First Priority Health – Individual Plans

Rate request filing ID # HGHM-131020597 - 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.

Overview

Initial requested average rate change:	8.7%
Revised requested average rate change:	13.9%
Range of requested rate change:	10.2% to 18.5%[1]
Effective date:	January 1, 2018
People impacted:	23,251
Available in:	Rating Area 3

Key information

Jan. 2016-Dec. 2016 financial experience

Premiums	N/A
Claims	N/A
Administrative expenses	N/A
Taxes & fees	N/A
Company made (after taxes)	**N/A**

How it plans to spend your premium
This is how the insurance company plans to spend the premium it collects in 2018:

Claims:	87%
Administrative:	7%
Taxes & fees:	6%
Profit:	0%

The company expects its annual medical costs to increase **12.9%**.

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/default.aspx.

[1] This range includes a) rate changes for people in 2017 plans that are continuing in 2018, and b) rate changes for people whose 2017 plans are ending in 2018, and who are being moved into new 2018 plans. An example of the later scenario would be a consumer in a 2017 bronze plan who is being moved ("mapped") into a silver plan in 2018 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.

Our decision

The company initially requested an average 8.7% rate change in the individual market for enrollees in current 2017 plans that continue coverage with the company in 2018. The statewide average rate increase request for individual plans, across all companies, was 8.8%. .

Process and Considerations for the 2018 Plan Year

The Department instructed issuers to file requested rates for 2018 ACA-compliant plans assuming the current federal regulatory framework would continue to be in place for the entirety of the 2018 plan year. Thus, the requested rate increases assumed that the federal government would continue to fully enforce the individual mandate, and cost-sharing reduction (CSR) payments would continue. The individual mandate requires individuals to maintain health insurance or pay a fee with their federal income tax. This incentivizes healthier people to buy health insurance, which reduces costs for everyone. Without the individual mandate, people could just buy insurance when they're sick and the cost of coverage would be much higher than it is today. CSR payments are payments made by the federal government to insurers to reduce out-of-pocket costs, like deductibles and copayments, for low- and middle-income enrollees. If the federal government stops making CSR payments, insurers are still required by federal law to reduce out-of-pocket costs for low- and middle-income enrollees, even though the insurers are not compensated by the federal government for the cost of those reductions.

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.

Although the Department has repeatedly requested assurance from the federal government that CSR payments will continue and the individual mandate will be fully enforced, this was not provided as of the federal deadline by which the state was required to finalize rates. Instead, the Trump administration has threatened to stop CSR payments, drastically cut marketing and outreach that encourages healthy people to enroll in coverage, and repeatedly supported attempts to repeal the individual mandate.

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 2018, the Department focused on making sure that Pennsylvanians in every county in the state continue to have access to health coverage. Ensuring that affordable options remain available to Pennsylvania consumers is a top priority for the Department.

With this goal in mind, the Department allowed insurers to adjust their rate filings to reflect the uncertainty related to CSR funding and enforcement of the individual mandate, and add new appropriately priced off-exchange silver plans to their portfolios. This insurer adjusted its filing to increase premiums for on-exchange silver plans in order to compensate for the potential lack of federal CSR payments. This means that premiums for on-exchange silver plans are increasing more than for other plans. The approximately 80 percent of on-exchange consumers who receive a subsidy will not experience this additional premium increase because their subsidy will

increase as well. Consumers who have an on-exchange silver plan and don't qualify for a subsidy should consider either purchasing an off-exchange silver plan or switching to an on-exchange bronze or gold plan, because these plans will likely have lower rate increases. The Department hopes to alleviate the consumer impact of this rate increase by helping to facilitate enrollment in the most appropriate plan through educational resources available at www.insurance.pa.gov. This insurer also adjusted its filing to reflect the uncertainty related to enforcement of the individual mandate by increasing its estimate of morbidity, or how much medical care its enrollees will need, by an additional 6 percent.

We also asked the company to reduce the initially filed morbidity factor from 1.003 to 1.000 before making the 6% adjustment for the individual mandate. The average final rate increase approved for this company is 13.9%.

The final statewide average rate increase approved by the department would have been 7.6%, 1.2% below the initial average request. However, because of the uncertainty regarding the federal regulatory environment, the final statewide average rate change is now 30.6%. As can be seen, uncertainty at the federal level has increased the statewide average by 23%, from the adjusted 7.6% to 30.6%.

General Note: 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.

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:

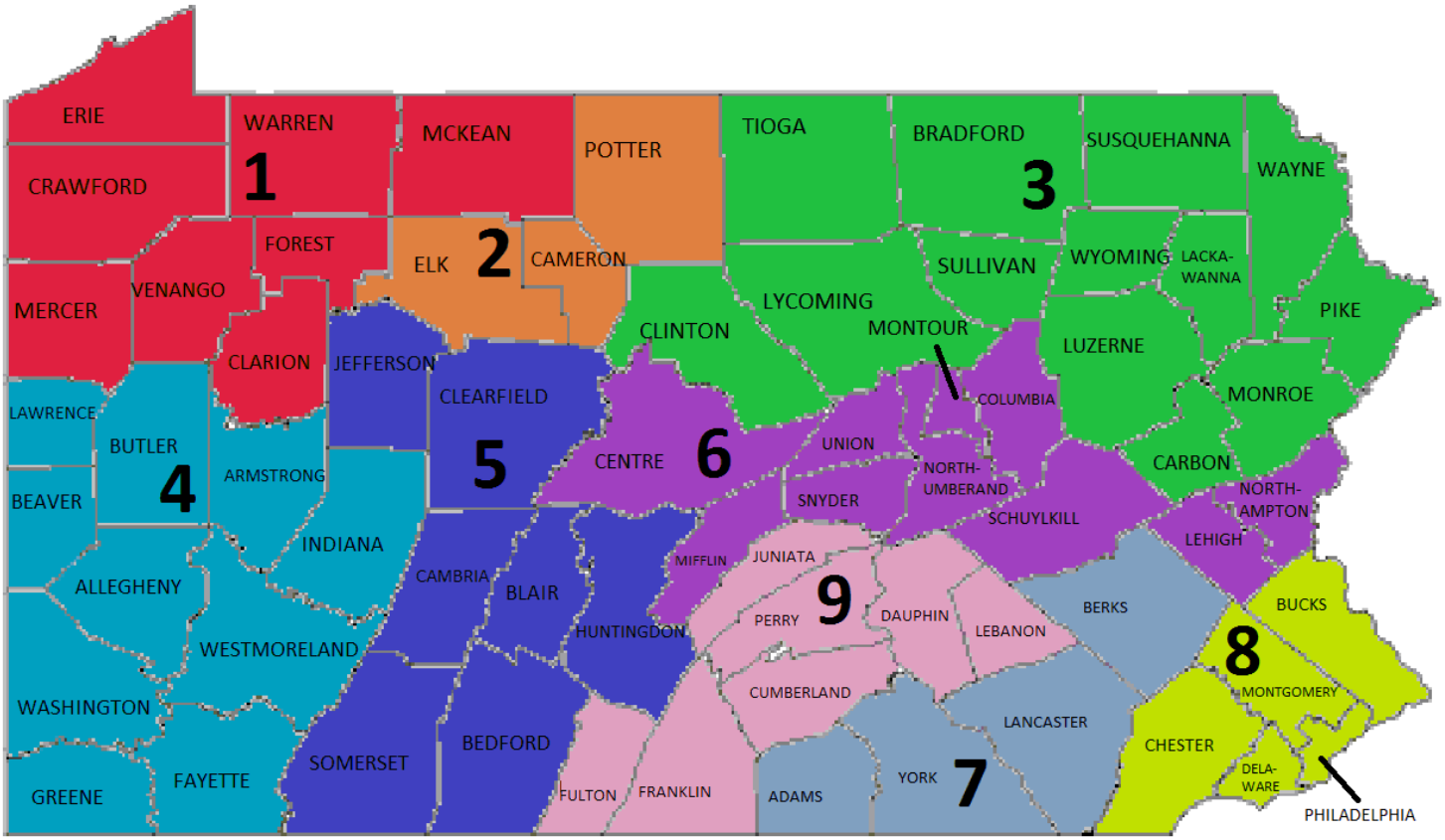
- Age: Older people can be charged up to 3 times more for premiums than younger people.
- Geographic location: Where you live has a big effect on your premiums. Competition, local regulation, and cost of living in different areas account for this.
- Tobacco Use: Insurers can charge tobacco users up to 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