California Large Group Annual Aggregate Rate Data Report Form

Version 3, September 7, 2017

(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) Other Comments

1) Company Name:

UnitedHealthcare of California

2) This report summarizes rate activity for the 12 months ending reporting year 2017.[1]

3) Weighted average annual rate increase (unadjusted)[2]

- All large group benefit designs 4.8 %
- Most commonly sold large group benefit design 4.8 %

Weighted average annual rate increase (adjusted)[3]

- All large group benefit designs 3.7 %
- Most commonly sold large group benefit design[4] 3.7 %

[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.
[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.

4) Summary of Number and Percentage of Rate Changes in Reporting Year by Effective Month

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	153	53.3%	316,926	3,877	$464.09	4.1%
February	6	2.1%	1,034	4,262	$768.15	2.1%
March	13	4.5%	3,216	309	$464.83	7.0%
April	15	5.2%	7,355	0	$436.33	6.8%
May	14	4.9%	9,571	0	$480.28	7.2%
June	11	3.8%	5,957	779	$413.27	7.2%
July	21	7.3%	17,174	607	$613.76	10.1%
August	9	3.1%	3,386	628	$458.91	7.1%
September	11	3.8%	1,701	0	$481.05	15.0%
October	12	4.2%	11,454	0	$538.56	7.6%
November	13	4.5%	4,913	0	$493.71	7.7%
December	9	3.1%	2,021	0	$403.82	12.4%
Overall	287	100%	384,708	10,462	$476.15	4.8%

See Health and Safety Code section 1385.045(a) and Insurance Code section 10181.45(a)

[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 HMO. 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	0
Blended (in part)	206	71.8%	43,239	1,970	$501.89	8.9%
100% Experience Rated	81	28.2%	341,469	8,492	$472.83	4.3%
Overall	287	100%	384,708	10,462	$476.15	4.8%

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 DMHC 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	285	97.9%	383,732	10,462	$476.48	4.8%
PPO	0	0.0%	0	0	$0.00	0.0%
EPO	0	0.0%	0	0	$0.00	0.0%
POS	0	0.0%	0	0	$0.00	0.0%
HDHP	6	2.1%	976	0	$344.41	6.5%
Other (describe)	0	0.0%	0	0	$0.00	0.0%
Overall	291	100%	384,708	10,462	$476.15	4.8%

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	62	92,512	23.5%	$10/$10 OV, $0 ded, $1000 OOPM
0.8 to 0.899	746	258,562	65.6%	$15/$15 OV, $0 ded, $1500 OOPM
0.7 to 0.799	193	39,930	10.1%	$10/$35 OV, $0 ded, $3500 OOPM
0.6 to 0.699	73	3,190	0.8%	$25/$40 OV, $1500 ded, $5000 OOPM
0.0 to 0.599	0	0	0.0%	N/A
Total	1,074	394,194	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	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%	

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	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%	

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	2	147	15.1%	$30/$50 OV, $2000 ded, $5000 OOPM
0.0 to 0.599	14	829	84.9%	$3000 ded, 80%, $6000 OOPM
Total	16	976	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 309 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 $55
- Specialist copay ranges from $10 to $70
- Deductible ranges from $0 to $3000
- Out of Pocket Maximum ranges from $1500 to $6000

Roughly 9.1% of covered lives are on standard plans. The remaining 90.9% 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)	Rates for each group vary depending on contractual arrangements with designated providers.
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 2017.
Occupation	N/A - not used
Industry	Factors are assigned based on a group's Standard Industrial Classification code. There is no change in 2017.
Health Status Factors, including but not limited to experience and utilization	There is no change in Underwriting methodology in 2017.
Employee, and employee and dependents,[7] including a description of the family composition used in each premium tier	There is no change in 2017.
Enrollees' share of premiums	Subject to the percent of premiums the Employer chooses to cover.
Enrollees' cost sharing	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 2017.
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)

5.6%

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]	6.7%
Hospital Outpatient (including ER)	8.5%
Physician/other professional services[9]	15.0%
Prescription Drug[10]	6.8%
Laboratory (other than inpatient) [11]	Combined in Other
Radiology (other than inpatient)	Combined in Other
Capitation (professional)	4.6%
Capitation (institutional)	3.5%
Capitation (other)	Combined in Other
Other (describe)	7.7%

[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]	$56.62	3.3%	4.3%		7.7%
Hospital Outpatient (including ER)	$57.92	6.1%	4.2%		10.5%
Physician/other professional services[13]	$13.08	8.8%	2.8%		11.8%
Prescription Drug[14]	$55.88	7.7%	5.7%		13.8%
Laboratory (other than inpatient)[15]	Combined in Other				Combined in Other
Radiology (other than inpatient)	Combined in Other				Combined in Other
Capitation (professional)	$117.97				5.1%
Capitation (institutional)	$71.61				4.7%
Capitation (other)	Combined in Other				Combined in Other
Other (describe)	$12.73				9.4%
Overall	$385.81				7.1%

[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, and (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).

For standard plans, the changes are as follows:
- Virtual visits benefit and associated cost sharing has been added to all plans
- Increased the deductible of the SignatureValue Alliance HSA 10% plan from $1500 to $3000
- Removed the SignatureValue Alliance HSA 20% plan.

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 -0.3%.

[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)***

We included virtual visits as a new benefit. 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 Large Group HMO include:
A) Working with our Behavioral Health partners, identifying potential opportunities for coordination between Behavioral and Medical health activities to improve quality of care with resulting decreases in overall costs for certain conditions.
B) Working with our PMG partners, encouraging utilization of highest quality and most efficient facility-based services.
C) Working with specific PMG partners, identifying opportunities to utilize quality Urgent Care Centers as an alternative to costly and time-consuming Emergency Rooms for non-emergent after hours care, this initiative includes Nurse Advice Line.
D) Gap Closure for Hedis and STAR measures – regular reporting to groups on potential gaps in care so that the medical groups can reach out to the members and
close the gaps.
E) Participation in the IHA Total Cost of Care Pay for Performance initiative which requires groups to hit total cost of care savings targets while maintaining Quality of care scores on standard HEDIS measures, member satisfaction, and meaningful use of health IT.

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) Other Comments

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

N/A