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:

UnitedHealthcare 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 __12.8__%
   - Most commonly sold large group benefit design __12.7__%

   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 __17.0__ %
- Most commonly sold large group benefit design[4] __16.6__ %

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	396	56.3%	141,438	7,655	$544.54	14.7%
February	14	2.0%	1,925	222	$471.13	21.5%
March	17	2.4%	3,178	102	$540.94	11.2%
April	40	5.7%	5,717	1,235	$568.39	6.9%
May	29	4.1%	3,016	1,902	$659.79	11.0%
June	42	6.0%	3,011	2,993	$585.81	11.1%
July	41	5.8%	10,138	3,662	$552.36	7.8%
August	27	3.8%	2,625	5,584	$495.03	3.5%
September	20	2.8%	3,377	702	$474.82	8.0%
October	23	3.3%	6,537	1,189	$509.30	6.4%
November	17	2.4%	2,584	0	$594.00	10.6%
December	37	5.3%	5,039	1,895	$504.85	11.1%
Overall	703	100%	188,585	27,141	$543.65	12.8%

[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).*

The most commonly sold benefit design is PPO. Renewal increases for Q4 may not yet be final for all groups and reflect a best estimate of what is expected to be sold.

5) Segment type: Including whether the rate is community rated, in whole or in part
See Health and Safety Code section 1385.045(c)(1)(B) and Insurance Code section 10181.45(c)(1)(B)

1	2	3	4	5	6	7
Rating Method	Number of Renewing Groups	Percent of Renewing Groups *(number for each rating method in column 2 divided by overall total)*	Number of Enrollees/ Covered Lives Affected By Rate Change	Number of Enrollees/ Covered Lives Offered Renewal Without A Rate Change	Average Premium PMPM After Renewal	Weighted Average Rate Change Unadjusted
100% Community Rated (in whole)	0	0.0%	0	0	$0.00	0.0%
Blended (in part)	624	88.8%	87,670	12,838	$583.04	14.5%
100% Experience Rated	79	11.2%	100,915	14,303	$509.30	11.4%
Overall	703	100%	188,585	27,141	$543.65	12.8%

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.

There is no distinction in the methodology to apply credibility weights by product on the CDI license.

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	0	$0.00	0.0%
PPO	664	73.1%	115,585	25,480	$550.39	12.7%
EPO	53	5.8%	19,108	716	$516.57	9.6%
POS	0	0.0%	0	0	$0.00	0.0%
HDHP	191	21.0%	53,892	945	$536.12	14.4%
Other (describe)	0	0.0%	0	0	$0.00	0.0%
Overall	908	100%	188,585	27,141	$543.65	12.8%

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.

Groups may have more than one product type, resulting in the group count being counted multiple times.

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

PPO

Actuarial Value (AV)	Number of Plans	Covered Lives	Distribution of Covered Lives	Description of the type of benefits and cost sharing levels for each AV range
0.9 to 1.000	0	0	0.0%	N/A
0.8 to 0.899	18	5,081	3.6%	$15/$15 OV, $250 ded, $2000 OOPM
0.7 to 0.799	265	94,192	66.8%	$20/$40 OV, $100 ded, $1000 OOPM
0.6 to 0.699	186	26,849	19.0%	$15/$15 OV, $1500 ded, $3000 OOPM
0.0 to 0.599	78	14,943	10.6%	$2000 ded, 80%, $5000 OOPM
Total	547	141,065	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	0	0.0%	N/A
0.8 to 0.899	40	12,170	61.4%	$20/$20 OV, $0 ded, $1500 OOPM
0.7 to 0.799	12	4,268	21.5%	$25/$45 OV, $0 ded, $2000 OOPM
0.6 to 0.699	14	2,399	12.1%	$30/$50 OV, $500 ded, $3000 OOPM
0.0 to 0.599	9	987	5.0%	$5500 ded, 80%, $6350 OOPM
Total	75	19,824	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	0	0	0.0%	N/A
0.8 to 0.899	0	0	0.0%	N/A
0.7 to 0.799	0	0	0.0%	N/A
0.6 to 0.699	0	0	0.0%	N/A
0.0 to 0.599	0	0	0.0%	N/A
Total	0	0	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	0.0%	N/A
0.8 to 0.899	0	0	0.0%	N/A
0.7 to 0.799	0	0	0.0%	N/A
0.6 to 0.699	9	2,673	4.9%	$1500 ded, 90%, $3000 OOPM
0.0 to 0.599	245	52,164	95.1%	$2700 ded, 90%, $5400 OOPM
Total	254	54,837	100%	

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

In the comment section below, provide the following:

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

Place comments here:

We offer 866 Standard medical plans available across a variety of networks. The following is the range of cost sharing levels available in our Standard plans:

- PCP copay ranges from $10 to $40
- Specialist copay ranges from $10 to $100
- Deductible ranges from $0 to $6350
- Member Coinsurance ranges from 0% to 40%
- Out of Pocket Maximum ranges from $250 to $6650

Roughly 17.0% of covered lives are on standard plans. The remaining 83.0% of covered lives are on custom 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)	Geographic factors are based upon historical and expected health care costs in a given region. For 2018, we adjusted area factors based on experience and projected health care cost data.
Age, including age rating factors (describe definition, such as age bands)	Health care costs tend to vary with a member's age. There is no change to age rating factors in 2018.
Occupation	N/A - not used
Industry	Factors are assigned based on a group's Standard Industrial Classification code. There is no change in 2018.
Health Status Factors, including but not limited to experience and utilization	There is no change in Underwriting methodology in 2018.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	There is no change in 2018.
Enrollees' share of premiums	Subject to the percent of premiums the Employer chooses to cover
Enrollees' cost sharing, including cost sharing for prescription drugs	Please refer to the answer to Question 12 below.
Covered benefits in addition to basic health care services and any other benefits mandated under this article	Subject to the optional benefits the Employer chooses to cover.
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	There is no change to credibility weights in 2018.
Any other factor (e.g. network changes) that affects the rate that is not otherwise specified	In addition to our Full Network offering, narrow networks are available.

[7] i.e. premium tier ratios

9) Overall large group medical allowed trend factor and trend factors by aggregate benefit category:

Overall Medical Allowed Trend Factor

"Overall" means the weighted average of trend factors used to determine rate increases included in this filing, weighting the factor for each aggregate benefit category by the amount of projected medical costs attributable to that category.

Allowed Trend: (Current Year) / (Current Year – 1)

7.4%

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]	6.4%
Hospital Outpatient (including ER)	7.9%
Physician/other professional services[9]	4.9%
Prescription Drug[10]	10.8%
Laboratory (other than inpatient) [11]	Combined in Other
Radiology (other than inpatient)	Combined in Other
Capitation (professional)	Combined in Other
Capitation (institutional)	Combined in Other
Capitation (other)	Combined in Other
Other (describe)	7.0%

[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]	**$122.23**	**2.7%**	**3.9%**	**0.0%**	**6.8%**
Hospital Outpatient (including ER)	**$148.84**	**6.3%**	**4.0%**	**0.0%**	**10.6%**
Physician/other professional services[13]	**$110.85**	**2.8%**	**2.4%**	**0.0%**	**5.3%**
Prescription Drug[14]	**$60.46**	**6.1%**	**4.8%**	**0.0%**	**11.2%**
Laboratory (other than inpatient)[15]	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**
Radiology (other than inpatient)	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**
Capitation (professional)	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**
Capitation (institutional)	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**
Capitation (other)	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**	**Combined in Other**
Other (describe)	**$51.35**	**-1.6%**	**5.3%**	**0.0%**	**3.6%**
Overall	**$493.73**	**3.5%**	**3.9%**	**0.0%**	**7.6%**

[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).

There were no modifications to existing plans in the Standard portfolio. However, we have added 8 plans (3 of which are HSAs). For custom plans, the level of cost sharing is subject to what the employer chooses to offer and is customizable upon request.

(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 has changed by -1.1%.

[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)

Any change to optional enrollee benefits is managed by the Employer.

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

On-going efforts at cost containment and quality improvement for Small Group and Large Group PPO include:
A) Member communications encouraging in-network utilization, so members can seek high-quality, contracted providers at lower out of pocket costs
B) Initiatives to ensure members seek appropriate care for Emergency Room Services, and to ensure facilities bill appropriately for Emergency Room care.
C) My cost estimator to help members understand their financial responsibility when seeking a variety of services
D) Advocate for me helps members making complex care decisions
E) Nurse advice line – available to members trying to deal with urgent issues

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.

N/A