Submission Date:
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State:
California

Project Title:
Premium Review Program

Project Quarter Reporting Period:
Quarter 3 (04/01/2011-06/30/2011 via SERFF)

Grant Project Director:
Maureen McKennan, Acting Deputy Director, Plan and Provider Relations

Email:
MMcKennan@dmhc.ca.gov

Phone:
916-445-7976

Grant Authorizing Representative:
Edward G. Heidig, Interim Director, Department of Managed Health Care

Email:
EHeidig@dmhc.ca.gov

Phone:
916-322-2314

Grant Performance Period-Cycle I: April 1, 2011 through June 30, 2011

Reporting Period:

Quarterly Report 1:	August 9, 2010 through December 31, 2010
Quarterly Report 2:	January 1, 2011 through March 31, 2011
Quarterly Report 3:	April 1, 2011 through June 30, 2011
Quarterly Report 4:	July 1, 2011 through September 30, 2011

Timeframe for Delivery:

Quarterly Report 1	January 31, 2011-February 28, 2011
Quarterly Report 2:	April 30, 2011-TBD
Quarterly Report 3:	July 1, 2011- July 29, 2011
Quarterly Report 4:	October 31, 2011-TBD

PART I: NARRATIVE REPORT FORMAT

Introduction:

The regulation of health insurance in California is divided between two agencies -- the Department of Managed Health Care (DMHC), which regulates HMOs and some PPOs that comprise approximately 61 percent of the California regulated insured market, and the Department of Insurance (CDI), which regulates indemnity coverage and some PPOs, with approximately 39 percent of the California regulated insured market.

On August 16, 2010, the DMHC and the CDI (the Departments) were jointly awarded $1 million in grant funds to support the rate review activities. These grant funds are being used to implement the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF), to enhance the Departments' information technology (IT) capacity to support rate review, to enhance the Departments' Web sites to provide transparency of rate filing information and allow public comments on rate filings, and to obtain actuarial services. The Health Insurance Rate Review Grant Program will improve the premium rate data collection, analysis, and reporting capabilities for both Departments.

In a continuing effort to improve California's rate review program, DMHC and CDI intend to submit separate applications for the Health Insurance Rate Review – Cycle II grant. Letters of intent were submitted by CDI and DMHC on June 28 and 30, 2011, respectively.

Program Implementation Status:

1. *Accomplishments to Date*:

IT Enhancements:

The DMHC Office of Technology and Innovation has established the IT infrastructure for reviewing premium rate filings. A process has been developed for posting premium rate

information on the DMHC public Web site – one posting geared to consumers (http://wpso.dmhc.ca.gov/RateReview/) and one to health plans (http://dmhc.ca.gov/healthplans/rep/rep_premiumrates.aspx). All IT hardware and software for access to the SERFF has been procured and installed, including five monitors and five copies of Adobe Acrobat Professional software for financial exam staff. The SERFF Licensing agreement was completed, and a database was established to securely store SERFF data on the DMHC servers.

Both the DMHC and the CDI participated in the development process for the modifications to the SERFF to accommodate new federal Department of Health and Human Services (HHS) reporting requirements. Rate Review Grant Program funds of $21,054 were utilized for California's share of this SERFF modification.

SERFF went live for the DMHC on February 17, 2011. The DMHC continues to improve the system through enhancements to accommodate future rate review guidance development. As of June 30, 2011, the DMHC has received 15 rate filings via the SERFF.

In conjunction with implementing the SERFF, the DMHC also updated its website to include rate filing forms, guidelines and the posting of the rate filings submitted via the SERFF. The update allows the public to view the documents and submit comments online. Director's Letter (Letter 8-K), guidance on rate review, was issued on May 24, 2011. Five rate filing forms were posted in June giving health plans additional guidance on rate review filings. In order to be more transparent, the DMHC has expanded the amount of information posted on the DMHC's website to include all information that is filed by health plans for rate review except for contracted provider rates, which are confidential under Health and Safety Code section 1351(d).

While CDI had already been receiving and reviewing rates for individual policies via the SERFF, posting the rate submissions on its public website, and receiving public comments, it expanded its process capacity to receive and review rates for small group and large group policies, expanded its rate comment system to include small and large group filings, and improved the comment system functionality to make it easier for the public to post and view comments. Since January 1, 2011, the CDI posted more information received in conjunction with individual and small group market rate filings than had been publicly available in the past.

Legislative Enhancements:

California Senate Bill (SB) 1163 (SB 1163, Chapter 661, Statutes of 2010), effective January 1, 2011, was enacted to implement the rate review provisions of the ACA, providing the DMHC and the CDI with the authority to review health plan and insurer premium rate increases, beginning January 1, 2011.

However, although SB 1163 expanded the rate review process, it did not give the two Departments the authority to deny or disapprove rate increases. Under SB 1163, the Departments cannot reject excessive rates.

Under SB 1163, the DMHC has a number of new requirements. Health plans are now required to submit to the DMHC rate filings, with the current emphasis on the individual and small group markets. These rate filings must include actuarial certification justifying the premium rate increases. Every individual and small group commercial rate filing must include a certification by an independent actuary that the proposed rate increase is based on accurate and sound actuarial assumptions and methodologies. Filings for large group rate increases (including actuarial certifications) are required only for unreasonable rate increases (as defined in the ACA).

SB 1163 expanded rate filing and rate review requirements for the DMHC; and also significantly expanded the CDI's rate review authority. Prior to SB 1163, the CDI received rate filings for individual and small employer health policies and rejected some individual rates as "unacceptable for filing." Under SB 1163, the CDI's rate review authority was expanded to include large group filings. The rate review for all product types under SB 1163 involves reviewing rate filings to identify unjustified rate increases, and both the CDI and the DMHC are required to post a finding that a rate increase is unjustified on their respective Web sites.

In order to ensure that policyholders have at least 60 days notice before an increase becomes effective, both health plans and insurers must file proposed rate increases with the DMHC and the CDI at least 60 days in advance of their implementation.

Assembly Bill (AB) 52 was introduced on December 6, 2010, and is pending consideration by the state Legislature. AB 52, attached, expands California's rate review authority by requiring prior approval from the DMHC and the CDI before a health plan or insurer can increase rates charged to policyholders or subscribers, beginning January 1, 2012. Rates requiring prior approval include health care premiums, copayments, or deductibles. This bill has passed the California State Assembly and is currently under review in the California State Senate. However, until the passage of the bill, the two Departments still lack authority to deny, disapprove, or require prior approval for rate increases.

Rate Review Program and Actuarial Services Enhancement:

Prior to enactment of the ACA, the DMHC had extremely limited rate review authority. The only rates that were required to be filed, with very limited scope of review, were rates for small group, HIPAA-guaranteed issue, and conversion products. Health plans were not required to file commercial rates for individual or large group products. As a result, the DMHC did not have a rate review department/program or employ actuaries. Instead, the DMHC contracted with the outside consulting firm of Oliver Wyman Actuarial Consulting, Inc. (OWAC) whenever actuarial review of any rate matter was necessary.

Under the ACA, the DMHC has budgeted $455,000 from the grant funds for an actuarial contract with OWAC to not only provide actuarial services, but to help create a DMHC

rate review program. As part of the program development process, the DMHC has been approved by the California Department of Finance to hire two associate life actuaries for the upcoming fiscal year, which begins July 1, 2011. The DMHC is currently recruiting for both positions and the job opportunity notices have been posted on the California State Personnel Board's website.

Pursuant to SB 1163, both Departments are posting rates received after January 1, 2011, for individual and group health insurance on their Web sites, with improved public comment functionality (including visibility of the public comments received). In addition to the rate filings themselves, a plain-language summary of each rate filing will also be posted on the Departments' Web sites. After a process of fine-tuning the language on the DMHC's website relating to premium rate review, and facilitating public comments as required by SB 1163, the website is now enhanced to accommodate the changes, and is located at http://wpso.dmhc.ca.gov/RateReview/.

The CDI augmented its existing actuarial capacity by hiring two additional credentialed health actuaries, and entered into a full-time contractor relationship with a third consulting actuary, effective January 1, 2011. This added staff increases the CDI's capacity to perform its rate review activities. The fees paid to the independent contractor will be paid by the grant program. The CDI posts individual health insurance rate filings and public comments on its Web site. The filings and review notes can be viewed at http://www.insurance.ca.gov/0250-insurers/IndHlthRateFilings/ for insurers, with a parallel link at http://www.insurance.ca.gov/0100-consumers/0020-health-related/ for consumers.

The CDI and the DMHC continue to conduct weekly teleconferences to coordinate implementation of SB 1163 and to coordinate federal grant monies for rate review. The DMHC also held several meetings with the health plans and consumer groups to receive their input on rate filing reviews. Several such meetings were with Kaiser and Blue Shield, where actuaries presented their rate review issues and considerations. The presentations were very informative and helpful for better understanding the rate-making process. The CDI has held meetings with consumer groups and stakeholders, as well as solicited and received written comments, as part of its development of industry guidance pursuant to its authority under Insurance Code section 10181.9 (SB 1163, Stats. 2010) for the rate submission and review process.

The DMHC and the CDI have entered into an interagency agreement to coordinate and establish "rate review guidance and process" on a consistent basis between the two regulators. The Departments have been coordinating and communicating in an effort to provide and issue consistent SB 1163 implementation guidance to the health plans and insurers.

2. *Challenges and Responses*:

SERFF and IT Implementation:

The DMHC will be making some additional enhancements to its rate review website so that information will be more accessible and easier for consumers to understand. The DMHC will also be posting its state and federal quarterly reports online so consumers can have a summary of what has happened in the last three months.

Implementation of Rate Review:

SB 1163 authorizes the Departments to issue guidance to the health plans/insurers outside of the Administrative Procedure Act until July 2012. Director's Letter (Letter 8-K), guidance on rate review, was issued on May 24, 2011. Five rate filing forms were posted in June giving health plans additional guidance on rate review filings. In order to be more transparent, the DMHC has expanded the amount of information posted on the DMHC's website to include all information that is filed by health plans for rate review except for contracted provider rates, which are confidential under Health and Safety Code section 1351(d).

CDI issued its Guidance 1163:2 in draft form on February 3, 2011, for public comment, and in final form on April 5, 2011. This guidance established 15 factors that will be included in its consideration of whether a rate increase is unreasonable, provided requirements for notice and the content of actuarial certifications, and specified filing requirements and data submittal forms to be used in rate submission. The guidance and forms can be accessed on the CDI website at http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm.

Working in coordination with the CDI, the DMHC has developed an inventory of guidance issues and priorities. The DMHC's 1163 guidance was issued on April 22, 2011, and allows for a seven-day public comment period. After closure of the comment period, the DMHC will review the comments, make any revisions it believes are necessary and then issue final guidance. The DMHC's guidance is similar, but not identical, to the CDI's 1163:2 guidance. Guidance and forms can be accessed on the DMHC website at http://www.dmhc.ca.gov/healthplans/rep/rep_premiumrates.aspx.

Shortage of Actuarial Resources:

The DMHC does not currently employ actuaries, and although it has been approved to hire two in the upcoming fiscal year (after July 1, 2011), hiring actuaries to work for the state may be challenging. Actuarial salaries in the private sector are generally about twice what the state is able to pay for civil service employees. Additionally, there may be a shortage of health care actuaries, because many have already been hired due to the ACA and other new state laws, or are consulting for health plans/insurers or other regulatory agencies.

Increased Reporting Requirements:

SB 1163 requires the Departments to submit various reports to several agencies/entities, including the Departments' Web sites, the California Legislature, and the California Health Benefit Exchange.[1] These reporting requirements impose additional workload on the Departments' staff and resources at a time when resources are very limited due to state budget matters.

Significant Activities: Undertaken and Planned

Premium Rate Review Program Development:

The DMHC is creating and developing its rate review program, but the premium rate review process is dependent on actuarial services. The development of the rate review program was delayed by budgetary issues, which impacted the DMHC's ability to contract with OWAC. The DMHC does not have any actuarial staff. Therefore, the contract with the actuarial consultants at OWAC was vital in order for the premium rate review to move forward. With the current OWAC contract in place, the DMHC's rate review program is being developed by OWAC. The DMHC was approved to hire two limited-term actuary staff in the next fiscal year (July 2011). Both positions were posted in June for recruitment.

The DMHC has implemented the review program, which includes processes for staff to use in screening rate filings for additional actuarial review. OWAC is helping the DMHC to develop its rate review program to effectively review the data and documentation provided by the health plans' rate filings. On May 24-25, 2011, OWAC provided some on-site training to DMHC staff on rate review.

The DMHC is currently creating a "Request for Proposal" to contract with an independent actuarial consulting firm for actuarial services in the next fiscal year to continue the premium rate review program and to assist in enhancing the DMHC's rate review program.

Consistent with the CDI's broadened rate review authority under recently-enacted state law (SB 1163), it has hired two additional credentialed health actuaries and has entered into a full-time contractor relationship with a third consulting actuary, effective January 1, 2011, to review large group, small employer group, and individual premium rate filings to assure compliance with the ACA and state law; expand detailed examination of actuarial assumptions, actuarial formulations, and underlying calculation accuracy and data integrity of the health insurance rate filings; provide reporting to HHS; and, on an ongoing basis, evaluate the rate review program and make necessary modifications, including recommending regulatory or statutory changes.

[1] The California Health Benefit Exchange was established by California Senate Bill 900 and Assembly Bill 1602

Operational/Policy Developments/Issues

Legislative Activity:

As previously mentioned, SB 1163 gave the DMHC and the CDI the authority to review health plan and insurer premium rate increases beginning January 1, 2011. AB 52, which would expand the Departments' authority to regulate rates and require prior approval before a health plan or insurer could raise rates, is pending in the California legislature. (See "Legislative Enhancements" at p. 4.)

Leadership Changes:

Both the DMHC and the CDI have experienced leadership changes. The DMHC's director recently resigned, and the Department is being led by an Interim Director. The Insurance Commissioner is an elected independent state constitutional officer; the new Insurance Commissioner, Dave Jones, took office on January 3, 2011.

Public Access Activities

The DMHC and the CDI have developed their respective Web sites to display required health plan-specific information in plain/understandable language. Such proposed rate increase information includes justification for any unreasonable rate increase, overall medical trend or factor assumptions, actual claim costs by aggregate benefit category, and the amount of projected trend attributable to use of services, price inflation, or fees/risk by aggregate benefit category. This information must also be posted on the health plan's Web site. The DMHC and CDI Web sites allow the public to view rate filings and to submit public comments about the health plans' rate increases.

Collaborative Efforts

The DMHC and the CDI engage in weekly teleconferences to coordinate implementation of SB 1163 for rate review.

The CDI has participated with the NAIC in developing improvements to the SERFF, and in analyzing and reporting premium rate trends and other ACA required data to the federal HHS. The SERFF has committed to providing an enhanced public file search option to states in the first quarter of calendar year 2011, utilizing a link to the SERFF through the state Web site. Once this function becomes available, it is anticipated that the CDI will utilize grant funds to undertake a substantial revamp of its Web site.

Lessons Learned:

The DMHC and the CDI recognize the value of lessons learned, sharing, and communication. From the comments and requests for information received from the public regarding premium

rate increases, the Departments understand the impact these rates have on many Californians. This impact underlines the importance of establishing an effective rate review program. Although the Departments' programs are still early in the implementation stage, and many lessons learned are premature at this time, the Departments have learned that it is important to have as much information as possible, transparent and available to public on the rate review filings, so consumers can be informed on rate increases that may be affecting them.

Budget:

Expenditures, including the third quarter financial report, total $398,405 and are detailed below:

Expenditures to date include:

SERFF Enhancement	$18,808
Computer equipment	1,022
Computer software	1,224
NAIC Travel Reimbursement	1,109
Contract Services	376,242
Total	$398,405

Based on the above expenditure pattern, the DMHC will be submitting a no-cost extension. Additionally, the DMHC is in receipt of the guidance issued on June 8, 20ll providing further direction regarding the maintenance of effort requirements. The letter outlines that states are permitted to use grant funds to reimburse only the portion of time current state staff spend on activities specifically approved under the states' grant program. The DMHC will be submitting a rebudget based on this guidance.

Updated Work Plan and Timeline

The DMHC's rate review grant objective is to develop a program for reviewing premium rate increases to assure compliance with ACA. However, this process is impacted by the ability to obtain actuarial services and resources, as well as any future guidance from the federal HHS relating to rate review.

The following associated activities with this objective are still under development.

1. *Developing and enhancing California's rate review program. (Time Period End 12/31/2011)*

   During Cycle I, this development had been delayed by the California budget impasse, which impacted the DMHC's ability to contract with the actuarial consultants at OWAC. Now that the contract with OWAC is completed, the program is moving forward. The DMHC has implemented the review program, which includes the SERFF as well as staff to screen rate filings for additional actuarial review. Once potentially unreasonable rate increases are identified, staff forwards the filings for actuarial review to OWAC. The definition of "unreasonable rate increase" has not been defined in the federal HHS

Proposed Regulations, and the DMHC continues to refine its rate review processes and determine under what criteria a filed rate increase will be deemed reasonable or unreasonable. The DMHC continues to work with OWAC to define its processes in a manner that meets the needs of SB 1163, taking into consideration the needs and resources of the DMHC, while becoming an effective rate review program as defined by the federal HHS.

Meanwhile, the DMHC is reviewing premium rate filings with OWAC to assure compliance with the recently enacted SB 1163 legislation, and will review filings to assure consistency with federal health care reform requirements.

As the definition of "unreasonable rate increase" evolves, the DMHC may develop further filing and review guidance, and will continue to work with the CDI, the health plans, and consumer groups.

At his January, 2011 inauguration, Insurance Commissioner Dave Jones issued emergency regulations that provide legal authority to enforce the federal 80 percent loss ratio requirement in the individual health insurance market. Thereafter, the CDI issued guidance, and required filing forms and spreadsheets to establish requirements for the data and documentation submitted by health insurers in support of proposed rate increases (See guidance and required forms at http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm).

Utilizing its existing actuarial resources, plus additional actuaries hired using grant funds, supplemented by a contract actuary, the CDI examines all rate increase submissions to evaluate the reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity and actuarial credibility of the historical data underlying its assumptions regarding, among other factors, the medical trend and the utilization trend. The CDI evaluates the health insurer's data regarding its actual experience, as well as the reasonableness of past projections utilized by the insurer.

Insurers are required to submit rates (See California Rate Filing form at http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/RateFileFm2.cfm), and the CDI evaluates the impact of medical trend changes, utilization changes, and cost sharing changes by major service categories. For the periods related to the rate increase, the CDI actuaries evaluate the impact of benefit changes, changes in enrollee risk profile, and the impact of any overestimate or underestimate of medical trend for prior years, as well as product "under-pricing" for prior years. The insurer's surplus condition is evaluated. Insurers report changes in administrative costs, including those administrative costs related to programs that improve health quality.
Medical loss ratios are examined, using two separate, concurrent approaches: (1) the projected attainment of the federally required aggregate loss ratios as required by 45 CFR 158.210, using the method described in 45 CRF 158.221, and (2) in addition, for products in the individual health insurance market, compliance with the 70 percent lifetime anticipated loss ratio, on a policy form basis, described at title 10, California Code of

Regulations, section 2222.10, et seq. Changes in applicable taxes, licensing, or regulatory fees, if any, are also considered. The CDI's determination that a rate increase is reasonable or unreasonable is made under a standard set forth in Guidance 1163:2, issued under the statutory authority granted by Insurance Code section 10181.9.

2. *Developing a program to address health plan non-compliance, including potential enforcement action and posting of identified unreasonable rates to the Departments' Web sites. (Time Period End 12/31/2011)*

   This activity parallels the first activity listed above, and the work plan and timeline will be associated with the above narrative. The Departments continue to develop their rate review programs. Although SB 1163 gives the Departments the authority to review and post on their Web sites specified rate information, they do not have the authority to deny rate increases. Although the DMHC has not yet posted any identified "unreasonable" rates to its website, it has requested two health plans (Anthem Blue Cross and California Physicians' Service (aka Blue Shield of California)) to provide further data and information that can demonstrate that its individual product rate increases were not "unreasonable," and that the rate increases were justified. These two rate filings are posted on the DMHC Web site for public comment, as are the letters sent to the two health plans.

<u>Narrative Description of Significant Rate Reductions</u>

During the period April 1- June 30, 2011, the Department of Insurance rate review process resulted in the following rate reductions and adjustments:

1) Aetna Life Insurance Company
PF-2011-00542
SERFF Tr Num: AETN-127060798
Disposition Date: June 2, 2011
The company initially requested 12-month rate increases averaging 17.9%. After review by and discussions with the Department the company agreed to lower its average rate increase request to 12.2%. As a result of these changes, approximately 43,000 Aetna policyholders will see savings totaling approximately $6.7 million dollars in comparison to what they would otherwise have paid. Policyholders with renewal dates beginning July 1st will see savings totaling an average of 4.8% on an annualized basis. An additional $1 million dollars in ratepayer savings will result from Aetna's agreement to the Commissioner's request that it delay implementation of April 1st rate increases for at least 60 days. As a result, policy holders with renewal dates effective during this quarter avoided a planned rate increase that averaged 2.8% for this quarter.

2) Aetna Life Insurance Company
PF-2010-02396 and PF-2010-02367
SERFF Tr Num: AETN-126940379 and AETN-126940373
Disposition Date: June 2, 2011
The company originally intended to implement rate increases for these filings on April 1, 2011. After review by the Department, the implementation date was moved back to July 1, 2011. Because the company increases rates on its individual medical policies every quarter,

postponement of the effective dates of the rate increases to July 1 effectively nullified the impact of this filing.

3) Anthem Blue Cross Life and Health Insurance Company
PF-2011-00660
SERFF Tr Num: AWLP-127103976
Disposition Date: June 20, 2011.
After the department reviewed a proposed quarterly rate increase by Anthem Blue Cross, the company agreed to cut its quarterly premium increase in half - from 6.0 percent to 3.0 percent on average for certain health insurance products sold in the small group market. This rate filing contained proposed quarterly rate increases for the Solution 2500 PPO, Solution 3500 PPO and Solution 5000 PPO ("Solutions Plans"), which are purchased by small businesses with 2-50 employees. The rate increases for these Anthem Blue Cross PPO products affect nearly 18,000 members and went into effect on July 1st. The average quarterly increase was 3 percent (with a maximum increase of 4 percent). State law for small group policies allows the insurer to apply a risk adjustment factor of 0.90 to 1.10 to the small employer group standard employee risk rates. This creates a "rate band" within which the carrier may adjust employer rates for risk factors such as previous use of health services or industry type. The estimated total savings to small employers who have the Solutions PPO plans as a result of Anthem's decision to reduce the rate increase is $2 million. This rate filing is one of the first small group rate filings that the Department of Insurance reviewed under the new state law that went into effect January 1, 2011, SB 1163.

<u>Enclosures/Attachments</u>

None.

<u>PART II: HEALTH INSURANCE RATE DATA COLLECTION</u>

The Departments' summary data for Table A is provided below. The data for Tables B-D is from the DMHC internal electronic filing system, and is not available through the SERFF.

Table A. Rate Review Volume

State	Quarter 1	Quarter 2 DMHC/CDI/Total	Quarter 3	Quarter 4	Annual Total
Number of submitted rate filings[1]	45	3/13/16	13[2]/15/28		
Number of policy rate filings requesting increase in premiums	34	3/10/13	13/15/28		
Number of filings reviewed			4[3] [4]/5		

[2] The number includes two filings not submitted via SERFF and excludes one UHC of California HIPPA individual rate and filings that were withdrawn or re-filed.
[3] The number includes filings received in the prior quarter and review completed during the period April 1 – June 30, 2011.

for approval/denial[2]	35	3/24/27			
Number of filings approved[3]	29	0/7/7	0/5/5		
Number of filings denied[4]	0	0/not applicable	1/0		
Number of filings deferred	10	3/44/47	14/0/14		

Note 1: "Number of rate filings submitted" denotes the number of major medical filings received by the CDI during the period Jan. 1 – Mar. 31, 2011. The number includes filings for new rates, as well as for rate increases.
Note 2: "Number of filings reviewed / Actuarial Review completed" includes all the actuarial reviews of major medical filings completed by CDI during the period. Some of these filings had been received by CDI before Jan. 1, 2011.
Note 3: "Approved" denotes files for which review has been completed without disapproval or a finding of an unjustified unreasonable rate increase. This includes all the major medical filings for which the CDI arrived at a final disposition during the period.
Note 4: "Denied" denotes files for which review has been completed with a finding of an unreasonable rate increase.

Table B. Number and Percentage of Rate Filings Reviewed – Individual Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	**HMO-1 PPO/HMO-1**	**DMHC: None CDI: PPO**	**DMHC: 2[5] CDI:PPO**		
Number of Policyholders	**Not Available**	**DMHC & CDI: Not Available**	**DMHC & CDI: Not Available**		
Number of covered lives affected	**Not Available**	**DMHC: Not Available CDI: 271,000**	**DMHC: 70,833 CDI: 99,716**		

Table C. Number and Percentage of Rate Filings Reviewed – Small Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO,	**PPO-2 HMO-10**	**HMO-3**	**DMHC: 11 CDI:PPO[6]**		

[4] During the second quarter, on April 29, 2011, the DMHC made one determination that Anthem Blue Cross' individual rate filing regarding two of its PPO products was "unreasonable." This filing is also available for public comment and review on the DMHC rate review website (http://wpso.dmhc.ca.gov/RateReview/)

[5] The number includes one California Physician's Services filing not submitted via SERFF and excludes one UHC of California HIPPA individual rate and filings that were withdrawn or re-filed.

etc.)	PPO/HMO-4				
Number of Policyholders	**Not Available**	**Not Available**	**Not Available**		
Number of covered lives affected	**Not Available**	**Not Available**	**DMHC: 1,272,361 CDI: 20481**		

Table D. Number and Percentage of Rate Filings Reviewed – Large Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	**Not Applicable**	**Not Applicable**	**Not Applicable**		
Number of Policyholders	**Not Applicable**	**Not Applicable**	**Not Applicable**		
Number of covered lives affected	**Not Applicable**	**Not Applicable**	**Not Applicable**		

[6] The number includes one Chinese Community Health Plan filing not submitted via SERFF and excludes filings that were withdrawn or re-filed.