First Priority Health– Individual Plans

Rate Request filing ID # HGHM-132820374 – This document is prepared by the insurance company submitting the rate filing as a consumer tool to help explain the rate filing. It is not intended to describe or include all factors or information considered in the review process. For more information, see the filing at https://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/ACA-Health-Rate-Filings.aspx

Overview

Initial requested average rate change:	6.64%
Revised requested average rate change:	4.36%
Range of requested rate change:	4.36% to 4.36%[1]
Effective date:	January 1st, 2022
Mapped members:	28
Available in:	Rating Area 3

Key Information

Jan. 2020-Dec. 2020 financial experience

Premiums	$388,841
Claims	$145,120
Administrative Expenses	$18,592
Taxes & Fees	$5,937
Insurers made (after taxes)	$219,191

How it plans to spend your premium[2]

This is how the insurance company plans to spend the premium it collects in 2022

Claims:	92%
Administrative:	8%
Taxes & Fees:	0%
Profit:	0%

The insurer expects its annual medical costs to increase **9.43%**.

Our Decision

The insurer requested an average 6.64% rate change in the individual market for enrollees in current 2021 plans who will continue with the insurer in 2022. The insurer later revised its rate filing to request a rate change of 4.36% due to revisions made during the Department's standard review. The statewide average rate change request across all insurers was originally 2.0% and was revised to 0.2%. Two of the

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[2] Due to rounding, the percent total, in How it plans to spend your premium section, may not sum to 100%. Claims percentage does not represent 80% MLR requirement. The MLR 80% calculation takes into consideration claims, premium, quality improvements, and taxes and fees.

factors contributing to the rate change are the expected effects of COVID-19 and the change in reimbursement from the state reinsurance program.

Process and Considerations for the 2022 Plan Year

Consistent with plan year 2021, the Department instructed insurers to file requested rates for 2022 Affordable Care Act compliant plans assuming the federal government would not make Cost-Sharing Reduction (CSR) payments. Cost-Sharing Reductions apply to certain out-of-pocket costs, like deductibles and copayments, for low- and middle-income enrollees. Although the federal government has stopped making CSR payments, insurers are still required by federal law to reduce out-of-pocket costs for low- and middle-income enrollees.

Insurers offering on-exchange silver plans adjusted premiums for those plans in order to compensate for the ending of federal CSR payments. This means that premiums for on-exchange silver plans are greater than the premiums for off-exchange silver plans. Many on-exchange consumers who receive the Advanced Premium Tax Credit (APTC) will not experience the full effect of any rate change because this subsidy will change as well. Consumers who have an on-exchange silver plan and do not qualify for a subsidy may want to consider evaluating other metal level plans available on-exchange or purchasing an off-exchange silver plan because these plans will likely have lower premiums relative to the coverage level.

Pennsylvania was granted a 1332 Waiver by the federal government allowing the Commonwealth to create a state-based insurance exchange (Pennie™) and reinsurance program. The state reinsurance program began providing coverage effective on January 1, 2021. The state reinsurance program will reimburse insurers for a portion of claims above a set dollar amount threshold which will allow the companies to lower premiums. As a result of the reinsurance program, Pennsylvania residents who purchase individual ACA compliant health policies effective in 2022 will have premiums that are 5.5% less on average than they otherwise would have been without that program.

Examples of other changes impacting rates include the federal policy changes around the American Rescue Plan Act. The enhanced subsidies have the potential to increase enrollment of members who, on average, could be healthier than the existing pool. This could result in morbidity improvement, where other factors may negatively impact rates, such as the availability of short-term limited duration (STLD) plans and association health plans (AHP) offered outside of the ACA markets. Both of these types of plans may provide less expensive coverage options that frequently do not offer the full patient protections and benefits assured under the ACA. These policies may destabilize the ACA risk pool by enticing healthier risks into lower-cost non-comprehensive coverage while leaving consumers who require more comprehensive health care in the ACA risk pool. Consequently, the Department requested insurers to assume 1% higher morbidity to reflect the adverse effect that STLD plans and AHPs may have on the market.

For each requested plan, the Department reviewed the contract to see if the plan included all the benefits required by state and federal law, if the rates are reasonable in relation to the benefits, and if the insurer will be able to pay projected claims and expenses. The Department also considers factors

such as the insurer's revenues, medical and administrative costs, actual and projected profits, and past rate changes, as well as the effect the 2022 rate change will have on Pennsylvania consumers. In approving rates for 2022, the Department focused on making sure that Pennsylvanians in every county in the state continue to have access to health care coverage. Ensuring that affordable options remain available to Pennsylvania consumers is a top priority for the Department. The resulting average final rate change approved for this insurer is 4.36%, ranging from 4.36% to 4.36%[1].

General Note: An insurer may not increase your rates more than once in a calendar year. The change in premium for a specific individual or employer may vary from the average rate change shown in this summary due to plan-specific factors, like the benefit package and provider network used by the plan, as well as four factors specific to the individual or employer/employees: geographic location, age, tobacco use, and family size.

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What we consider

Premium is made up of three parts: medical claims, administrative expenses, and profit or loss. We review all of the information in rate filings for individual and small group health plans, including the plans' medical claims, administrative expenses, and projected profit or loss.

A key component used to calculate projected claims is medical trend. Medical trend is the change in claims costs over a specific period of time—usually one to two years—and is often based on both the company's past claims costs and what they expect to spend on claims in the future.

Administrative expenses are any expenses not related to the cost of medical claims; including, but not limited to, employee salaries and benefits, the cost of the company's office and equipment, customer service, appeals costs, taxes, agent commissions, etc.

The company's projected profit (or contribution to surplus) is a small part of the premium. The reasonableness of the projected profit may depend on the company's current surplus level and other factors.

Federal law requires health insurance companies to have a medical loss ratio (MLR) of at least 80%. This means that your insurance company must spend at least 80% of your premium dollars on medical care and activities that improve the quality of care. If your insurance company spends less than 80% on medical care and quality improvement, then the company must give you money back in the form of a rebate. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar for administrative costs and profits. The Department does not approve rates in this market that appear likely to result in an MLR of less than 80%.

Glossary

Annual rate change: Companies normally file a rate change each year due to their medical claims experience. The annual rate request may or may not include benefit changes.

Average rate change: The average amount rates will change for all enrollees.

For individual health plans: How much your premium will change depends on your age, where you live, how many family members are covered on your plan, whether or not you or your family members smoke and which benefits you choose

For small employer health plans: The employer's premium will vary based on their employees' age, the employer's location, their employee's family size, and the benefits they choose.

Claims/Medical Costs: What the health plan spends on direct medical services including hospital stays, providers, and prescription drugs.

Individual Plans: Insurance you buy from an insurance company for yourself and/or your dependents; not insurance you get from your employer.

Premium: Under federal law, insurance companies can take into account only four factors when varying your rate in order to set the premium costs you will be charged each month. These four factors are:

- Age: Older people can be charged up to 3 times more for premiums than younger people.
- Geographic location: Where you live has a big effect on your premiums. Competition, local regulation, and cost of living in different areas account for this.
- Tobacco Use: Insurers can charge tobacco users up to 50% more than those who don't use tobacco.
- Individual vs. family enrollment: Insurers can charge more for a plan that covers a spouse and/or dependents.

Profit: The amount of money remaining after the company's claims, administrative expenses, and taxes and fees are paid.

Rate: The rate is the base amount that an insurance company charges a person. An insurance company can increase the base rate depending on four factors in order to calculate the monthly premium that a consumer will be charged. See "Premium."

Rating Area: Federal law requires that each state have a set number of geographic areas that all insurance companies may use to adjust how much they charge consumers. When insurance companies calculate premiums, all enrollees within a rating area will have the same adjustment factor applied. Depending on the rating area you live in the prices you pay may be higher or lower than the state average. Pennsylvania has 9 rating areas. (See the Pennsylvania Geographic Rating Area Map below.)

Small Group Plans: Small group plans are those sold to employers with 1-50 employees.

Surplus: An insurer's funds on hand for which the company has no corresponding liabilities. Insurers maintain a surplus so that they have sufficient funds to withstand adverse business conditions such as unexpectedly high medical claims or low enrollment, and in order to make investments in infrastructure and technology.

Pennsylvania Geographic Rating Areas