California Large Group Annual Aggregate Rate Data Report Form

1) Company Name (Health Plan)

UnitedHealthcare of California

2) This report summarizes 12-month rate activity for the following reporting year [1] :

2023

3) Weighted Average Rate Increase, and Number of Employees Subject to the Rate Change

Weighted Average Annual Rate Increases (Unadjusted) [2]	
* All Large Group Benefit Designs	7.6%
* Most Commonly Sold Large Group Benefit Design	7.6%
Weighted Average Annual Rate Increases (Adjusted) [3]	
* All Large Group Benefit Designs	7.8%
* Most Commonly Sold Large Group Benefit Design[4]	7.8%

[1] Provide information for January 1 - December 31 of the reporting year: 2023

[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 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	8	9
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups	Number of Enrollees/Covered Lives Affected by a Rate Change [5]	Number of Enrollees/Covered Lives Unaffected by a Rate Change at Renewal	Total Number of Enrollees/Covered Lives	Average Premium PMPM BEFORE Renewal	Average Premium PMPM AFTER Renewal	Weighted Average Rate Change Unadjusted [6]
January	295	46.4%	93,571	5,899	99,470	$581.89	$618.54	6.3%
February	13	2.0%	5,931	0	5,931	$756.15	$822.07	8.7%
March	14	2.2%	1,082	0	1,082	$439.44	$482.60	9.8%
April	37	5.8%	4,592	0	4,592	$495.31	$539.77	9.0%
May	22	3.5%	6,703	0	6,703	$552.02	$587.94	6.5%
June	38	6.0%	7,616	0	7,616	$480.61	$532.73	10.8%
July	62	9.7%	14,931	0	14,931	$717.13	$787.43	9.8%
August	22	3.5%	3,768	0	3,768	$384.48	$415.13	8.0%
September	37	5.8%	5,304	0	5,304	$504.38	$559.39	10.9%
October	35	5.5%	7,294	0	7,294	$576.36	$633.40	9.9%
November	24	3.8%	3,046	0	3,046	$490.44	$543.06	10.7%
December	37	5.8%	3,480	0	3,480	$444.68	$505.56	13.7%
Overall	**636**	**100.0%**	**157,318**	**5,899**	**163,217**	**$579.31**	**$623.23**	**7.6%**

[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 sum of number of covered lives shown 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 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

1	2	3	4	5	6	7	8	9
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups	Number of Enrollees/Covered Lives Affected by a Rate Change [5]	Number of Enrollees/Covered Lives Unaffected by a Rate Change at Renewal	Total Number of Enrollees/Covered Lives	Average Premium PMPM BEFORE Renewal	Average Premium PMPM AFTER Renewal	Weighted Average Rate Change Unadjusted [6]
100% Community Rated (in Whole)	0	0.0%	0	0	0	$0.00	$0.00	

Blended (n part)	587	92.3%	61,539	185	61,724	$504.09	$553.25	9.8%
100% Experience Rated	49	7.7%	95,779	5,714	101,493	$625.05	$665.80	6.5%
Overall	**636**	**100.0%**	**157,318**	**5,899**	**163,217**	**$579.31**	**$623.23**	**7.6%**

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 different credibility weights by product.

6) Product Type

1	2	3	4	5	6	7	8	9
Month Rate Change Effective	Number of Renewing Groups	Percent of Renewing Groups	Number of Enrollees/Covered Lives Affected by a Rate Change [5]	Number of Enrollees/Covered Lives Unaffected by a Rate Change at Renewal	Total Number of Enrollees/Covered Lives	Average Premium PMPM BEFORE Renewal	Average Premium PMPM AFTER Renewal	Weighted Average Rate Change Unadjusted [6]
HMO	630	99.1%	156,912	5,899	162,811	$579.93	$623.89	7.6%
PPO	0	0.0%	0	0	0	$0.00	$0.00	
EPO	0	0.0%	0	0	0	$0.00	$0.00	
POS	0	0.0%	0	0	0	$0.00	$0.00	
HDHP	6	0.9%	406	0	406	$330.22	$359.67	8.9%
Other (describe)	0	0.0%	0	0	0	$0.00	$0.00	
Overall	**636**	**100.0%**	**157,318**	**5,899**	**163,217**	**$579.31**	**$623.23**	**7.6%**

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 other needed comments, here:

NA

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7) Products Sold with Materially Different Benefits, Cost Share

Please complete the following tables. In completing these tables, please see definition of "Actuarial Value" in the tab, LGARD-#18-AdditionalInfo, which can be referenced via the link below:
LGARD-#18-AdditionalInfo

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	111	69,091	42.4%	0 OV, $0 ded, $1000 OOPM
0.8 to 0.899	641	54,318	33.4%	5 OV, $0 ded, $2000 OOPM
0.7 to 0.799	535	29,881	18.4%	5 OV, $0 ded, $3500 OOPM
0.6 to 0.699	201	8,985	5.5%	OV, $2500 ded, $6000 OOPM
0.0 to 0.599	7	536	0.3%	OV, $2000 ded, $5000 OOPM
Total	1,495	162,811	100.0%	

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			0.0%	
0.8 to 0.899			0.0%	
0.7 to 0.799			0.0%	
0.6 to 0.699			0.0%	
0.0 to 0.599			0.0%	
Total	0	0	0.0%	

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%	
0.8 to 0.899			0.0%	

0.7 to 0.799			0.0%	
0.6 to 0.699			0.0%	
0.0 to 0.599			0.0%	
Total	0	0	0.0%	

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%	
0.8 to 0.899			0.0%	
0.7 to 0.799			0.0%	
0.6 to 0.699			0.0%	
0.0 to 0.599			0.0%	
Total	0	0	0.0%	

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	5	294	72.4%	0 ded, 100%, $3000 OOPM
0.0 to 0.599	4	112	27.6%	00 ded, 80%, $6000 OOPM
Total	9	406	100.0%	

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			0.0%	
0.8 to 0.899			0.0%	
0.7 to 0.799			0.0%	

0.6 to 0.699			0.0%	
0.0 to 0.599			0.0%	
Total	0	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:

We offer 222 standard plans available across a range of networks. The following is the range of cost sharing levels available in our standard plans.

PCP copay ranges:	$0 to $35
Specialist copay ranges:	$20 to $80
Deductible ranges:	$0 to $5000
OOPM ranges:	$1500 to $7800

Roughly 25% of covered lives are on standard plans. The remaining 75% of covered lives are on custom plans.

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8) Factors Affecting the Base Rate

Describe any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

Factor	Provide Actuarial Basis, Change in Factors, and Member Months During 12-Month Period
Geographic Region (describe)	Rates for each group vary depending on contractual arrangements with designated providers.
Age, including Age Rating Factors (provide further details, such as Age Bands)	Health care costs tend to vary with a member's age. There is no change to age rating factors in 2023.
Occupation	N/A - not used
Industry	Factors are assigned based on a group's Standard Industry Classification code.
Health Status Factors, including, but not limited to Experience and Utilization	There is no change in Underwriting methodology in 2023.
Employee, and Employee and Dependents, including a description of the Family Composition (i.e, Tier Ratios) used in each Premium Tier	There is no change in 2023
Enrollees' Share of Premiums	Subject to the percent of premiums the Employer chooses to cover.
Enrollee's Cost Sharing, including Cost Sharing for Prescription Drugs	Please refer to the answer to Question 12.
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 scales in 2023.
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.

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9) Overall[7] Experience Medical Services Trend

Experience Medical Services Allowed Trend by Trend Category
Allowed Trend: 2023 / 2022

Service Category	2022 Aggregate Dollars (PMPM)	2023 Aggregate Dollars (PMPM)	Overall 2023 Trend
Hospital Inpatient[8]	$57.16	$61.21	7.1%
Hospital Outpatient (Including ER)	$44.32	$49.12	10.8%
Physician/Other Professional Services[9]	$20.11	$23.02	14.4%
Laboratory (Other than Inpatient)[10]	$0.00	$0.00	0.0%
Radiology (Other than Inpatient)	$0.00	$0.00	0.0%
Capitation (Professional)	$160.84	$166.96	3.8%
Capitation (Institutional)	$110.66	$114.81	3.8%
Capitation (Other)	$25.67	$25.67	0.0%
Other (Describe in Comment Box Below)	$16.00	$17.34	8.3%
Overall Medical Services	$434.77	$458.11	5.4%
Prescription Drug[11]	$59.46	$63.41	6.6%
Overall Medical Services + Prescription Drug	$494.23	$521.52	**5.5%**

[7] "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

[8] Measured as inpatient days, not by number of inpatient admissions.

[9] Measured as visits.

[10] Laboratory and Radiology measured on a per-service basis.

[11] Per Prescrption.

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

Lab and Radiology included in other.

10) Projected Medical Services Trend

Projected Medical Services Allowed Trend by Trend Category
Allowed Trend: 2024 / 2023

Service Category	2023 Aggregate Dollars (PMPM)	2024 Trend Attributable to: Use of Services	Price Inflation	Fees and Risk	2024 Projected Aggregate Dollars (PMPM)	Overall 2024 Trend
Hospital Inpatient[12]	$61.21	2.2%	4.8%	0.0%	$65.54	7.1%
Hospital Outpatient (including ER)	$49.12	5.8%	4.7%	0.0%	$54.43	10.8%
Physician/Other Professional Services[13]	$23.02	10.5%	3.5%	0.0%	$26.34	14.4%
Laboratory (Other than Inpatient)	$0.00	0.0%	0.0%	0.0%	$0.00	0.0%
Radiology (Other than Inpatient)[14]	$0.00	0.0%	0.0%	0.0%	$0.00	0.0%
Capitation (Professional)	$166.96	0.0%	3.8%	0.0%	$173.30	3.8%
Capitation (Institutional)	$114.81	0.0%	3.8%	0.0%	$119.12	3.8%
Capitation (Other)	$25.67	0.0%	0.0%	0.0%	$25.67	0.0%
Other (Describe in Comment Box Below)	$17.34	0.0%	8.3%	0.0%	$18.78	8.3%
Overall Medical Services	$458.11	1.4%	4.0%	0.0%	$483.18	5.5%
Prescription Drug[15]	$63.41	5.5%	1.0%	0.0%	$67.63	6.6%

Overall Medical Services + Prescription Drug	$521.52	1.9%	3.6%	0.0%	$550.81	**5.6%**

[12] Measured as inpatient days, not by number of inpatient admissions.

[13] Measured as visits.

[14] Laboratory and Radiology measured on a per-service basis.

[15] Per Prescription.

Please provide an explanation if any of the categories under 10) are zero or have no value.

Lab and Radiology included in other.

California Large Group Annual Aggregate Rate Data Report Form

UnitedHealthcare of California
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11) CA Large Group Historical Rate Data Reporting Spreadsheet

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) Claim Costs, if any
(iii) Administrative Expenses
(iv) Taxes & Fees
(v) Quality Improvement Expenses. Administrative Expenses include General and Administrative Fees, Agent and Broker Commissions

Complete CA Large Group Historical Data Spreadsheet - Excel

California Large Group Annual Aggregate Rate Data Report Form

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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:

(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).

Place comments here:

The standard portfolio was modified to remove unpopular plan designs, add plan designs per market feedback, and introduce cost-sharing features that help control total cost of care. 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 -1.2%.

[16] Please determine weighted average actuarial value based on the company's own plan relativity model. For this purpose, the company is not required to use the CMS model.

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13) Changes in Enrollee 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).

Place comments here:

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

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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

In addition to Code referenced on Cover-Input Page, see California Health Benefit Exchange, April 7, 2016 Board Meeting materials:
https://board.coveredca.com/meetings/2016/4-07/2017%20QHP%20Issuer%20Contract_Attachment%207__Individual_4-6-2016_CLEAN.pdf

Place comments here:

On-going efforts at cost containment and quality improvement for Small Group and 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.

California Large Group Annual Aggregate Rate Data Report Form

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15) Number of Products that Incurred 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.

Place comments here:

N/A

California Large Group Annual Aggregate Rate Data Report Form

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16) Large Group Prescription Drug Form

Complete the Large Group 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) Percentage 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 Large Group Prescription Drug Cost Reporting Form

California Large Group Annual Aggregate Rate Data Report Form

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17) Other Comments

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

Place comments here:

N/A

California Large Group Annual Aggregate Rate Data Report Form

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18) Additional Information

The following glossary lists out some additional information related to terms contained in the Large Group Aggregate Data Report Form:

Term	Definition
Actuarial Basis	The methodology used to determine the rating factors and the purpose of the factors
Actuarial Value	As reported in Item 7 on the Large Group Annual Aggregate Data Report Form, this calculation should utilize the covered benefits described in the February 20, 2013 Methodology for the 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 this value; this is not an instruction to use the MV Calculator to perform the 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, 5) Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, 6) Imaging (CT/PET scans, MRI), 7) Rehabilitative Speech Therapy, 8) Rehabilitative Occupational and Rehabilitative Physical Therapy, 9) Preventive Care/Screening/Immunization, 10) Laboratory Outpatient and Professional Services, 11) X-rays and Diagnostic Imaging, 12) Skilled Nursing Facility, 13) Outpatient Facility Fee (e.g., Ambulatory Surgery Center), 14) Outpatient Surgery Physician/Surgical Services, 15) Drug Categories: Generics, Preferred Brand, Non-Preferred, and
Any factors affecting the base rate, and the actuarial bases for those factors	Factors provided by the health plan or insurers, such as those factors listed from Health & Safety Code Section 1385.045(c)(2) A-K and California Insurance Code Section 10181.45(c)(2) A-K , affecting the base rate and briefly describing the actuarial basis (i.e., geographic region, age, occupation, industry, health status, employee and employee dependents, enrollee, and segment type (partial or full community rates vs. experience rates)).
Custom Plan	The opposite of "standard plan" as referenced in item 7, this is a large group plan in which the purchaser has the opportunity to select an array of benefits, contractual provisions, and cost sharing.
Excise Tax	Puts a 40 percent tax on the most expensive health insurance plans whose costs exceed certain thresholds
Large Group	Commercial full-service health care service plans as defined in Health & Safety Code section 1385.01, subdivision (a) and as defined in California Insurance Code 10181, subdivision (a). For the purpose of report requirements contained in this workbook, large group plans shall include fully insured commercial products and In Home Support Services (IHSS) products.
Number of Enrollees/Covered Lives	The number of employees, including covered 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.
Percent of Total Rate Changes	Measurement of the distribution of the number of rate changes for a given category (e.g., effective month) in items 4-6 of this report.
Product Type	Refers to 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 network type within a service area. "Plan", on the other hand, with respect to an issuer and a product, means the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.
Projected Trend	Pricing trend for the 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, where CY refers to the Current (or Reporting) Year.
Reporting Year	The calendar year (i.e., the current year) that a health plan or health insurer files the California Large Group Annual Aggregate Rate Data Report
Segment Type	Category of rate determination method (i.e., community/manual rates, in whole or in part). For the purpose of this section, segment types are 100% community/manual rated (in whole), blended (in part), and 100% experience rated (none).
Standard Plan	A large group plan (and not an individual or small group plan), as referenced in item 7, sold by the health plan to the purchaser with little or no opportunity for customization regarding benefits, contractual provisions, or cost-sharing.

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet (Fully Insured)
For Policies subject to CIC 10181.45 or CHSC 1374.21

UnitedHealthcare of California
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Historical Data - Premium and Claims

HMO/POS

		Historical Data				
		2018	2019	2020	2021	2022
1.	Premium:					
	1.1 Total premium	1,857,037,737	1,440,536,359	1,336,135,969	1,310,321,388	1,254,169,894
2.	Claims:					
	2.1 Claims Incurred and Paid	1,485,451,197	1,138,391,982	1,098,343,140	1,137,935,509	1,106,693,127
	2.2 Direct claim reserves	125,711	0	0	41,134	0
	2.3 Experience rating refunds (rate credits) paid	187,428	96,117	0	0	0
	2.4 Reserve for experience rating refunds (rate credits)	(151,931)	4	0	150,229	226,738
	2.5 Contingent benefit and lawsuit reserves	0	0	0	0	0
	2.6 Total incurred claims	1,485,612,405	1,138,488,102	1,098,343,140	1,138,126,872	1,106,919,864
3.	Federal and State Taxes and Licensing or Regulatory Fees					
	3.1 Federal taxes and assessments					
	3.1a Federal income taxes deductible from premium in	42,085,069	31,932,353	15,076,968	(1,863)	(8,212,082)
	3.1b Patient Centered Outcomes Research Institute	1,026,827	842,897	930,342	937,529	957,842
	3.1c Affordable Care Act section 9010 Fee	42,139,789	0	27,516,205	0	0
	3.1d Federal Transitional Reinsurance Fee	0	0	0	0	0
	3.1e Other Federal Taxes and assessments deductible	7,186	3,382	(3)	188	0
	3.2 State Premium Tax	0	0	0	0	0
	3.3 State Income Tax	29,372,386	21,715,489	7,282,702	3,779,632	1,230,338
	3.4 Regulatory authority licenses and fees	754,515	698,268	671,855	692,026	760,204
	3.5 Other Taxes and Fees	0	0	0	0	0
	3.6 Total Federal and State Taxes and fees	115,385,773	55,192,389	51,478,070	5,407,512	(5,263,698)
4.	Health Care Quality Improvement Expenses Incurred					
	4.1 Improve health outcomes	14,856,302	11,524,291	4,076,701	3,464,346	2,986,874
	4.2 Activities to prevent hospital readmission	0	0	1,701,785	1,572,805	795,566
	4.3 Improve patient safety and reduce medical errors	0	0	2,338,584	1,627,980	1,751,036
	4.4 Wellness and health promotion activities	0	0	6,128,414	2,118,781	3,025,221
	4.5 Health information technology expenses related to improving health care quality	0	0	4,239,321	2,629,842	2,784,438
	4.6 Allowable Implementation ICD-10 expenses (not to exceed 0.3% of premium)	0	0	0	0	0
	4.7 Total Incurred Health Care Quality Improvement Expenses	14,856,302	11,524,291	18,484,805	11,413,754	11,343,134
5.	Non-Claims Costs					
	5.1 Administrative Expenses	61,741,994	55,320,287	59,004,230	57,262,913	67,465,088
	5.2 Agents and brokers fees and commissions	14,680,707	23,306,483	22,494,337	24,293,720	26,207,033
	5.3 Other general and administrative expenses	83,820,171	53,443,049	62,253,497	56,555,843	62,301,231
	5.4 Total non-claims costs	160,242,873	132,069,819	143,752,064	138,112,476	155,973,352
6.	Other Indicators or information					
	6.1 Number of covered lives	402,796	342,758	343,138	337,819	322,886
	6.2 Member months	4,908,012	4,159,864	4,174,622	4,043,132	3,844,704

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet (Fully Insured)
For Policies subject to CIC 10181.45 or CHSC 1374.21

UnitedHealthcare of California
Reporting Year: 2023
Historical Data - Premium and Claims

PPO/EPO

		Historical Data				
		2018	2019	2020	2021	2022
1.	Premium:					
	1.1 Total premium					
2.	Claims:					
	2.1 Claims Incurred and Paid					
	2.2 Direct claim reserves					
	2.3 Experience rating refunds (rate credits) paid					
	2.4 Reserve for experience rating refunds (rate credits)					
	2.5 Contingent benefit and lawsuit reserves					
	2.6 Total incurred claims	0	0	0	0	0
3.	Federal and State Taxes and Licensing or Regulatory Fees					
	3.1 Federal taxes and assessments					
	3.1a Federal income taxes deductible from premium in MLR					
	3.1b Patient Centered Outcomes Research Institute (PCORI)					
	3.1c Affordable Care Act section 9010 Fee					
	3.1d Federal Transitional Reinsurance Fee					
	3.1e Other Federal Taxes and assessments deductible from					
	3.2 State Premium Tax					
	3.3 State Income Tax					
	3.4 Regulatory authority licenses and fees					
	3.5 Other Taxes and Fees					
	3.6 Total Federal and State Taxes and fees	0	0	0	0	0
4.	Health Care Quality Improvement Expenses Incurred					
	4.1 Improve health outcomes					
	4.2 Activities to prevent hospital readmission					
	4.3 Improve patient safety and reduce medical errors					
	4.4 Wellness and health promotion activities					
	4.5 Health information technology expenses related to improving health care quality					
	4.6 Allowable Implementation ICD-10 expenses (not to exceed 0.3% of premium)					
	4.7 Total Incurred Health Care Quality Improvement Expenses	0	0	0	0	0
5.	Non-Claims Costs					
	5.1 Administrative Expenses					
	5.2 Agents and brokers fees and commissions					
	5.3 Other general and administrative expenses					
	5.4 Total non-claims costs	0	0	0	0	0
6.	Other Indicators or information					
	6.1 Number of covered lives					
	6.2 Member months					

California Department of Managed Health Care/Department of Insurance
CA Large Group Historical Data Spreadsheet (Fully Insured)
For Policies subject to CIC 10181.45 or CHSC 1374.21

UnitedHealthcare of California
Reporting Year: 2023
Historical Data - Premium and Claims

HMO/POS

		Historical Data				
		2018	2019	2020	2021	2022
1.	Total Dollars					
	1.1 Premiums	1,857,037,737	1,440,536,359	1,336,135,969	1,310,321,388	1,254,169,894
	1.2 Claims Costs	1,485,612,405	1,138,488,102	1,098,343,140	1,138,126,872	1,106,919,864
	1.3 Administrative Expenses	160,242,873	132,069,819	143,752,064	138,112,476	155,973,352
	1.4 Taxes and Fees	115,385,773	55,192,389	51,478,070	5,407,512	(5,263,698)
	1.5 Quality Improvement Expenses	14,856,302	11,524,291	18,484,805	11,413,754	11,343,134
2.	PMPM					
	2.1 Premiums	378	346	320	324	326
	2.2 Claims Costs	303	274	263	281	288
	2.3 Administrative Expenses	33	32	34	34	41
	2.4 Taxes and Fees	24	13	12	1	(1)
	2.5 Quality Improvement Expenses	3	3	4	3	3
3.	Average Change in Rating Components (%)					
	3.1 Premiums	N/A	-8.5%	-7.6%	1.3%	0.7%
	3.2 Claims Costs	N/A	-9.6%	-3.9%	7.0%	2.3%
	3.3 Administrative Expenses	N/A	-2.8%	8.5%	-0.8%	18.8%
	3.4 Taxes and Fees	N/A	-43.6%	-7.1%	-89.2%	-202.4%
	3.5 Quality Improvement Expenses	N/A	-8.5%	59.8%	-36.2%	4.5%

PPO/EPO

		Historical Data				
		2018	2019	2020	2021	2022
1.	Total Dollars					
	1.1 Premiums	0	0	0	0	0
	1.2 Claims Costs	0	0	0	0	0
	1.3 Administrative Expenses	0	0	0	0	0
	1.4 Taxes and Fees	0	0	0	0	0
	1.5 Quality Improvement Expenses	0	0	0	0	0
2.	PMPM					
	2.1 Premiums					
	2.2 Claims Costs					
	2.3 Administrative Expenses					
	2.4 Taxes and Fees					
	2.5 Quality Improvement Expenses					
3.	Average Change in Rating Components (%)					
	3.1 Premiums	N/A				
	3.2 Claims Costs	N/A				
	3.3 Administrative Expenses	N/A				
	3.4 Taxes and Fees	N/A				
	3.5 Quality Improvement Expenses	N/A				