UPMC Health Options, Inc. – Small Group Plans

Rate request filing ID UPMC-130071358- 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/ACARelatedFilings.

Overview

Approved average rate change:	**Not applicable - new products**
Requested average rate change:	Not applicable - new products
Effective date:	Jan. 1, 2016
People impacted:	0 (40,245 in products no longer being offered)[1]
Available in:	Geographic Rating Areas 1, 2, 4, 5 and 6

Key information

Jan. 2014-Dec. 2014 financial experience*

Premiums	$491,976,656
Claims	$485,513,269
Administrative expenses	$39,027,700
Company made (before taxes)	**$-32,564,313**

The company expects its annual medical costs to increase **5.9%**.

How it plans to spend your premium
This is how the insurance company plans to spend the premium it collects in 2016:

Claims:	83.27**%**
Administrative:	9.0**%**
Taxes & fees	7.73%
Profit:	0.0 **%**

Our decision

This company filed new products with us for 2016. Because these products did not exist in 2015, they do not have a rate increase. The enrollment and financial information shown above reflects data for previous products no longer being offered. 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.

After our review of the company's benefit design and the reasonableness of its rates, the Department approved the requested rates. The Department determined that the proposed rates are actuarially sound and justified and no modifications were necessary.

An insurer cannot increase your rates more than once in a 12-month period. 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

[1] This company offered products in the small group market in 2014 and 2015, so the company had financial experience in 2014. However, the company is offering all new products in 2016. Because these products didn't exist in 2015, they don't have a rate change. In addition, no people are yet enrolled in these new products, which is why "people impacted" is listed as zero. However, we note that 40,245 people are enrolled in this company's current 2015 products.

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:

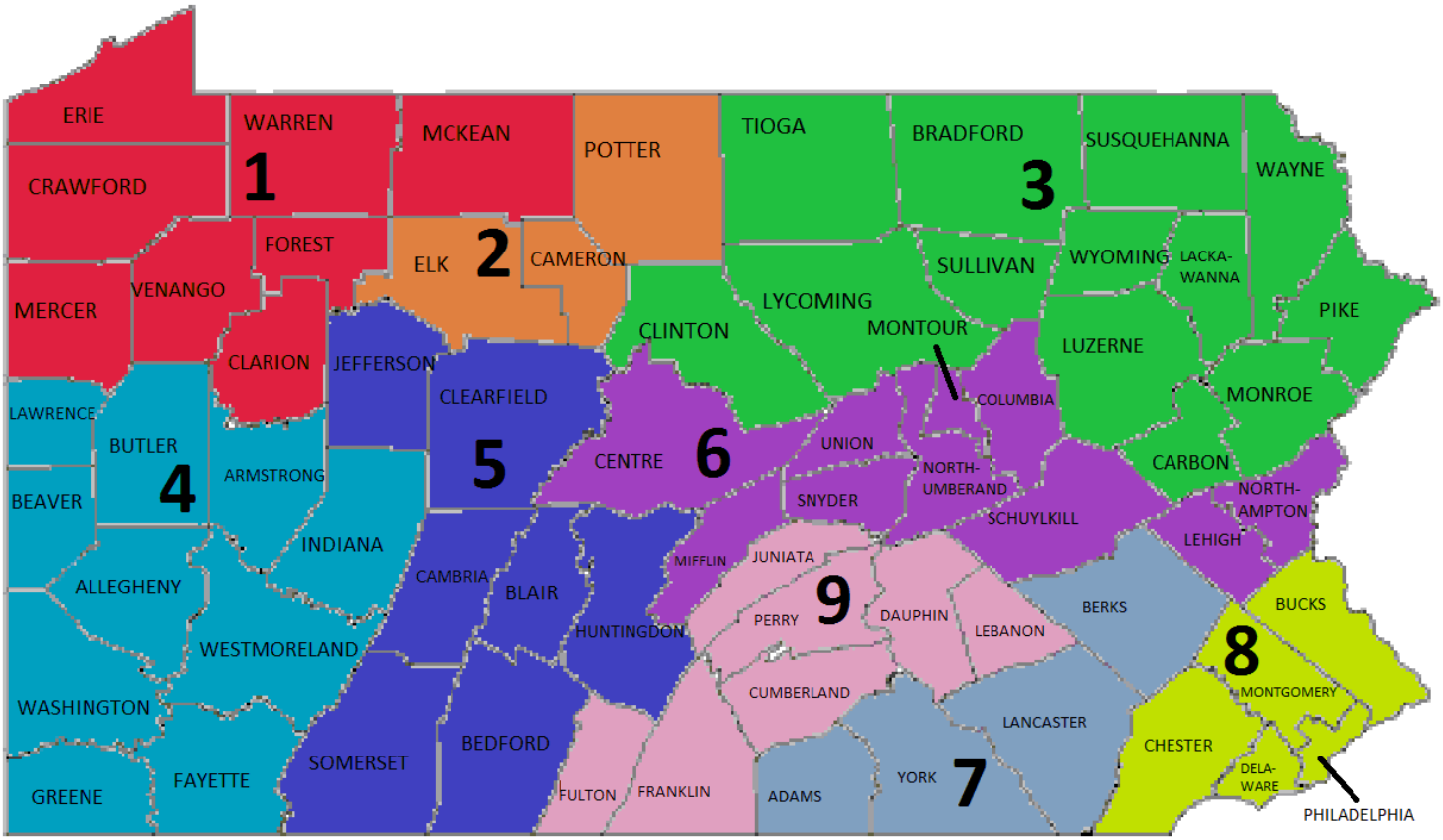
- Age: Older people can be charged up to 3 times more for premiums than younger people.
- Geographic location: Where you live has a big effect on your premiums. Competition, local regulation, and cost of living in different areas account for this.
- Tobacco Use: Insurers can charge tobacco users up to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