)	POS/EPO - The geographic location where members reside impacts group premiums. Northern California and Southern California have completely separate rating models due to different market and cost structure. Northern California is divided into three sub-regions, each with a different geographic factor. These geographic adjustments apply only to the manual rating methodology. The factors did not change in 2018. PPO/OOA - Rates are area-adjusted and area factors are based on zip code. The factors did not change in 2018.
Age, including age rating factors (describe definition, such as age bands)	Health care costs depend on the member's age and gender due to variations in utilization and intensity pattern. Our age / gender factor slope is based on our book of business experience. The factors did not change in 2018.
Occupation	N/A
Industry	We use industry factors to reflect the health care cost differentials attributed to the industry classification. The factors did not change in 2018.
Health Status Factors, including but not limited to experience and utilization	Our base rates reflect the claims experience of the underlying population.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	For existing groups, our rating model produces rates on a per member per month (pmpm) basis. Within broad limits, the employer is free to choose the tier ratios used to convert pmpm rates to tiered rates.
Enrollees' share of premiums	Rates may be adjusted for employer contribution.

[7] i.e. premium tier ratios

Enrollees' cost sharing, including cost sharing for prescription drugs	We use benefit adjustment factors to reflect the cost sharing provisions of the employee benefit plan.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Employers may buy additional benefits for an additional premium.
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	POS/EPO - Generally groups averaging 1,000+ members during the experience period are 100% experience rated. Smaller groups receive a combination of experience rating and community rating. PPO/OOA - All groups are community-rated.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	POS/EPO - Early retirees and COBRA members are expected to incur higher health care costs, and thus adjustments are included in rating. These adjustments apply only to the manual rating methodology and apply to all members of the group. The COBRA factor increased and the early retiree factor decreased in 2018. PPO/OOA – The adjustment for Early retirees and COBRA status does not apply.

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)

6.1%

Medical Allowed Trend Factor by Aggregate Benefit Category

The aggregate benefit categories are each of the following – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(A) and Insurance Code section 10181.45(c)(3)(A)

Hospital Inpatient[8]	6.1%
Hospital Outpatient (including ER)	6.1%
Physician/other professional services[9]	6.1%
Prescription Drug[10]	7.0%
Laboratory (other than inpatient) [11]	6.1%
Radiology (other than inpatient)	6.1%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	6.1% (Ambulance, Home Health, SNF, DME, etc.)

[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]	$161	0.0%	4.4%	0.0%	4.4%
Hospital Outpatient (including ER)	$113	0.0%	4.4%	0.0%	4.4%
Physician/other professional services[13]	$99	0.0%	4.4%	0.0%	4.4%
Prescription Drug[14]	$94	0.0%	5.0%	0.0%	5.0%
Laboratory (other than inpatient)[15]	$10	0.0%	4.4%	0.0%	4.4%
Radiology (other than inpatient)	$13	0.0%	4.4%	0.0%	4.4%
Capitation (professional)	$0	0.0%	N/A	0.0%	N/A
Capitation (institutional)	$0	0.0%	N/A	0.0%	N/A
Capitation (other)	$0	0.0%	N/A	0.0%	N/A
Other (describe)	$59	0.0%	4.4%	0.0%	4.4%
Overall	**$549**	**0.0%**	**4.5%**	**0.0%**	**4.5%**

[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).

Point of Service (POS) * In-Network Tier

(1) Statin Drug Coverage
Effective January 1, 2018 Kaiser Permanente covers statin drugs at $0 when prescribed by a plan provider to members who meet the USPSTF guidelines, and who are on plans with the ACA preventive package. The USPSTF recommends $0 coverage of statins for adults without a history of cardiovascular disease (CVD) when:

a) they are aged 40 to 75 years;
b) they have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking); and
c) they have a calculated 10-year risk of a cardiovascular event of 10% or greater

(2) Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (BHT) & Applied Behavioral Analysis (ABA) Cost Share Changes
To comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the Department of Managed Health Care (DMHC) directives, Kaiser Permanente has reclassified BHT/ABA services as a "program." Since the services will be treated as program services, KP will administer a single member cost share per day for any combination of individual or group sessions.

(3) Creation/Revision of HCR Benefit Services for HOSP and SURG Ancillary Preventive Services
Update of benefit designs to accommodate the exclusion of women's sterilization

procedure and its associated anesthesia for religious purchasers and certain grandfathered plans.

(4) Retire Autism Therapy Benefit Services

There will no longer be a distinction in therapy benefit services based on a diagnosis of autism. Same cost share is applied and is subject to deductible as applicable to the corresponding physical therapy (PT), occupational therapy (OT), or speech therapy (ST) benefit services. SB 946 requires health plans provide "behavioral health treatment" to members with autism and must be provided consistent with mental health parity. SB 946 provides that physical therapists, occupational therapists, or speech pathologists may be considered "qualified autism service providers," along with other types of medical providers. However, SB 946 does not provide that PT/OT/ST are "behavioral health treatments."

(5) Telehealth Benefit Services and Cost Share (would apply to any HSA-Qualified HDHP; none today)

To comply with the U.S. Treasury Rules applicable to HSA-Qualified HDHPs, telehealth benefits for scheduled telephone visits and interactive video visits will be subject to the health plan deductible, and $0 copay after the deductible has been met.

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.

If a Kaiser Permanente plan was in place after the Affordable Care Act ("ACA") was signed into law on or after March 23, 2010, it's considered a "non-grandfathered" plan.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements (Large Group POS, PPO, OOA)

The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:

a) Counseling of children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
b) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
    - individuals are aged 40-75 years;
    - they have one or more cardiovascular risk factors; and
    - they have a calculated 10- year risk of a cardiovascular event of 10% or greater.
c) Aspirin for the prevention of colorectal cancer when prescribed by a licensed health care professional authorized to prescribe drugs.
d) Over the counter and prescriptions drugs necessary to prepare the bowel for the colorectal cancer screening procedure is now included under coverage for colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
e) A counseling visit to discuss the lung cancer screening is now included under coverage for lung cancer screening with low-dose computed tomography.
f) Fertility awareness-based contraceptive methods, including the lactation amenorrhea method are now included under coverage for all prescribed FDA-approved contraceptive methods for women with reproductive capacity.

(2) Non-Emergency Services Obtained from a Non-Contracting Individual Health Professional at a Participating Provider Facility (Large Group POS, PPO)

In accordance with new requirements under California law (AB 72), for contract effective dates beginning on or after July 1, 2017, the covered person will be responsible for paying no more than the Participating Provider Tier cost-sharing amount (the in-network cost share) for non-emergency covered services obtained from a non-contracting individual health professional at a Participating Provider facility located in California.

(3) Optional Chiropractic and Acupuncture benefit (Large Group PPO, OOA)

Covered chiropractic and acupuncture services obtained at both the Participating Provider Tier and Non-Participating Provider Tier are no longer subject to the Deductible.

(4) Out-of-Pocket Maximum change (Large Group PPO HDHP Plans with HSA option)

To maintain affordability, the Out-of-Pocket Maximum (OPM) amount at the Participating Provider Tier has increased from $5,200 to $5,400 per accumulation period for individuals and from $10,400 to $10,800 per accumulation period for a family. The OPM amount at the Non-Participating Provider Tier has increased from $10,400 to $10,800 per accumulation period for individuals and from $20,800 to $21,600 per accumulation period for a family.

(5) Deductible change (Large Group PPO HDHP Plans with HSA option)

In accordance with requirements for HDHPs under federal law to ensure HSA qualification, the Deductible amount at the Participating Provider Tier has increased from $2,600 to $2,700 per accumulation period for individuals and from $5,200 to $5,400 per accumulation period for a family. Commensurately, the Out-of-Pocket-Maximum amount at the Non-Participating Provider Tier has increased from $4,100 to $4,200 per accumulation period for individuals and from $8,200 to $8,400 per accumulation period for a family.

Grandfathered (GF) Plans

If a Kaiser Permanente plan was in place before ACA was signed into law on March 23, 2010, it's considered a "grandfathered" plan. Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2018.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements (Large Group POS, PPO, OOA)

The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:

a) Counseling of children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
b) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
    - individuals are aged 40-75 years;
    - they have one or more cardiovascular risk factors; and
    - they have a calculated 10- year risk of a cardiovascular event of 10% or greater.
c) Aspirin for the prevention of colorectal cancer when prescribed by a licensed health care professional authorized to prescribe drugs.
d) Over the counter and prescriptions drugs necessary to prepare the bowel for the

colorectal cancer screening procedure is now included under coverage for colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

e) A counseling visit to discuss the lung cancer screening is now included under coverage for lung cancer screening with low-dose computed tomography.

f) Fertility awareness-based contraceptive methods, including the lactation amenorrhea method are now included under coverage for all prescribed FDA-approved contraceptive methods for women with reproductive capacity.

(2) Non-Emergency Services Obtained from a Non-Contracting Individual Health Professional at a Participating Provider Facility (Large Group POS, PPO)

In accordance with new requirements under California law (AB 72), for contract effective dates beginning on or after July 1, 2017, the covered person will be responsible for paying no more than the Participating Provider Tier cost-sharing amount (the in-network cost share) for non-emergency covered services obtained from a non-contracting individual health professional at a Participating Provider facility located in California.

(3) Deductible change (Large Group PPO HDHP Plans with HSA option)

In accordance with requirements for HDHPs under federal law to ensure HSA qualification, the Deductible amount at the Participating Provider Tier has increased from $2,600 to $2,700 per accumulation period for individuals and from $5,200 to $5,400 per accumulation period for a family. The Out-of-Pocket-Maximum amount at the Non-Participating Provider Tier has increased from $4,100 to $4,200 per accumulation period for individuals and from $8,200 to $8,400 per accumulation period for a family.

** The In-Network portion of the Point-of-Service (POS) Plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PPO and Indemnity tiers of the POS Plan. KPIC is a subsidiary of KFHP.*

(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]

The weighted average actuarial value decreased by 0.2% from 76.3% in 2017 to 76.1% in 2018.

[16] Please determine weight average actuarial value base on the company's own plan relativity model. For this purpose, the company is not required to use the CMS standard model.

13) Changes in enrollee/insured benefits

Describe any changes in benefits for enrollees/insureds over the prior year, providing a description of benefits added or eliminated, as well as any aggregate changes as measured as a percentage of the aggregate claims costs. Provide this information for each of the following categories: hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe).

See Health and Safety Code section 1385.045(c)(3)(E) and Insurance Code section 10181.45(c)(3)(E)

Point of Service (POS) * In-Network Tier

(1) Statin Drug Coverage

Effective January 1, 2018 Kaiser Permanente covers statin drugs at $0 when prescribed by a plan provider to members who meet the USPSTF guidelines, and who are on plans with the ACA preventive package. The USPSTF recommends $0 coverage of statins for adults without a history of cardiovascular disease (CVD) when:

a) they are aged 40 to 75 years;
b) they have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking); and
c) they have a calculated 10-year risk of a cardiovascular event of 10% or greater

- The cost impact is 0.2%.

(2) Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (BHT) & Applied Behavioral Analysis (ABA) Cost Share Changes

To comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the Department of Managed Health Care (DMHC) directives, Kaiser Permanente has reclassified BHT/ABA services as a “program.” Since the services will be treated as program services, KP will administer a single member cost share per day for any combination of individual or group sessions.

- This change has little to no impact on aggregate claims cost.

(3) Creation/Revision of HCR Benefit Services for HOSP and SURG Ancillary Preventive Services

Update of benefit designs to accommodate the exclusion of women's sterilization procedure and its associated anesthesia for religious purchasers and certain grandfathered plans.

- This change has little to no impact on aggregate claims cost.

(4) Retire Autism Therapy Benefit Services

There will no longer be a distinction in therapy benefit services based on a diagnosis of autism. Same cost share is applied and is subject to deductible as applicable to the corresponding physical therapy (PT), occupational

therapy (OT), or speech therapy (ST) benefit services. SB 946 requires health plans provide "behavioral health treatment" to members with autism and must be provided consistent with mental health parity. SB 946 provides that physical therapists, occupational therapists, or speech pathologists may be considered "qualified autism service providers," along with other types of medical providers. However, SB 946 does not provide that PT/OT/ST are "behavioral health treatments."

- This change has little to no impact on aggregate claims cost.

(5) Telehealth Benefit Services and Cost Share (would apply to HSA-Qualified HDHP; none today)

To comply with the U.S. Treasury Rules applicable to HSA-Qualified HDHPs, telehealth benefits for scheduled telephone visits and interactive video visits will be subject to the health plan deductible, and $0 copay after the deductible has been met.

- This change has little to no impact on aggregate claims cost.

Point of Service (POS)*, Preferred Provider Organization (PPO) and Out-of-Area (OOA) Contracted Network Tier and Out-of-Network Tier

Non-grandfathered (NGF) Plans only

The changes described below apply to non-Grandfathered plans only.

If a Kaiser Permanente plan was in place after the Affordable Care Act ("ACA") was signed into law on or after March 23, 2010, it's considered a "non-grandfathered" plan.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements (Large Group POS, PPO, OOA)

The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:

a) Counseling of children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

b) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
   - individuals are aged 40-75 years;
   - they have one or more cardiovascular risk factors; and
   - they have a calculated 10- year risk of a cardiovascular event of 10% or greater.

c) Aspirin for the prevention of colorectal cancer when prescribed by a licensed health care professional authorized to prescribe drugs.

d) Over the counter and prescriptions drugs necessary to prepare the bowel for the colorectal cancer screening procedure is now included under coverage for colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

e) A counseling visit to discuss the lung cancer screening is now included under coverage for lung cancer screening with low-dose computed

tomography.

f) Fertility awareness-based contraceptive methods, including the lactation amenorrhea method are now included under coverage for all prescribed FDA-approved contraceptive methods for women with reproductive capacity.

- The cost impact is 0.2%.

(2) Non-Emergency Services Obtained from a Non-Contracting Individual Health Professional at a Participating Provider Facility (Large Group POS, PPO)

In accordance with new requirements under California law (AB 72), for contract effective dates beginning on or after July 1, 2017, the covered person will be responsible for paying no more than the Participating Provider Tier cost-sharing amount (the in-network cost share) for non-emergency covered services obtained from a non-contracting individual health professional at a Participating Provider facility located in California.

- This change has little to no impact on aggregate claims cost.

(3) Optional Chiropractic and Acupuncture benefit (Large Group PPO, OOA)

Covered chiropractic and acupuncture services obtained at both the Participating Provider Tier and Non-Participating Provider Tier are no longer subject to the Deductible.

- The cost impact is less than 0.1%

(4) Out-of-Pocket Maximum change (Large Group PPO HDHP Plans with HSA option)

To maintain affordability, the Out-of-Pocket Maximum (OPM) amount at the Participating Provider Tier has increased from $5,200 to $5,400 per accumulation period for individuals and from $10,400 to $10,800 per accumulation period for a family. The OPM amount at the Non-Participating Provider Tier has increased from $10,400 to $10,800 per accumulation period for individuals and from $20,800 to $21,600 per accumulation period for a family.

- The cost impact is less than 0.1%

(5) Deductible change (Large Group PPO HDHP Plans with HSA option)

In accordance with requirements for HDHPs under federal law to ensure HSA qualification, the Deductible amount at the Participating Provider Tier has increased from $2,600 to $2,700 per accumulation period for individuals and from $5,200 to $5,400 per accumulation period for a family. Commensurately, the Out-of-Pocket-Maximum amount at the Non-Participating Provider Tier has increased from $4,100 to $4,200 per accumulation period for individuals and from $8,200 to $8,400 per accumulation period for a family.

- The cost impact is less than 0.5%

Grandfathered (GF) Plans

If a Kaiser Permanente plan was in place before ACA was signed into law on

March 23, 2010, it's considered a "grandfathered" plan. Grandfathered plans remain largely unchanged for plan years beginning on or after January 1, 2018.

(1) Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements (Large Group POS, PPO, OOA)

The preventive care services that are covered at no charge and not subject to any Deductible when received at the Participating Provider Tier have been expanded to include coverage for the following:

a) Counseling of children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

b) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
   - individuals are aged 40-75 years;
   - they have one or more cardiovascular risk factors; and
   - they have a calculated 10- year risk of a cardiovascular event of 10% or greater.

c) Aspirin for the prevention of colorectal cancer when prescribed by a licensed health care professional authorized to prescribe drugs.

d) Over the counter and prescriptions drugs necessary to prepare the bowel for the colorectal cancer screening procedure is now included under coverage for colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

e) A counseling visit to discuss the lung cancer screening is now included under coverage for lung cancer screening with low-dose computed tomography.

f) Fertility awareness-based contraceptive methods, including the lactation amenorrhea method are now included under coverage for all prescribed FDA-approved contraceptive methods for women with reproductive capacity.

- The cost impact is 0.2%.

(2) Non-Emergency Services Obtained from a Non-Contracting Individual Health Professional at a Participating Provider Facility (Large Group POS, PPO)

In accordance with new requirements under California law (AB 72), for contract effective dates beginning on or after July 1, 2017, the covered person will be responsible for paying no more than the Participating Provider Tier cost-sharing amount (the in-network cost share) for non-emergency covered services obtained from a non-contracting individual health professional at a Participating Provider facility located in California.

- This change has little to no impact on aggregate claims cost.

(3) Deductible change (Large Group PPO HDHP Plans with HSA option)

In accordance with requirements for HDHPs under federal law to ensure HSA qualification, the Deductible amount at the Participating Provider Tier has increased from $2,600 to $2,700 per accumulation period for individuals and from $5,200 to $5,400 per accumulation period for a family. The Out-of-Pocket-Maximum amount at the Non-Participating Provider Tier has increased from $4,100 to $4,200 per accumulation period for individuals and

from $8,200 to $8,400 per accumulation period for a family.

- The cost impact is less than 0.5%

** The In-Network portion of the Point-of-Service (POS) Plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PPO and Indemnity tiers of the POS Plan. KPIC is a subsidiary of KFHP.*

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/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

POS In-Network Tier and EPO

1.01 Coordination and Cooperation

Kaiser Permanente is structured differently than most health plans. The most important differentiator is our integrated system. Having an integrated system means that our insurance function, our network of health facilities, and our health care providers are all effectively part of one organization. Most decisions on the day- to-day management are made at the regional and local level by three separate but cooperating entities, the Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Hospitals (KFH) and the Northern and Southern Permanente Medical Groups (Permanente providers). KFHP contracts with individuals and group customers to arrange to provide comprehensive health care services under the range of KFHP benefit plans. KFHP also contracts exclusively with KFH and the Permanente providers to provide the hospital and professional medical services under these benefit plans to meet the health care needs of KFHP members.

Our integrated system brings together physicians, nurses and other health care providers to provide covered health care services to KFHP members. The integrated system supports high quality by centering on the patient. These services are provided by physician-led delivery systems, supported by cutting edge technology and an extensive care management infrastructure in order to provide superior care in the most appropriate setting for a lower overall cost, and at a better value for KFHP members.

1.02 Ensuring Networks are Based on Value

Performance Program

Kaiser Permanente participates in the Integrated Healthcare Association's (IHA) Pay for Performance (P4P) Program, which is designed to encourage evidence-based, high-quality, and cost-effective performance. The program grants “Excellence in Healthcare” awards for high performance across health care quality, patient experience, and cost measures.

IHA determines the top physician groups that have demonstrated best overall performance on select health care quality and cost effectiveness measures, including preventive care and chronic care management, patient satisfaction, and the total cost of care provided to members.

Physician groups whose overall clinical quality, patient experience, and total cost of care scores exceed the median scores for each of these domains are awarded “Excellence in Healthcare” awards.

Thirteen of the 22 California Medical Groups that met the total cost of care threshold and received a 2015 “Excellence in Healthcare” award were Permanente Medical Groups (South San Francisco, Antelope Valley, Baldwin Park, Downey, Fontana and Ontario, Kern County, Orange County, Panorama City, Riverside, San Diego, South Bay, West Los Angeles, and Woodland Hills). In addition, all Permanente Medical Groups exceed the quality and patient experience thresholds. In Northern California, the Modesto/Manteca/Stockton service area received a “Most Improved” award in 2015 as well.

Physician groups whose overall clinical quality, patient experience, and total cost of care scores exceed the median scores for each of these domains are awarded “Excellence in Healthcare” awards. Our South San Francisco medical group met the total cost of care threshold and received a 2015 “Excellence in Healthcare” award. In addition, all of the 15 Permanente Medical Groups exceed the quality and patient experience thresholds. In Northern California, the Modesto/Manteca/Stockton service area received a “Most Improved” award in 2015 as well.

While we submit data to the IHA for the P4P Program, Kaiser Permanente does not participate in the financial incentive part of the program because our physicians are paid by salary. Participation in the IHA program allows us a venue to publicly report our data and be benchmarked against other physician groups. IHA partners with the California State Office of the Patient Advocate (OPA) to produce an annual public report card of P4P results, and select measures are publicly reported by the organization. The report card is available on OPA's website at opa.ca.gov/Pages/ReportCard.

Kaiser Permanente also has a pay-for-performance program that is different from other health plans. Our doctors are rewarded for prevention, quality care, and member satisfaction. Unlike fee-for-service health plans and claims-based organizations, our physicians are not incentivized to provide more care at higher costs for more compensation. Instead, we incentivize for providing the right care at the right time. We use a comprehensive system of performance incentives to reward our medical centers and physicians for delivering care that helps keep our members healthy and productive.

Member Satisfaction

Measuring how well Kaiser Permanente meets or exceeds members' expectations is a critical activity for quality assessment and improvement. Member satisfaction is measured

through a variety of sources. Data gathered from these sources is translated into specific information, which is used to provide relevant member feedback for services delivered at every level in the organization.

To measure member satisfaction, we use a number of tools including the following:

-Consumer Assessment of Healthcare Providers and Systems care experience surveys

-Complaint and appeal data

-Member experience tracking evaluation and opinion research

-Family experience with Hospice bereavement services survey

To assess member satisfaction, ongoing comprehensive data analyses are conducted periodically at service-area levels and regional levels. Analyses are presented and updated at quarterly board meetings and executive on-site visits as well.

Kaiser Permanente engages in a variety of performance improvement interventions and strategies aimed at promoting the availability and accessibility of health care services and increasing the satisfaction of its members. Strategic service priorities are set based on identified areas of opportunity to address members' service needs. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member satisfaction.

1.03 Demonstrating Action on High Cost Providers

Kaiser Permanente is an integrated care delivery system that owns and operates our hospitals and provides comprehensive care through the Permanente Medical Groups. One hundred percent of our members receive care within our integrated model. We compensate providers via salary, thereby eliminating misaligned incentives. Providers are not paid per procedure, but rather through an exclusive partnership with the Kaiser Foundation Health Plan. This model incentivizes efficient care that keeps patients healthy — we leverage technology wherever possible to connect members to their providers in the manner best suited to their condition and circumstance.

Kaiser Permanente has pioneered many of the cost-saving strategies the rest of the industry is just now scrambling to create. For more than 70 years, we've been an innovator, providing affordable, high-quality care to our members and communities. Through our integrated model, caregivers from doctors to nurses to pharmacists work together to provide the right care at the right time — improving outcomes while keeping costs low. They're connected through our industry-leading electronic health record system and able to share accurate medical information about members in real time; this allows us to continuously check to make sure members are up-to-date with preventive care, reducing avoidable illnesses and unnecessary sick days. Our innovative online employee engagement tools give members the power to actively manage their health.

Our cost reductions focus on areas including:

Enhancing care quality and efficiency: We continue to develop and share best practices

across the organization, and leverage our collaborative model to ensure better outcomes and cost efficiencies. With our coordinated, team-based approach, we have the unique ability to analyze and improve how care is delivered across the entire treatment continuum — leading to better outcomes, appropriate levels of utilization, and management of long-term expenses. Some ways we're working to ensure consistent, reliable, and safe care for our members include reducing unnecessary variations in care through predictive modeling and new protocols; continuing to lead the industry in prevention and disease management; leveraging our electronic health record system to prevent errors and duplication; and maximizing pharmacy savings through generics, formularies, and purchasing. For members who require specialized care, we offer both internal specialty centers and external Centers of Excellence (COEs). Our specialty centers perform specialized procedures not performed regionally, while our external COEs perform transplants and other specialized procedures not performed within our facilities. These COEs are located at premier medical centers, known nationally for their particular expertise.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Kaiser Permanente regards evidence-based medicine and value assessments as essential tools in managing our formulary. The formulary process uses a systematic approach in the review of drugs on the formulary. Along with a critical review of the literature, drug review takes into consideration: American Society of Clinical Oncology Value of Cancer Treatment Options, The Institute for Clinical and Economic Review Value Assessment Framework, and United Kingdom's National Institute for Health and Care Excellence when making formulary recommendations. These sources are integrated into our monograph template to ensure they are consistently reviewed and the information is captured appropriately to share with key stakeholders. Information from National Comprehensive Cancer Network (NCCN) Resource Stratification Framework and NCCN Evidence Blocks are considered. Value assessment is one part of our formulary process and is weighed along with efficacy and safety of the drug.

Kaiser Permanente has a proactive evidence-based formulary review process that takes into account the efficacy and safety of the drug, how it compares to others in its class, and total cost of care to address cost and quality objectives. We collaborate with key stakeholders to develop strategic initiatives to manage cost and ensure quality of care. Kaiser Permanente takes advantage of the availability of generic drugs and maximizes the use of these products when feasible. We have a dedicated team that monitors drug prices and market dynamics whose information is integrated into the formulary management. Various benefit designs are used as solutions to assist in driving down total cost of care. Additionally, specific disease-focused strategies are performed to target high-cost chronic conditions to improve health outcomes and control costs (i.e., Hepatitis C, multiple sclerosis).

Within Kaiser Permanente, individual physicians determine whether a given therapy will be used. Physicians prescribe based on various factors: Clinical evaluation, available alternatives, available evidence, expert consensus, disease management plans, and their own experience.

We employ a variety of tactics to increase efficiencies, reduce costs, and eliminate waste in purchasing and distribution, including establishing quantity limits on select drugs to avoid waste if the drug is discontinued for any reason.

Our industry-leading integrated care model allows us to better serve our members because all their prescription data is captured in one electronic database. Our physicians, pharmacists, care managers, and nurses have instant access to this information and can easily view all written and dispensed prescriptions — offering safety, consistency, privacy, and cost-effectiveness to our members.

1.05 Quality Improvement Strategy

The agreements between Kaiser Foundation Health Plan and both the Permanente Medical Groups and Kaiser Foundation Hospitals are perpetually renewed and have been in place in the Northern and Southern California Regions since we were established more than 70 years ago.

Maintaining a high standard of clinical quality is a cornerstone of the care that we provide to our members. All Permanente Medical Group providers are expected to contribute to a culture of continuously improving care by taking responsibility for a variety of quality metrics — physician leaders hold their peers accountable.

Kaiser Foundation Health Plan works with the Permanente Medical Groups to identify goals each year. Measures are determined by the significance of the impact on members' health and community health, ability to improve overall performance, and ability to reduce undesirable variation. Performance monitoring includes a comparison of results from prior periods for the region overall and by medical centers.

Clinical areas include inpatient quality measures such as sepsis and stroke care; outpatient quality measures such as cancer screening, osteoporosis management, cardiovascular health, medications for asthma, depression management, pediatric immunizations, and chemical dependency; and patient safety measures such as surgical safety, hospital-acquired infections, hospital-acquired pneumonia, and intensive care unit mortality.

HEDIS® (Healthcare Effectiveness and Data and Information Set) is a group of standardized performance measures designed to ensure that the Centers for Medicare & Medicaid Services and the public have the information needed to accurately compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS measures are an integral part of health plan accreditation by the National Committee for Quality Assurance.

In addition, we monitor whole-system measures in six related domains of quality, which are used to better understand and improve the overall performance of our entire health system:

-Clinical effectiveness
-Patient safety
-Risk management
-Service
-Resource stewardship
-Equitable care

Kaiser Permanente closely tracks and monitors performance on quality and service measures and targets those measures that have not performed well for performance improvement activities. Much of our success has to do with our highly integrated, organized, and coordinated approach around how we provide care. Our philosophy, structure, and

incentives make it possible for our physicians, nurses, and staff to work collaboratively to provide comprehensive care, achieve superior clinical outcomes, and help our members maximize their total health.

1.06 Participation in Collaborative Quality Initiatives

The following table (extracted from Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract) includes a list of the Plan's participation in collaborative quality initiatives.

	Describe the nature of engagement	**Engaged in**	**Other**
Leapfrog Hospital Rewards	Not engaged	Not Engaged	Not applicable
California Hospital Assessment	Kaiser Permanente submits data to the Collaborative.	Engaged	Not applicable
California Health Performance	Engaged	Engaged	Not applicable
Integrated Healthcare	Engaged	Engaged	Not applicable
California Maternal Data Center	We report on a number of measures to decrease maternal morbidity and mortality related to obstetric hemorrhage and preeclampsia. Kaiser Permanente is also a CMQCC partner organization; we have physicians on the CMQCC Executive Committee, which determines policy and direction for the collaborative.	Engaged	Not applicable
Appropriate use of C-sections:	Kaiser Permanente representatives serve as advisory members and provide feedback on initiatives and projects.	Engaged	Not applicable
California Joint Replacement	Not engaged	Not Engaged	Not applicable
California Immunization	Engaged	Engaged	Not applicable

NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)	Engaged	Engaged	Not applicable
Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Engaged	Engaged	Not applicable
National Neurosurgery Quality and Outcomes Database (N2QOD) of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data	Not engaged	Not Engaged	Not applicable
IHA Payment Bundling demonstration	Not engaged	Not Engaged	Not applicable
Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)	Not engaged	Not Engaged	Not applicable
CMMI Comprehensive Primary Care initiative (CPC)	Not engaged	Not Engaged	Not applicable
CMMI Transforming Clinical Practice Initiative	Not engaged	Not Engaged	Not applicable
CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)	Not engaged	Not Engaged	Not applicable
CMMI Partnership for Patients Hospital Safety Initiative	Kaiser Permanente representatives provide feedback on initiatives and projects.	Engaged	Not applicable
Health plan-sponsored accountable care programs	Not engaged	Not Engaged	Not applicable
California Perinatal Quality Care Collaborative	Kaiser Permanente physicians are members of the CPQCC Executive Committee, which meets regularly to debate, review, prioritize, and plan the direction of the Collaborative. CPQCC includes 136 member hospitals, 20 of which are Kaiser Permanente hospitals. Our hospitals submit data to the CPQCC Data Center.	Engaged	Not applicable
California Quality Collaborative	Not engaged	Not Engaged	Not applicable

Statewide Workgroup on Overuse (opioids, imaging for low back pain, C-sections) sponsored by DHCS, CalPERS, and Covered California	Engaged	Engaged	Not applicable
Other (described in detail box)	Not engaged	Not Engaged	Not applicable

1.07 Data Exchange with Providers

Our paperless electronic health record (EHR) system, Kaiser Permanente HealthConnect®, is the largest private-sector EHR in the world. It enables us to improve care, reduce errors, and eliminate paper waste. Inefficient paper records add to the expense of health care with substantial costs for record storage and administrative support staff; larger medical facilities can see up to $1 million in transcription costs in a year.

While only 34 percent of office-based physicians use EHR, 100 percent of our physicians, nurses, and medical support staff use KP HealthConnect at every point of service in every medical facility, enabling richer analysis of data, remote health monitoring, and long-distance virtual consultations.

The HIMSS Analytics™ Stage 7 Award honors hospitals that operate in a paperless environment and represent best practices in the implementation of electronic medical record (EMR) systems. Nearly one in five U.S. hospitals certified by HIMSS as Stage 7 for EMR adoption — the most advanced level possible — is a Kaiser Permanente medical center. Thirty-seven Kaiser Permanente hospitals are certified as Stage 7 by HIMSS, the world's premier health information technology organization. In California, only 45 hospitals have been certified as Stage 7 and 35 of them are Kaiser Permanente facilities.

Benefits of our EHR system, KP HealthConnect, include:

- Decision support within the EHR that makes care gaps visible at the point of care using the patient's most up-to-date clinical information

- Offering clinical guidelines and powerful decision-support capabilities that enable us to implement the latest advances in evidence-based medicine rapidly

- Providing our researchers with a rich database that offers an unprecedented ability to study the health of chronic disease populations and provide evidence-based care much faster than independent medical providers

- Providing members greater online access to their own health information and self-management tools, such as HealthMedia®, which teaches members to manage chronic conditions such as allergies, asthma, back pain, chronic obstructive pulmonary disease, diabetes, high blood pressure, high cholesterol, or HIV/AIDS to improve their health

- Primary care physicians and specialists have access to the same information using the integrated EHR

1.08 Data Aggregation across Health Plans

As we are not a fee-for-service health care organization, we process a relatively small number of claims. Our members only file claims when they receive care out-of-network in an emergency situation, or for a non-Plan specialist referral. Otherwise, the claims process is

invisible to providers and members — billing is not part of the patient experience.

Our electronic health record system, securely brings together all aspects of a member's care experience — medical information, test results, prescription information, visit summaries, allergies, immunizations, hospital registration, and best-practices updates — all of which are instantly available to a member's entire health care team. A crucial tool that enables collaboration among providers, KP HealthConnect enhances medical safety by alerting physicians and pharmacists of potential drug interactions while also providing overall cost savings by eliminating unnecessary or duplicate tests, among other benefits.

Our use of evidence-based medicine means clinicians can integrate their professional expertise with established external best practices and research. Through the clinical content available on KP HealthConnect, our clinicians have access to evidence-based knowledge at the point of care.

For POS, PPO and OOA Contracted Network Tier and Out-of-Network Tier:

This response applies to Kaiser Permanente Insurance Company's (KPIC's) PPO and OOA products and tiers 2 and 3 of the POS product. Since 2017, KPIC's Pharmacy Benefit Manager (PBM) has continued full administration of KPIC's outpatient prescription drug benefit. This includes maintenance of the formulary, utilization of the PBM's Pharmacy & Therapeutics and Formulary Committee (P&T Committee), and adoption of its cost containment processes. KPIC formularies, pharmacy utilization management edits and supporting medication treatment guidelines are reviewed and approved by PBM's P&T Committee and are based upon a thorough review of the medical literature reflecting published treatment guidelines recommended by national medical organizations. The P&T Committee reviews key therapeutic drug categories on a continuous basis to ensure they reflect the most up to date medication treatment recommendations.

Drugs presented to the P&T Committee for consideration are reviewed on the following evidence-based criteria:

1. Safety, including concurrent drug utilization review (cDUR) when applicable,
2. Efficacy: the potential outcome of treatment under optimal circumstances,
3. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary,
4. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available,
5. Relevant benefits of current formulary agents of similar use,
6. Condition of potential duplication of similar drugs currently on formulary,
7. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

KPIC's PBM monitors the ability of the utilization management programs applied at point of sale to ensure that KPIC delivers a highly efficient cost effective pharmacy benefit program to our membership.

KPIC's PBM also received NCQA Utilization Management (UM) Accreditation in 2017. This

accreditation demonstrates that KPIC's PBM has the systems, processes and personnel to conduct utilization management in accordance with the strictest quality standards with focus on quality through consumer protection and improvement in service to customers with emphasis that organizations continually work on quality improvement. Some areas of focus:

- The PBM has the quality improvement infrastructure needed to improve the UM functions and services provided to its members.
- The PBM has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.
- The PBM applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.
- The PBM continually assesses member and practitioner experience with its UM process to identify areas in need of improvement.

Drugs requiring prior authorization:
Prior authorization is generally applied to drugs that have multiple indications, qualify as Specialty medications per our protocol (cost >$600/month, requires complex monitoring and/or administration, complex clinical condition/disease state), are high in cost, have a high abuse potential (topical testosterone) or have a significant safety concern.

Drugs requiring step therapy:
Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Under step therapy, KPIC insureds may first need to try a proven, cost-effective medication before using a more costly treatment.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the insured's drug history, prior to the use of another drug (2nd line agent). If the licensed prescribing provider determines that a first-line drug is not appropriate or effective, a second-line drug, may be covered after meeting certain conditions.

15) Excise tax incurred by the health plan

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

N/A

16) 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 10181.45(c)(4)(A), 10181.45(c)(4)(B), 10181.45(c)(4)(C)

17) Complete the SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans 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) 25 Most Frequently Prescribed Drugs
(ii) 25 Most Costly Drugs by Total Annual Plan Spending
(iii) 25 Drugs with the Highest Year-Over-Year Increase in Total Annual Plan Spending
(iv) Overall Impact of Drug Costs on Health Care Premiums

Complete SB 17 - Prescription Drug Cost Reporting Form for Commercial Plans - Excel

See Health and Safety Code section 1367.243(a)(2)(A), 1367.243(a)(2)(B), 1367.243(a)(2)(C), 1367.243(b) and Insurance Code section 10123.205(a)(2)(A), 10123.205(a)(2)(B), 10123.205(a)(2)(C), 10123.205(b)

18) Other Comments

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

None