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:

Kaiser Permanente 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 _2.8_%
   - Most commonly sold large group benefit design _1.2_%

   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 _3.3_ %
- Most commonly sold large group benefit design[4] _0.7_ %

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 the 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
January	99	42%	1,144	0	$994.50	1.7%
February	6	3%	194	0	$951.45	12.8%
March	6	3%	42	0	$816.62	2.3%
April	8	3%	30	0	$1,015.36	-7.6%
May	7	3%	29	0	$829.62	7.2%
June	16	7%	2,489	0	$481.68	1.5%
July	26	11%	277	0	$1,116.15	4.8%
August	6	3%	222	0	$1,064.10	-4.3%
September	16	7%	156	0	$1,296.99	8.1%
October	11	5%	62	0	$1,189.04	2.8%
November	9	4%	74	0	$1,235.74	11.3%
December	24	10%	89	0	$1,302.02	5.8%
Overall	**234**	**100%**	**4,808**	**0**	**$756.82**	**2.8%**

[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 2022 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)	204	87%	1,900	0	$1,077.12	2.2%
Blended (in part)	25	11%	401	0	$920.41	3.0%
100% Experience Rated	5	2%	2,507	0	$487.90	2.4%
Overall	**234**	**100%**	**4,808**	**0**	**$756.82**	**2.8%**

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 are 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	**Total**
100% Community Rated (in whole)	31%	0%	9%	0%	**40%**
Blended (in part)	0%	0%	8%	0%	**8%**
100% Experience Rated	0%	50%	2%	0%	**52%**
Overall	**31%**	**50%**	**19%**	**0%**	**100%**

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	137	59%	1,487	0	$1,104.57	**2.1%**
EPO	2	1%	2,426	0	$467.88	**1.2%**
POS	95	41%	895	0	$962.25	**4.0%**
HDHP	0	0%	0	0	N/A	N/A
Other (describe)	0	0%	0	0	N/A	N/A
Overall	**234**	**100%**	**4,808**	**0**	**$756.82**	**2.8%**

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.

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**	**0%**	

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	14	509	34%	$250/$500 DED; $15/30% OV; 10% IP; $15/$40 RX
0.8 to 0.899	22	746	50%	$1000/$2000 DED; $25/50% OV; 10% IP; $15/$40 RX
0.7 to 0.799	5	232	16%	$2800 DED; $20/50% OV; 20% IP; $15/$40 RX
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**41**	**1,487**	**100%**	

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%	N/A
0.8 to 0.899	2	2,426	100%	$1400DED; 20%OP; 20%IP; 100%RX
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**2**	**2,426**	**100%**	

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	34	895	100%	$1000/$2000 DED; $25/20%/40% OV; 20% IP; $20/$40 RX
0.8 to 0.899	-	-	0%	N/A
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**34**	**895**	**100%**	

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**	**0%**	

Other (describe)

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	-	-	0%	N/A
0.8 to 0.899	-	-	0%	N/A
0.7 to 0.799	-	-	0%	N/A
0.6 to 0.699	-	-	0%	N/A
0.0 to 0.599	-	-	0%	N/A
Total	**0**	**0**	**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:

(1) All of the plans are custom plans.
(2) There are 234 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 2022. PPO/OOA - Rates are area-adjusted and area factors are based on zip code. The factors did not change in 2022.
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 2022.
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 2022.
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,[1] 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.

[7] i.e. premium tier ratios

Enrollees' share of premiums	Rates may be adjusted for employer contribution.
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 - 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 factors did not change in 2022. PPO/OOA and EPO – 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:

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)

3.7%

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[2]	3.4%
Hospital Outpatient (including ER)	3.4%
Physician/other professional services[3]	3.4%
Prescription Drug[4]	6.0%
Laboratory (other than inpatient) [5]	3.4%
Radiology (other than inpatient)	3.4%
Capitation (professional)	N/A
Capitation (institutional)	N/A
Capitation (other)	N/A
Other (describe)	3.4%(Ambulance, Home Health, SNF, DME, etc.)

Note: Trends vary by experience period. Trends shown here were used for renewals using July 2021 – June 2022 claims.

[2] Measured as inpatient days, not by number of inpatient admissions.
[3] Measured as visits.
[4] Per prescription.
[5] Laboratory and Radiology measured on a per-service basis.

Please provide an explanation if any of the categories under 9(b) are zero or have no value.

KPIC does not pay capitation.

10) Projected medical trend:

Use the same aggregate benefit categories used in item 9 – hospital inpatient, hospital outpatient (including emergency room), physician and other professional services, prescription drugs from pharmacies, laboratory services (other than hospital inpatient), radiology services (other than hospital inpatient), other (describe). Furthermore, within each aggregate category quantify the sources of trend, i.e. use of service, price inflation, and fees and risk.

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

Projected Medical Allowed Trend by Aggregate Benefit Category

		Trend attributable to:			
Allowed Trend: (Current Year + 1) / (Current Year)	Current Year - Aggregate Dollars (PMPM)	Use of Services	Price Inflation	Fees and Risk	Overall Trend
Hospital Inpatient[12]	$257.48	-3.7%	7.2%	0%	3.2%
Hospital Outpatient (including ER)	$165.83	-1.2%	4.5%	0%	3.2%
Physician/other professional services[13]	$177.34	1.9%	1.3%	0%	3.2%
Prescription Drug[14]	$74.91	1.3%	4.7%	0%	6.0%
Laboratory (other than inpatient)[15]	$45.41	-1.8%	5.1%	0%	3.2%
Radiology (other than inpatient)	$54.77	0.2%	3.0%	0%	3.2%
Capitation (professional)	$0	N/A	N/A	N/A	N/A
Capitation (institutional)	$0	N/A	N/A	N/A	N/A
Capitation (other)	$0	N/A	N/A	N/A	N/A
Other (describe)	$3.07	0.6%	2.6%	0%	3.2%
Overall	**$778.80**	**-1.1%**	**4.6%**	**0%**	**3.5%**

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

KPIC does not pay capitation.

[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), Preferred Provider Organization (PPO) and Out-of-Area (OOA) - Contracted Network Tier and Out-of-Network Tier

Non-Grandfathered (NGF) Plans only

1. Specialty Drugs per script max increase from $200 to $250
    a. Applies to LG NGF - PPO, HSA, POS, OOA

Point of Service (POS) - Contracted Network Tier and Out-of-Network Tier

2. Add coverage for prosthetic and orthotics to POS NGF and GF plans (s/to Precert)
    a. Cost share follows the plan's existing coinsurance structure (mirrors the urgent care cost share).

Point of Service (POS) and Preferred Provider Organization (PPO) - Contracted Network Tier Only

3. Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements - add the following preventive care services at no charge and not subject to Deductible (for PPO and POS, when received at the Participating Provider tier):

a. Pre-eclampsia screening with blood pressure measurements throughout pregnancy.
b. Screening by asking questions about unhealthy drug use in adults age 18 years or older.
c. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease

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

4. New USPSTF Preventative Service Recommendation:
    a. No additional cost share for behavioral counseling for healthy weight gain in pregnancy

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

5. Single Level of Claims Appeal – The following change has been made as an improvement to the claims appeal administrative process:
   Effective January 1, 2022, the internal appeals process will be transitioned from the current process of two (2) levels of appeal to one (1) level of appeal. This change applies to appeals initiated on or after January 1, 2022, regardless of the group's renewal date. Insureds will continue to be afforded the full timeframe for filing an appeal in compliance with existing federal and/or state laws.

(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 remained unchanged at 89.2% from 2021 to 2022.

[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), Preferred Provider Organization (PPO) and Out-of-Area (OOA) - Contracted Network Tier and Out-of-Network Tier

Non-Grandfathered (NGF) Plans only

1. Specialty Drugs per script max increase from $200 to $250
    a. Applies to LG NGF - PPO, HSA, POS, OOA

- Cost impact: 0.1% reduction

Point of Service (POS) - Contracted Network Tier and Out-of-Network Tier

2. Add coverage for prosthetic and orthotics to POS NGF and GF plans (s/to Precert)
    a. Cost share follows the plan's existing coinsurance structure (mirrors the urgent care cost share).

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

Point of Service (POS) and Preferred Provider Organization (PPO) - Contracted Network Tier Only

3. Coverage of Preventive Services in accordance with Affordable Care Act (ACA) requirements - add the following preventive care services at no charge and not subject to Deductible (for PPO and POS, when received at the Participating Provider tier):
    a. Pre-eclampsia screening with blood pressure measurements throughout pregnancy.
    b. Screening by asking questions about unhealthy drug use in adults age 18 years or older.
    c. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease

- Cost impact: 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

4. New USPSTF Preventative Service Recommendation:
    a. No additional cost share for behavioral counseling for healthy weight gain in pregnancy

- Cost impact: 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

5. Single Level of Claims Appeal – The following change has been made as an improvement to the claims appeal administrative process:
   Effective January 1, 2022, the internal appeals process will be transitioned from the current process of two (2) levels of appeal to one (1) level of appeal. This change applies to appeals initiated on or after January 1, 2022, regardless of the group's renewal date. Insureds will continue to be afforded the full timeframe for filing an appeal in compliance with existing federal and/or state laws.

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

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 (for this purpose, “category of health benefit plan” means product type, such as HMO, PPO, EPO, etc.). 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

POS In-Network Tier and EPO

1.01 Coordination and Cooperation

100% of our care is already delivered in an integrated health model. All Kaiser Permanente patients benefit from our integrated system, in which health conditions are managed in a robust and comprehensive delivery system. Members need not actively enroll in special programs to manage their health, as they are proactively identified using real time clinical information, after which they automatically receive outreach and preventive care. Our focus is to ensure members have their conditions under control before they present harmful and costly acute issues. Kaiser Permanente relies on our clinical experts to implement current evidence-based care recommendations, and individual care is always designed to deliver the greatest benefit and lowest risk to each member. Cases are managed on an individual basis, and as such, incur costs associated with the most appropriate care for each member. Our integrated model is designed to ensure that members are diagnosed early, are treated appropriately, and have access to the care they need. Systems supporting our success include:

- Team-based approach: Physicians and pharmacists can view each other's notes, monitor lab results, coordinate care plans, and resolve benefits issues to align treatment at every point of care — and they work together to assess the clinical evidence behind each new drug.
- Evidence-based care: Our clinical teams evaluate the most up-to-date recommendations to help ensure treatment is grounded in evidence-based guidelines. Through outcomes management we aim to improve the effectiveness and value of treatments.
- Efficient purchasing and distribution: Most of these drugs are dispensed directly through our national specialty pharmacy, rather than contracted facilities. This gives us leveraging power to negotiate directly with manufacturers, so any savings can be passed directly on to customers and members. In addition, we dispense select resource-intensive specialty therapies through our national specialty pharmacy.
- Integrated care: Kaiser Permanente's program seamlessly weaves comprehensive disease management into our care delivery model which, supported by our integrated system, technology, and dedicated care teams, ensures that patients with complex chronic conditions and multiple health issues receive proactive coordinated care to maintain optimal health with maximum convenience.

Kaiser Permanente's approach to population care is a proven model that improves the health of our members. We consistently score among the best in the nation on publicly reported quality measures, including those related to population health, and we are dedicated to continuously improving our care delivery.

1.02 Ensuring Networks are Based on Value

Kaiser Foundation Health Plan (KFHP) contracts exclusively with The Permanente Medical Group (TPMG) in Northern California and Southern California Permanente Medical Group (SCPMG) in a mutually exclusive relationship to provide comprehensive medical services to our California members. Because of this exclusive relationship, we oversee quality assurance and performance improvement to ensure high performance across all Kaiser Permanente hospitals and clinicians. Our incentive structure drives efficiency to provide high quality care and reduce cost.

Value-based care is at the core of our delivery model and we continue ongoing improvement efforts to ensure enhanced value to our members and purchasers.

Quality and service are top priorities for Permanente physicians. Our physicians practice evidence-based medicine regardless of the setting in which they provide care. Our physicians bring this evidence-based care, team approach, and best practices into non-Kaiser hospitals and work collaboratively with our non-Kaiser partners to assure that our patients receive the best care possible.

In addition, Permanente Medical Group (PMG) physicians actively participate in medical staff activities in our plan hospitals, often serving as Department Chairs and even as the Chief of Staff. By providing this leadership, our PMG physicians promote a culture of safety, quality and service.

All hospitals in the KP network are expected to maintain a high standard of care - per regulatory requirements (NCQA, DMHC), policies and procedures, and hospital contract quality language.

- Credentialing process, which includes an initial on-site visit to review quality standards of the clinicians and their facilities.
- Focused site reviews are conducted, as needed.
- KP quality leads maintain line of sight to quality metrics that may indicate a need to address issues, improve practices, reduce variation, spread success.
- Ongoing monitoring of member complaints and response, significant events, accreditation status, and regulatory sanctions.
- Should a contracted clinician fail to meet KP criteria, an action plan is developed, and progress is reported, until all issues have been resolved.

We have a council that is responsible for presenting a set of core quality metrics and a standardized annual quality plan template to KP's governing body over quality assurance for KP facilities and contracted plan hospitals. Once the standard template and core metrics are approved by the quality committee, the plans to achieve the goal metrics are jointly developed by quality leads that have a contracted plan hospital and the quality lead at the contracted plan hospital. These jointly developed annual quality plans are presented to the quality committee for approval. Implementation of the approved quality plans and monitoring of the core metrics are done through the joint operating committees that govern the health services agreement between KP and the Plan Hospitals. KP Northern California and Southern California are both represented.

Additionally, each KP service area with a contracted plan hospital has a governance structure comprised of KP and contracted plan hospital leadership (administration, physician, quality):

- An executive oversight committee: scope includes strategic focus and process improvement
- A joint operations committee: scope includes sharing of operations best practices and ensuring common goal quality metrics are achieved

Kaiser Foundation Health Plan contracts with Kaiser Foundation Hospitals in a mutually exclusive arrangement, providing or arranging for hospital services. Within our integrated delivery system, a majority of the care we provide is delivered at our own facilities. As much as possible, we provide care as part of our integrated system - health plan, medical group, and hospital network. Only when a specific highly specialized method of care is not

available within our network do we contract with external Centers of Excellence.

To improve the clinical outcomes and health status of our members and to help ensure a high-quality care experience, Kaiser Permanente has stringent selection criteria for choosing Centers of Excellence. All our hospitals are licensed by the California Department of Health Services, Division of Licensing and Certification; accredited by The Joint Commission; and certified to receive federal funds for Medicare and Medi-Cal. Our medical center leadership continues to meet periodically with Plan hospital leaders to discuss common quality goals with our contracted partners.

All of our clinicians are expected to contribute to a culture of continuously improving care by taking responsibility for a variety of quality metrics. Clinical metrics include inpatient quality measures such as sepsis and stroke care; outpatient quality measures such as cancer screening and cardiovascular health; and patient safety measures such as surgical safety and hospital-acquired infections. Our philosophy, structure, and incentives enable our clinicians to work collaboratively to deliver comprehensive care, achieve superior clinical outcomes, and help members maximize their total health. We do not anticipate any barriers in continuing this work.

1.03 Demonstrating Action on High Cost Providers

Kaiser Foundation Health Plan (KFHP) contracts exclusively with The Permanente Medical Group (TPMG) in Northern California and Southern California Permanente Medical Group (SCPMG) in a mutually exclusive relationship to provide comprehensive medical services to our California members. Most of the compensation KFHP pays is an annually negotiated per member per month amount (capitation rate). The remaining compensation is generally for actual costs, or a percentage thereof, for specific items, such as leased equipment. This arrangement provides limitations on the potential gain or loss of each medical group.

Because KP is an integrated system, we manage cost variation with much more transparency of data than fee-for-service health plans. We compare cost and underlying drivers of cost, such as productivity, wage rates, and supply costs/patient day. We work to understand variation, eliminate inappropriate variation, spread best practices, and tightly manage expenses. Furthermore, as a prepaid delivery system, our is incented to be as efficient as possible — both from ensuring quality is high (since high quality is the most cost-effective care in the long run) to being operationally efficient.

1.04 Demonstrating Action on High Cost Pharmaceuticals
Formulary Design Value

Our formulary is determined by our doctors, who decide which drugs to include, relying on clinical research and recommendations from pharmacists, rather than on pharmaceutical company marketing. Unlike many healthcare plans with formularies not maintained at the clinical level, our physicians and pharmacists work together to implement brand-to-generic conversions. In addition to the FDA process for approving generic medications, we have an extensive approval process to ensure that our preferred generic drugs are of high quality. With input from our pharmacists, pharmacy committees at each of our medical facilities, and individual physicians, our regional pharmacy and therapeutics committees decide on all inclusions and changes to the Formulary. Clinical efficacy, cost, safety, and inactive ingredients are evaluated. Member acceptance of, and compliance with, the use of medications is also considered, so medications are also evaluated for their product labeling, ease of handling and use, and even product flavor and texture.

E-Prescribing System

Our e-prescribing system, automatic drug utilization review, and targeted safety initiatives help to avoid costs associated with adverse events caused by lack of information, communication errors, or process breakdowns. They also help to prevent costs associated with unnecessary duplication of prescriptions and enable our physicians, pharmacists, and other clinical staff to work more efficiently.
Because we own and operate our inpatient, retail, and mail-order pharmacies, we have greater control over the purchasing, administration, and fulfillment costs that can have a significant effect on pharmacy benefits pricing. For example, we negotiate pricing directly with drug manufacturers, and our integrated system gives us a distinct advantage over payers that operate in a fragmented health care environment because we can systematically shift market share to contracted, cost-effective alternatives within therapeutic drug classes. This enables us to negotiate advantageous pricing for select drugs, which helps to offset pharmacy cost increases overall and maintain competitively priced pharmacy benefits for employers. In addition, our national warehousing capabilities allow us to purchase large quantities of drugs before price increases take effect, resulting in documented annual savings of millions of dollars. We also generate significant savings by operating our own centralized repackaging and processing facilities.

Pharmacy Support Tools

Our e-prescribing system, automatic drug utilization review, and targeted safety initiatives help to avoid costs associated with adverse events caused by lack of information, communication errors, or process breakdowns. They also help to prevent costs associated with unnecessary duplication of prescriptions and enable our physicians, pharmacists, and other clinical staff to work more efficiently. Because we own and operate our inpatient, retail, and mail-order pharmacies, we have greater control over the purchasing, administration, and fulfillment costs that can have a significant effect on pharmacy benefits pricing. For example, we negotiate pricing directly with drug manufacturers, and our integrated system gives us a distinct advantage over payers that operate in a fragmented health care environment because we can systematically shift market share to contracted, cost-effective alternatives within therapeutic drug classes. This enables us to negotiate advantageous pricing for select drugs, which helps to offset pharmacy cost increases overall and maintain competitively priced pharmacy benefits for employers. In addition, our national warehousing capabilities allow us to purchase large quantities of drugs before price increases take effect, resulting in documented annual savings of millions of dollars. We also generate significant savings by operating our own centralized repackaging and processing facilities.

Potential or Current Collaboration Opportunities

Most insurers in the marketplace employ a Pharmacy Benefit Manager (PBM) to adjudicate pharmacy claims and the fee schedule for those drugs amounts to a discounted rate off of Average Wholesale Price (AWP). Kaiser Permanente is unlike other insurers in that we own our own pharmacies and warehouses, act as a direct purchaser of pharmaceuticals, and our drug costs are not based on AWP. We leverage our national size to negotiate up-front discounts directly with pharmaceutical manufacturers. Our fee schedules are developed to cover the cost of those drugs and pharmacy expenditures net of any negotiated discounts due to purchasing volumes. Given that our fee schedules are net of discounting from the manufacturers there are no additional rebates to pass on to our customers.

Kaiser Permanente's National Pharmacy Data Warehouse allows us the exceptional opportunity to leverage prescription drug information in evaluating our disease management

programs. Our National Pharmacy Data Warehouse is a repository for pharmacy utilization data from every Kaiser Permanente region. This data allows managers to track utilization trends across the country, measure the impact of cost-saving initiatives, and identify opportunities for improvement.

1.05 Quality Improvement Strategy

We own and operate our own inpatient, outpatient, and mail-order pharmacy services, and our physicians and pharmacists work together in our integrated system. This better enables us to implement comprehensive strategies to maintain a clinically effective, cost-efficient pharmacy program and provide employers with competitive pharmacy benefit rates that helps us better manage and control high cost pharmaceuticals.

100% of our care is already delivered in an integrated health model. All Kaiser Permanente patients benefit from our integrated system, in which health conditions are managed in a robust and comprehensive delivery system. Members need not actively enroll in special programs to manage their health, as they are proactively identified using real time clinical information, after which they automatically receive outreach and preventive care. Our focus is to ensure members have their conditions under control before they present harmful and costly acute issues. Kaiser Permanente relies on our clinical experts to implement current evidence-based care recommendations, and individual care is always designed to deliver the greatest benefit and lowest risk to each member. Cases are managed on an individual basis, and as such, incur costs associated with the most appropriate care for each member. Our integrated model is designed to ensure that members are diagnosed early, are treated appropriately, and have access to the care they need. Systems supporting our success include:

- Team-based approach: Physicians and pharmacists can view each other's notes, monitor lab results, coordinate care plans, and resolve benefits issues to align treatment at every point of care — and they work together to assess the clinical evidence behind each new drug.
- Evidence-based care: Our clinical teams evaluate the most up-to-date recommendations to help ensure treatment is grounded in evidence-based guidelines. Through outcomes management we aim to improve the effectiveness and value of treatments.
- Efficient purchasing and distribution: Most of these drugs are dispensed directly through our national specialty pharmacy, rather than contracted facilities. This gives us leveraging power to negotiate directly with manufacturers, so any savings can be passed directly on to customers and members. In addition, we dispense select resource-intensive specialty therapies through our national specialty pharmacy.
- Integrated care: Kaiser Permanente's program seamlessly weaves comprehensive disease management into our care delivery model which, supported by our integrated system, technology, and dedicated care teams, ensures that patients with complex chronic conditions and multiple health issues receive proactive coordinated care to maintain optimal health with maximum convenience.

Kaiser Permanente's approach to population care is a proven model that improves the health of our members. We consistently score among the best in the nation on publicly reported quality measures, including those related to population health, and we are dedicated to continuously improving our care delivery.

1.06 Participation in Collaborative Quality

For members and the public to have reliable information and better understand the quality of care we deliver, we share quality measurement outcomes on kp.org. As a way to compare our performance to other health plans, members and non-members have easy access to data about our quality and medical outcomes. Information on kp.org describes our organizational commitment to quality and safety, defines how quality is measured, and allows our members and the public to have reliable information about the quality of care we deliver. We also provide direct links to the websites of the credible independent health care organizations that evaluate us, many of which have provider network performance report cards and patient satisfaction surveys, including:

- National Committee for Quality Assurance (NCQA)
- The Joint Commission (TJC)
- Integrated Healthcare Association (IHA)
- The Centers for Medicare & Medicaid Services (CMS)
- State of California Office of the Patient Advocate (OPA)
- The California Cooperative Healthcare Reporting Initiative (CCHRI)
- California Hospital Assessment and Reporting Taskforce (CHART)

1.07 Data Exchange with Providers

As the largest, most comprehensive civilian electronic health record (EHR) system in America, KP HealthConnect securely links Kaiser Permanente facilities across the nation, making each member's current medical record securely available when and where it is needed. KP HealthConnect enhances member safety by linking members and authorized caregivers with electronic medical records (EMR) and online resources with just the click of a mouse. KP HealthConnect's Care Everywhere functionality permits providers to obtain information about procedures, labs and care completed in other KP regions. With fast and easy collaboration, critical data such as the patient's allergies, current medications, and recent medical history may be accessed by a member's entire care team in real time.

Pharmacy records and lab results, among other data, are accessible around the clock by members and their providers, mitigating the possibility of error that can develop with handwritten documentation. Physicians and pharmacists see drug alerts, which warn them of adverse reactions that might occur if patients receive certain combinations of medications simultaneously. As a result, potential miscommunication can be circumvented, and clinicians are assisted in providing the proper protocols and treatment.

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.

I. Administration of Outpatient Prescription Drug Benefit by KPIC's Pharmacy Benefit Manager (PBM)

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, 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.

II. Quality Management, Utilization Management, and Case Management by KPIC's delegated entity

KPIC's delegated entity, Permanente Advantage (PA), provides quality management, utilization management, and case management of care and services to KPIC's insureds.

1. **Quality Management Program.** The purpose of the Quality Management Program Description (QMPD) for Permanente Advantage (PA) is to assess and oversee the quality of care and services provided to Kaiser Permanente Insurance Company (KPIC) members throughout the continuum of care by non-KP practitioners and providers.

   The scope of the PA QMPD is limited to Preferred Provider Organization (PPO) or Point of Service (POS) members receiving care by non-KP practitioners and providers. POS members must be utilizing their tier 2 or tier 3 benefits to fall under the PA QMPD, otherwise the oversight of their care will be performed by the KP Regional Quality Program. The Program's activities are developed and implemented in compliance with state and federal regulations and are approved by the PA Quality Management Committee (QMC).

   Permanente Advantage (PA) Board of Managers (PBAM) has granted authority to the QMC for oversight of the Quality Management Program. The QMC is responsible for oversight and direction of the Permanente Advantage QM Program. The QMC recommends policy decisions, reviews and evaluates the results of all QM activities, oversees implementation of action plans and ensures follow-up as appropriate. The QMC meets at least quarterly and may meet more frequently if deemed necessary by the Committee Chair or the PABM.

   A. The functions of the QMC include, but are not limited to:
      1. Monitoring of clinical cases by peer review.
      2. Approve the Quality Management Program Description and work plan annually.
      3. Review of clinical decision-making processes for resource utilization and quality of care referred from UM Committee (UMC).
      4. Monitors key clinical quality indicators and benchmarks and identifies areas requiring focused review.
      5. Monitor data and outcomes of member and provider satisfaction, complaints, grievances and appeals.
      6. Reviewing, approving, or facilitating physician and/or provider education.

7. As appropriate, providing feedback to Regional and National Network management regarding provider network quality and/or access issues and/or education (Network is contracted with KPIC).
8. Maintains approved minutes of all QMC meetings

B. The members of the QM Committee include the following persons/representatives:
   1. PA Medical Director and QM Chairperson
   2. Federation Associate Medical Director for Quality
   3. PA Director of Care Management
   4. KFHP Resource Stewardship
   5. Behavioral Health Practitioner
   6. Physician representatives from KP regions

The goals and objectives of the PA QMPD are to:

A. Maintain a clearly defined Quality Management (QM) Program structure.
   1. Involve physicians in the QM Program through participation in the QMC.
   2. Ensure adequate staff and resources are available for implementation and maintenance of the QM Program.
   3. Ensure that all appropriate quality issues are reported to the QMC.
   4. Ensure issues addressed by the QMC are communicated to the Permanente Advantage Board of Managers (PABM) to facilitate its oversight of the Program.
   5. Promote a quality improvement approach to issue resolution and process enhancement.
   6. Communicate the results of studies, audits, and surveys to all staff.

B. Continuously improve the quality of care and services.
   1. Maintain no less than two (2) quality improvement projects per accreditation program that address performance improvement and/or opportunities to reduce errors.
   2. Ensure accurate and valid data collected for baseline, and re-measure level of performance at least annually for QM activities.
   3. Document changes or improvements relative to baseline measurement and conduct an analysis if goals are not met.
   4. Monitor adverse outcomes for trends and implement action plans as appropriate.
   5. Use of clinical practice guidelines (nationally recognized) as appropriate.

The Quality Management Program will be reviewed, revised and updated annually. The evaluation process includes a summary of activities accomplished over the year and the impact of the activities on the provision of patient care and service. The QM Program may be amended by a majority vote of the PA Board of Managers, QM Committee or upon recommendation of the PA Care Management Director and the Medical Director.

2. **Utilization Management.** The purpose of the PA Utilization Management (UM) Program Description is to identify components of the UM Program, roles and responsibilities of the UM staff, and to provide the framework for activities scheduled for the current year. PA has established a formal process for the oversight of resource utilization as defined in the UM Program Description and measured in the work plan and annual UM Program evaluation.

The PA UM Program will be applied equitably, and in compliance with existing Kaiser Permanente (KP) governance and administrative policies. Health care will be based on quality and appropriateness of care. Care will not be restricted on a cost basis and clinical review is not a guarantee of payment. Payment is always subject to member eligibility and available benefits at the date of service.

PA does not use financial incentives to encourage barriers to care or service and does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, or to promote under-utilization.

The UM Program Description will be updated, reviewed, and approved by the PA UM Committee, Medical Director, and Director of Care Management, annually or more frequently as necessary.

The purpose of the UM Program is to provide a comprehensive process in which reviews of inpatient and outpatient services are performed in accordance with the requirements of the Kaiser Permanente Insurance Company (KPIC) Group Policy (Certificate of Insurance and Schedule of Coverage). While the optimal scenario is for all Preferred Provider Organization (PPO) and Point of Service (POS) members to receive care within the KP delivery system, the PPO/POS environment is structured to allow such members to obtain care outside of that system from either a KP-contracted provider network, or a provider of the member's choice. The UM Program is designed to assure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner. The focus of the Program is to ensure efficiency and continuity by identifying, evaluating, monitoring, and correcting matters that affect the overall efficacy of the UM process. The Program's activities are developed and implemented in compliance with state and federal regulations and are approved by the PA Board of Managers (PABM) and the PA UM/QM Committee.

Permanente Advantage is URAC accredited in Health Utilization Management.

This Program provides for fair and consistent evaluation of medical necessity and appropriateness of care through the use of KP and nationally accepted clinical practice standards.

KP practitioners are included in the UM processes through participation in the various UM/QM Committees, which are functional components of the Program.

The scope of the UM Program includes the following:

A. Maintain a clearly defined Utilization Management Program structure.
   1. Involve providers in the UM Program through participation in the UM Committee, and through regular written communication with providers about the program.
   2. Ensure adequate staff and resources are available for implementation and maintenance of the UM Program.
   3. Ensure issues addressed by the UM/QM Committees are communicated to the PABM, Quality of Care Committee, and the KPIC Board of Directors to

facilitate Program oversight.

4. Coordinate with Regional and National Network Management to educate contracted providers on policies, procedures, goals, and objectives of the UM/QM Program, and to ensure compliance.

B. Provide ongoing monitoring and evaluation to address and correct inefficient coordination of health care.
   1. Perform prospective review of specific health care services to ensure services are provided within established guidelines and benefits of the member's plan.
   2. Monitor, evaluate, and optimize health care resource utilization by applying evidence- based criteria for medical necessity review.
   3. Perform medical management for acute inpatient hospitalizations and skilled nursing facility care to include:
      i. Pre-admission, admission, concurrent review, and discharge planning to ensure medical necessity, appropriate level of care, and timely services.
      ii. Follow-up communication with patient, physician, and provider to ensure adherence to discharge plan, and avoidance of post discharge complications.
   4. Medical Director review of all potential or actual clinical denials, excluding denials due to non-eligibility and non-benefit coverage.
   5. Perform retrospective review of health care services rendered to validate appropriateness of service.

C. Identify members through screening criteria appropriate for case or disease management and develop interventions that ensure efficient delivery of care.
   1. Identify and manage members with catastrophic, complex, or chronic illnesses.
   2. Refer members with targeted diagnoses to disease management programs.

D. Integrate the UM Program within the QM Program, where appropriate.
   1. Monitor both inpatient and outpatient care for possible quality of care deficiencies, utilizing referral indicator screening criteria, and report to the QM department.
   2. Respond to member or provider complaints or single level appeals after comprehensive and timely investigations associated with utilization issues.
   3. Perform peer review in conjunction with QM Program, when necessary.

E. Monitor for over and under-utilization trends that may lead to quality of care concerns and implement appropriate interventions when indicated.
   1. Analyze utilization, readmission, pharmacy, appeals and grievance, and claims data to identify adverse trends or recurrent patterns indicating over or under utilization.
   2. Measure effectiveness of interventions implemented to address over or under utilization, as indicated.

F. Promote legislative and regulatory compliance as applicable to the organizational structure and care delivery model.
   1. Utilize a continuous quality improvement approach in the development, implementation, and evaluation of the UM Program.

2. Assure governmental and other regulatory guidelines, standards, and criteria are adhered to, and submit required documentation to demonstrate compliance.

3. **Case Management.** The purpose of the PA Case Management (CM) Program is to provide and ensure the necessary tools are available to the Case Manager from the initial assessment, development of treatment plan and ongoing management of the case managed member. The goal is to achieve the desired outcomes by providing quality care across a continuum enhancing quality of life and containing costs.

   Case Management is defined by the Commission for Case Manager Certification (CCMC) as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

   Case Management will be performed on specifically identified members who have experienced a critical event or diagnosis requiring extensive use of resources and requires assistance in navigating the healthcare system to facilitate appropriate delivery of care and services.

   Case Management is a service available to all Kaiser Permanente Insurance Company (KPIC) members. Members have the right to decline participation or dis-enroll from the Case Management Program. Permanente Advantage is URAC accredited in Case Management.

   a) Member Identification - Members are identified for referrals to the Case Management Program via several data and personnel sources. This includes but is not limited to:
      1. Diagnosis data (cancer, trauma, chronic conditions)
      2. Claims data (high dollar, high utilizers)
      3. Authorization data (census and discharge)
      4. Physicians, providers, discharge planners, vendors
      5. PA Care Management staff and other Kaiser staff
      6. Disease Management program or specific conditions
      7. Member, family and/or caregiver

   b) Assessment
   Members who are enrolled in the Case Management Program are engaged in a detailed documented assessment of overall health status and condition specific issues pertaining to:
      i. Clinical history (medical issues)
      ii. Activities of daily living (ADL)
      iii. Mental Health status (psychological, psychosocial)
      iv. Life planning
      v. Cultural, health literacy, and/or linguistic factors, preferences or limitations
      vi. Family, caregiver and/or community support
      vii. Financial factors and/or resources
      viii. Continuity and coordination of care (immediate and future)

ix. Benefits (available and/or needed)

c) Opportunity Identification

Member, family, caregiver, and the healthcare team are essential participants in problem identification.

Problems identified for Case Management intervention where members outcomes can be positively influenced includes but is not limited to:

i. Lack of established or ineffective treatment plan
ii. Compromised patient safety
iii. Inappropriate utilization of services
iv. Alterations in function
v. Non-adherence to medication or treatment
vi. Lack of medication or treatment knowledge
vii. Lack of social or financial resources

Identification of referrals to Regional Kaiser Permanente (KP) Disease Management and/or other applicable programs.

d) Development of Case Management Care Plan

Collaboration with member, family, and/or caregiver and the multidisciplinary team, results in development of a member centered care plan, with ensuing follow-up dates determined by evidence-based algorithms utilized in the Case Management Documentation system to include:

i. Development of a member centered care plan including short- and long-term goals
ii. Resources utilized and interventions with timelines to meet goals
iii. Identification of care needs and barriers to meeting or complying with plan
iv. Development of follow-up schedule and communication with member and physician
v. Development and communication of self management plans for members
vi. Process to assess progress against the member centered care plan
vii. Maximize member's health, wellness, safety, self-care and support independence in decision making.

e) Implementation

Case Management plan of care is put into action by facilitating coordination of care, services, resources, and health education specific in the planned interventions

Collaboration with the member, family, and/or caregiver and multidisciplinary team, including physician(s).

f) Monitoring

Develops a process of ongoing assessment and documentation to monitor the quality of care, services and products delivered to the member. Assess knowledge and adherence to member centered care plan and medications. Assesses if the goals of the member centered care plan are achieved, remain appropriate and realistic and revise if appropriate.

g) Evaluation

Employs a methodology designed to measure healthcare and case management process focusing on response to the member's centered plan. The evaluation process occurs over specific time frames and is a continuous process. The evaluation process encourages in-put from the member, family and healthcare team to appropriately determine the impact of case management and healthcare

interventions.

h) Closure of Case Management services

Establish criteria for discharge of members or termination of Case Management services.

Bring mutually agreed upon closure to the member-case manager relationship and engagement in Case management recovery. The best possible outcomes, or when needs and desires of the member has changed.

i) Outcomes

Case Management is a goal-directed process. Identification and implementation of changes in the Care Management plan to produce outcomes that are positive, measurable and goal-oriented.

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 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.

None