First, we want to thank Commissioner Miller and the Insurance Department for providing us the opportunity to share our thoughts about the rates we filed for 2017. Before I address our specific approach to rate-setting, I thought it might be helpful to first touch upon the factors impacting premium costs generally and about the manner in which we at UPMC address those factors. I'll end by talking about the steps we have taken and will continue to take to address premium costs going forward.

While this likely goes without saying, the cost of health insurance is directly related to the cost of healthcare itself; the higher the cost of care the higher the premium necessary to cover the cost of that care. The cost of healthcare in the United States has been increasing for many years. It is predicted that, unless trends are mitigated, by 2024, 20% of the Gross Domestic Product will be spent on healthcare verses the 18% we spend today.[1]

There are a large number of factors that contribute to these rising costs. First, a growing number of people in this country suffer from chronic conditions, often more than one. These conditions include heart disease, obesity, high blood pressure, substance use disorders, COPD, asthma, and many others. A full 75% of all healthcare dollars spent are spent on the treatment of chronic disease.[2].

Second, people are living longer. While this is a very good thing and not every older adult develops a chronic disease or uses services, on the whole, age is correlated with health care needs and health care costs.

Additionally, every day, new, revolutionary and often life-saving treatments and medications are developed. Many of these treatments and medications are expensive; and some are very expensive. Obviously, if you or your loved one need one of these treatments, no one wants cost to be a barrier. Nonetheless, collectively these treatments/medications drive up healthcare costs.

So, too, does waste. In fact, some studies estimate that up to a third of what the US spends on healthcare may be wasteful.[3] Waste can be the result of poor care delivery, such as the costs associated with treating illnesses resulting from medical mistakes. Waste can be the result inadequate care coordination or lack of appropriate aftercare following a hospitalization resulting in an unnecessary hospital readmission, or from costs associated with duplicative or unnecessary diagnostics tests or procedures.

[1] Keehan SP Cuckler GA, Sisko AM, et al., Health Aff (Millwood). 2015 Aug;34(8):1407-17. doi: 10.1377/hlthaff.2015.060.

[2] Thorpe, Ken, PhD. http://fightchronicdisease.org/facing-issues/about-crisis.

[3] Health Policy Brief: Reducing Waste in Health Care." Health Affairs, December 13, 2012.

Much attention is being paid nationally to ways that quality and cost outcomes can be improved. One strategy being implemented is to change the current method of payment from a "Fee for Service" model, which pays for each individual procedure or service provided, to what is called a "value-based payment" model, which factors both quality and efficiency into payment methodologies. Additionally, much more emphasis is now being placed on preventative care, which is designed to keep people healthy, to prevent health conditions from progressing, and to better manage cost. Organizations such as UPMC have focused and will continue to focus not only on prevention, but also on creating protocols and developing technology that ultimately assist physicians and their healthcare teams to deliver the right care at the right time.

We at UPMC are doing what we can to tackle all of these cost-drivers, including by better aligning those who deliver care with those who pay for care through our "integrated delivery and finance system" or IDFS. UPMC's IDFS structure has allowed UPMC to be a leader in how health care is delivered and financed. As a leading academic center, we have pioneered innovative treatments, trained a large percentage of the future generation of physicians, nurses and other health care providers in the Western region. Additionally, twenty years ago we created an Insurance Division to provide western Pennsylvanians with competitive health coverage options. Before the Division's inception, more than 2/3rds of western Pennsylvanians purchased coverage from a single carrier.

Today, the UPMC Insurance Services Division includes eight licensed insurance companies, including the flagship company, UPMC Health Plan. Collectively, these companies offer the full spectrum of coverage options to Pennsylvanians, including commercial and exchange coverage; Medicare Advantage plans, including Special Needs Plan for those covered through Medicare and Medicaid; Children's Health Insurance Plans; Medicaid plans; as well as Workers' Compensation, Disability, EAP and Health and Wellness products. The Division also includes Community Care Behavioral Health Organization, one of the largest behavioral health managed care companies in the nation. Across all its products and services, the UPMC Insurance Services Division covers 3 million members. We serve approximately 10,000 employers, and offer multiple networks that include over 150 hospitals and facilities and over 20,000 physicians and allied health professionals. Our individual products, which are the subject of today's discussion, provide coverage in 2016 to more than 150,000 individuals.

Insurance competition has been very good for Western Pennsylvania. Today, when you count all the people who have any type of coverage in Western Pennsylvania, UPMC's insurance companies serve approximately one-third of the population, with the remaining two-thirds being split equally between the national carriers and Highmark. This increasingly competitive market has greatly benefitted consumers. In fact, western Pennsylvania has among the lowest priced insurance products in the nation. In the Pittsburgh market, fully

insured commercial premiums for employer groups and premiums for individuals covered through commercial insurance products are less expensive than almost every other major market nationwide.[4,5] In a survey by HHS of 59 cities, UPMC had the lowest priced silver benchmark plan.[6]

Today's discussion focuses on the individual insurance products and the rates we filed for our 2017 premiums. The background for these rates began with the enactment of the Affordable Care Act (ACA) and the advent of the Federal Marketplace. The ACA brought with it a new set of requirements for insurers, including the elimination medical underwriting. Medical underwriting had allowed insurers to vary premium amounts for, or deny coverage altogether to, individuals with certain medical conditions.

One of the key goals of the ACA was to increase the number of people who could afford insurance through the use of government subsidies based on income. Also under the ACA individuals would for the first time be mandated to purchase insurance coverage or pay a penalty. Certain employer groups, too, were required to provide coverage to their employees. All of these requirements were designed to create a balanced risk pool and reduce the risk that only people who had healthcare needs, or who thought they might soon develop such needs, would purchase coverage.

Costs associated with covering a new population are always an estimate. When the Part D program for Medicare was initially launched, it took a number of years before premiums were stabilized. The individual coverage available through the Federal or State marketplaces is no exception. As you may recall, in 2014, the first year of that coverage was available on the ACA's marketplaces, each insurance carrier's bid was "blind," meaning each bid was independently developed without specific knowledge or information about who would sign up for coverage or how other carriers would competitively bid. Bid development required all carriers to make certain assumptions about the health of potential enrollees and about the level of pent up demand for care they may have had.

Our 2014 bid started with assumptions reflecting a population that was previously uninsured or underinsured, and for whom certain insurance concepts of value-based networks, prior authorization, and drug formularies may have been unfamiliar. Using these assumptions we established a number that we believed was responsible, sustainable in the face of substantial

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[4] *See* Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Table IX.A.2 (2012). Pennsylvania analysis by Henry Miller, Ph.D., Berkeley Research Group.
[5] *See* "HIX Compare 2015-2016 Datasets" (2016). Robert Wood Johnson Foundation / Manatt, Phelps & Phillips. Available at http://www.rwjf.org/en/library/research/2015/12/hix-compare-2015-2016-datasets.html.
[6] Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace." Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. Available at https://aspe.hhs.gov/report/health-plan-choice-and-premiums-2015-health-insurance-marketplace.

risk, and competitive. While in retrospect we believe that our 2014 bid reflected the realities and risks of the individual insurance market and its consumers at that time, it was not competitive in our market. Although our bid was in the average-range of the bids submitted statewide and in line with national carriers that offered products in our service area, it was appreciably higher than that offered by our primary competitor at the time. Because individual insurance consumers typically shop first based on price, we garnered a small percentage of members that year.

In 2015, we had a choice to make. Because reliable data still was not available at the time of 2015 bid submission, we had to either maintain our existing position and risk being underbid again, or revisit the fundamental assumptions that led us to our 2014 bid in the first place. We looked closely at all of the limited information that we had and discussed trends in the broader market. We had created a smaller value network in 2014, but for our second year of bidding we created an additional cost-effective network. We "sharpened our pencils" and submitted a competitive bid that would allow us to grow in the individual market. Our 2015 pricing was more competitive, and resulted in 57,000 new marketplace members.

In 2016, we again priced as strongly as we could based on the anticipated maturation of the individual market and the still-developing profile of our marketplace members. We submitted a bid that was once again lower than our competitors, and garnered 133,000 new marketplace members.

The market dynamics in western Pennsylvania that began in 2014, resulted in rates that were originally too low and likely unsustainable. For the first time we were able to approach the 2017 bid with the sufficient credible data (i.e. utilization data from marketplace members who had enrolled in our plans in 2015) to develop a reliable cost estimate for the 2017 population. This data allowed us to make better, more reliable assumptions about the likely utilization of services by enrollees in 2017. We used the 2015 information to develop a cost-estimate for the 2017 population.

From an actuarial perspective, many variables can influence this utilization cost-estimate and, to develop an accurate bid, a carrier must factor these variables into its bid calculation. For example, for the 2017 bid, we assumed that the pent up demand for medical care by individuals who could not afford or otherwise lacked coverage before the ACA would likely be significantly reduced by 2017. We further assumed that, because the penalties for not having coverage had substantially increased between 2014 and 2017 – in some cases to amounts as high as the cost of buying coverage itself – even young people and people who would not anticipate a need for healthcare services would be more likely to purchase coverage.

Additional factors that impacted our bid were (1) the end of reinsurance in 2017; (2) the projected morbidity of new members, and (3) the 2017 holiday from the ACA insurer fee. Changes we made to our plan designs and to our network, including the expansion of counties in which we offered our Partner network, also impacted our bid submission. By applying all of these factors to the utilization assumptions I mentioned a moment ago, we projected a sustainable rate that we will implement over the next several years.

We want consumers to know that between now and our 2018 bid, we will continue to implement innovative means by which to manage care and cost, beginning with the manner in which we design our coverage products. Our products, for example, will continue to include coverage for preventive services and health screening at no cost to the consumer. We will continue to make it easy and affordable for persons with diabetes to get the insulin they need and for people who want to quit smoking to get the deterrents necessary. We will incentivize people to get the care they need in appropriate and least restrictive settings. We will offer wellness products and health coaches and health homes – all things designed to help people stay healthy, to get healthy and/or to manage the conditions they already have.

We will continue to offer to consumers products that provide access to our Partner Network, a network that, while narrower than some of our other network options, provides access to a large number of high-quality, high-performing providers at a lower premium price-point. For those who prefer a broader network, we will also continue to offer products utilizing our Select Network, as well as other network options.

We will continue to use technology and data analytics to deliver care in new and innovative ways. We currently offer and will continue to expand upon remote treatment alternatives, such as Anywhere Care and e-visits. We are developing mobile apps that someday will allow all of us to literally carry our doctors with us wherever we go.

Importantly, we will also do everything we can to arm consumers with the information they need to make wise treatment choices. Historically, even if one wanted to be a smart shopper about health care – if one wanted to determine which provider was most economical – the information necessary to do so was not readily available. We are working to change this so consumers can make fully informed choices based upon the cost and quality of each provider.

For all these reasons we believe that, though the premium increases we requested this year may be lower than those requested by other carriers, they are sufficient and will allow UPMC to continue to offer the high quality, affordable coverage options and the world class health care that Pennsylvanians deserve.

Let me close by thanking the Department for giving us this opportunity to speak with you today and by reiterating UPMC's commitment to continue to work with the Department to improve the health of the communities we serve.