Highmark Health Insurance Company – Individual Plans

Rate request filing ID # HGHM-130540841 - This document is a consumer tool to help explain the rate filing and decision made by the Insurance Department. It is not intended to describe or include all factors or information considered in our review process. For more information, see the filing at http://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/.

Overview

Requested average rate change:	48.1%
Approved rate change:	55.1%
Effective date:	1/1/2017
People impacted:	20,327 members
Available in:	Rating areas 1, 2, 4, 5, 6, 7, and 9

Key information

Jan. 2015-Dec. 2015 financial experience[1]

Premiums	$180,072,319
Claims	$228,315,314
Administrative expenses	$14,112,700
Company made (before taxes)	**($62,355,695)**

The company expects its annual medical costs to increase 12.5%.

How it plans to spend your premium

This is how the insurance company plans to spend the premium it collects in 2017:

Claims:	90%
Administrative:	8%
Taxes & fees:	2%
Profit:	0%

Explanation of requested rate change

The company provided a summary explanation of its requested rate change, which is available under "View Initial Filing Summary" at http://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/.

Our decision

The company initially requested an average 48.1% rate change in the individual market for enrollees in current 2016 plans that continue coverage with the company in 2017.

For each requested plan, we reviewed the contract to see if the plan included all of the benefits required by state and federal law, if the rates are reasonable in relation to the benefits, and if the company 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 change will have on Pennsylvania consumers.

Earlier this year, United Healthcare and Aetna announced their intent to stop offering individual market coverage on the federal exchange, healthcare.gov, in 2017 in a number of states, including Pennsylvania. Citing concerns over ongoing losses and federal actions that have undermined the stability of the market, additional

[1] The 2015 financial experience includes all 2015 individual market major medical business, on- and off-exchange, for ACA-compliant plans and pre-ACA (grandfathered and transitional) plans. The ACA-compliant plans that are the subject of this rate filing may be a subset of the company's individual market major medical business.

companies notified the Insurance Department that they were considering leaving the exchange, which could have resulted in a number of counties without any insurers offering coverage through the exchange.

Given these difficulties, the Department worked with insurers to make sure they continue to view Pennsylvania as a state in which they want to offer coverage through the exchange. In approving rates for 2017, the Department focused on making sure that Pennsylvanians in every county in the state continue to have access to health plans through the exchange. The subsidies that help many Pennsylvanians pay premiums are only available for plans bought on the exchange, so ensuring that options remain on the exchange is a top priority for the Department.

With this goal in mind, the Department allowed insurers to adjust their rate filings to reflect their emerging 2016 experience and their concerns regarding potentially large influxes of enrollment due to the ongoing volatility in the individual market. HHIC adjusted its filing to increase the amount it expects its annual medical costs (known as medical trend) to increase, from 11.5% to 12.5%, and modified its estimate of morbidity, or how much medical care its enrollees will need, from a 22% decrease over last year to a 16% decrease. We asked the company to remove the 3% it had included for profit/contingency, in accordance with the Departmental surplus order that applies to Blue Cross Blue Shield companies. The final rate increase approved for this company is 55.1%, ranging from 38.4% to 124.1%.[2]

It is the Department's hope that this rate increase represents a one-time correction to previous underpricing, and that in future years insurers will not need rate increases significantly above standard increases in medical costs.

An insurer cannot increase your rates more than once in a calendar year. The change in how much a specific individual or employer pays 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, and due to four factors specific to the individual or employer/employees: geographic location, age, tobacco use, and family size.

[2] This range includes a) rate changes for people in 2016 plans that are continuing in 2017, and b) rate changes for people whose 2016 plans are ending in 2017, and whose company will re-enroll them into new 2017 plans. An example of the later scenario would be a consumer in a 2016 bronze plan who is being re-enrolled ("mapped") into a silver plan in 2017 because the company is no longer offering bronze plans. In this case, the rate change that the consumer experiences is due to both the company's requested increase and the fact that the enrollee is being mapped to a plan with more generous benefits. Consumers are always free to choose any available plan during open enrollment, and do not have to keep the one into which they are mapped.

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 the cost of medical services over a specific period of time and is often based on the company's past experience and how they expect the cost of medical services to change in the future. Morbidity, a measure of the frequency with which illness appears in a population, is another key component used to calculate projected claims.

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