

Large Group Annual Aggregate Rate Data Report Form

1. **Actuarial basis:** means the methodology used to determine the rating factors and the purpose of the factors.
2. **Actuarial value:** For the purpose of item 7 on the Large Group Annual Aggregate Rate Data Report Form, in reporting the number of plans according to actuarial value, the actuarial value calculation should utilize the covered benefits described in the February 20, 2013 [Methodology](#) for the federal Minimum Value (MV) Calculator. Please note that this reference to the MV Calculator methodology is only for the purpose of describing the set of covered benefits to be used in the calculation of actuarial value; this is **not** an instruction to use the MV Calculator to perform the actuarial value calculation.

The benefits are: 1) Emergency Room Services, 2) All inpatient hospital services (including mental health & substance use disorder services), 3) Primary care visit to treat an injury or illness (excluding preventive well baby, preventive, and X-rays), 4) Specialist Visit, 4) Mental/Behavioral health and substance abuse disorder outpatient services, 5) Imaging (CT/PET scans, MRI), 6) Rehabilitative speech therapy, 7) Rehabilitative occupational and rehabilitative physical therapy, 8) Preventive care/screening/immunization, 9) Laboratory outpatient and professional services, 10) X-rays and diagnostic imaging, 11) Skilled nursing facility, 12) Outpatient facility fee (e.g., Ambulatory Surgery Center), 12) Outpatient surgery physician/surgical services, 13) Drug categories: generics, preferred brand drugs, non-preferred brand drugs, specialty drugs.

3. **Any factors affecting the base rate, and the actuarial bases for those factors:** The health plan or insurer shall provide any factors, such as those factors, listed from Health & Safety Code Section 1385.045(c) (2) A-K or California Insurance Code Section 10181.45(c) (2) A-K, affecting the base rate and briefly describe the actuarial basis. (i.e. geographic region, age, occupation, industry, health status, employee and employee dependents, enrollee's share of premium, enrollee's cost sharing, covered benefits in addition to basic health care services, and segment type (partial or full community rates vs. experience rates)).
4. **Current Year:** means the calendar year (i.e., reporting year) that a health plan or health insurer files the California Large Group Annual Aggregate Rate Data Report Form with the Department.

5. **Custom Plan:** For item 7, “custom plan” is the opposite of a “standard plan.” A “custom plan” is a large group plan in which the purchaser has the opportunity to select an array of benefits, contractual provisions, and cost sharing.
6. **Excise Tax:** The Consolidated Appropriations Act, 2016 (Pub. L. 114-113), signed into law on December 18, 2015, delayed the effective date of the excise tax on high cost employer-sponsored health coverage from taxable years beginning after December 31, 2017, to taxable years beginning after December 31, 2019. When it goes into effect in 2020, it will put a 40 percent tax on the most expensive health insurance plans whose costs exceed certain thresholds.
7. **Large Group:** means commercial full-service health care service plans as defined in Health & Safety Code section 1385.01, subdivision (a) or large group health insurance policies as defined in California Insurance Code 10181, subdivision (a). For the purpose of SB546 reporting requirements, large group plans shall include fully insured commercial products and In Home Support Services (IHSS) products.
8. **Number of Enrollees/Covered Lives:** means the number of employees, including dependents enrolled (i.e., members or covered lives), affected by rate changes during the 12-month reporting period; reasonable approximations are allowed when actual information is not available.
9. **Percent of Total Rate Changes:** means the distribution of number of rate changes.
10. **Product type:** means Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), Exclusive Provider Organization (EPO), and High Deductible Health Plan (HDHP).

“Product” references a discrete package of health insurance covered services that a health insurance issuer offers using a particular product network type within a service area.

“Plan” means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.
11. **Projected trend:** The health plan or insurer shall provide its pricing trends for calendar year CY+1 over calendar year CY and for calendar year CY over calendar year CY-1 used in pricing health coverage premium effective during the reporting period (CY = current year).

12. **Segment type:** refers to whether the premium rate is determined using community/manual rates, in whole or in part. For the purpose of this section, segments types are 100% community/manual rated (in whole), blended (in part), and 100% experience rated (none).

13. **Standard Plan:** For item 7, “standard plan” means a large group plan that it sold to the purchaser with little or no opportunity for customization regarding benefits, contractual provisions, or cost-sharing. This term does not refer to the standardized plans sold in the individual and small group markets.