Remarks by Alexis Miller
Pennsylvania 2017 Rates Public Information Session
July 27, 2016

- Good morning. My name is Alexis Miller, and I am Senior Vice President of Individual and Small Group Markets, for Highmark Inc.
- Highmark employees, including myself, live and work right here in the communities we serve, and our commitment to Pennsylvanians is something that we take very seriously.
- For more than 75 years, we have focused on offering high-quality, cost-effective products that meet the needs of Pennsylvanians. And we have a long history of providing coverage to the most vulnerable populations in Pennsylvania including through our long-running participation in the CHIP program for children.
- In keeping with our history of providing coverage to the most vulnerable, in 2013 we applied for approval to participate on the individual and small group marketplaces, which were created as part of the Affordable Care Act. We received approval from the Pennsylvania Insurance Department and the Centers for Medicare and Medicaid Services to begin offering ACA products with an effective date of Jan. 1, 2014.
- By the end of 2014 we had ~ 220k Pennsylvanians enrolled in our Individual ACA products. By the end of 2015 that number grew to ~270k.
- Many of these ACA policy holders were previously underinsured or uninsured.
- This made it very difficult for Highmark and other insurers to forecast utilization of health care services for the newly-enrolled, and therefore, to determine where to set premium rates.
- As a result, in 2014, 2015 and to date in 2016 we have paid out more in claims than we have collected in premium.
- Now that we have some level of claims history for our ACA policy holders, we have filed premium rates for 2017 that we feel are necessary to cover the cost of care for ACA policy holders.
- The Pennsylvania Insurance Department has asked us to explain some of the drivers of our requested premium rates for 2017. I will speak generally about these drivers, and then will ask our Actuary, Jeff Scheib, to discuss them in more detail.

- The rising overall cost of healthcare, unanticipated utilization and adverse selection are key factors that are driving premium rates higher.
- Over the last three years, as the ACA has unfolded, little has been done to control rising health care costs – particularly specialty drug costs.
- At the same time ACA policy holders have utilized health care more than we anticipated.
- In fact, a recent study by the Blue Cross Blue Shield Association found that newly-enrolled policy holders in Blue Cross and Blue Shield ACA plans had medical costs that were, on average, 19 percent higher than employer-based group policy holders in 2014 and 22 percent higher in 2015.
- Adverse selection has also driven up premium rates. Adverse selection occurs when a policy holder enrolls in benefits, uses benefits and then discontinues paying for coverage before the end of the year.
- In addition to these factors, the phasing out of government programs that were originally instituted to stabilize premiums has an impact on 2017 premium rates.
- Before I turn it over to Jeff, I want to assure you that at Highmark, we are working to continuously improve the quality and cost effectiveness of health care.
- For example, we have recently implemented robust care management programs designed to manage the unique and complex care needs of our ACA policy holders.
- Because we are committed to improving the health and wellness of the Pennsylvanians that we serve, we are going to continue to work to invest in capabilities and programs to enhance the quality and cost-effectiveness of care.
- Now, I'd like to turn it over to Jeff.

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Remarks by Jeff Scheib
Pennsylvania 2017 Public Rate Hearing
July 27, 2016

- As Alexis said, my name is Jeff Scheib and I am a Vice President in the Actuarial Department at Highmark Inc.
- My team develops the ACA premium rates for Highmark.
- To do this, one of the key things that we look at is past claims experience.
- Specifically, we focus on utilization trends (that's the number of services people are using, such as the number of times per year that they see their primary care physician) and service cost trends (that's the actual cost of each service, such as the cost of an Emergency Room visit).
- We then combine that historical knowledge with a comprehensive review of factors that will likely make the future different than the past. These factors include such developments as a new medical technology that is going to be hitting the market, a new contract with a hospital, or an influx of new policy holders into the market.
- We take all of that information, and use it to develop premium rates that we consider to be actuarially sound. It's important to note that professional and regulatory standards require that rates are not excessive, inadequate or unfairly discriminatory.
- That means that the rates are not too high, but it also means that they aren't too low. It is the actuary's job to determine a reasonable estimate of future claim costs, to ensure the future solvency of our company so that we can pay claims and continue to be here for our policy holders when they need us.
- Across the country, many companies have filed significant rate increases for their 2017 ACA individual health insurance products to align the premiums with the actual cost of insuring their ACA populations. Some companies have even chosen to abandon the ACA marketplace altogether, which is occurring right here in Pennsylvania.
- In our Pennsylvania markets, we have requested an average rate increase of 41.4% for our Individual ACA products and 5.9% for our Small Group ACA products.
- The requested increases will vary for each of our companies and by plan to account for the changes in the value of the benefits of the specific plan.

- The requested increases will vary for each of our companies and by plan to account for the changes in the value of the benefits of the specific plan.

- The single-digit average Small Group increase is a direct result of having established pools where historical experience has been available to develop future projections. Most of those employer groups have provided health coverage for some time, adding to the credibility of the data.

- The Individual ACA rate development is considerably more complicated. While many factors are driving up the cost to insure the Individual ACA population, many insurers are concluding that a key driver is higher-than-anticipated medical costs for newly insured ACA individuals.

- It is highly likely that many of those policy holders were either uninsured or underinsured before the ACA.

- The current health needs of this population are driving greater utilization than anticipated.

- Our data has shown that, on average, people who purchased an Individual ACA plan utilized services more than those who received their coverage through an employer.

- The good news is that people who have been without insurance for some time are getting the services they need to address their health, but now the cost for that level of care needs to be built into the rates going forward.

- In addition to the higher-than-expected utilization by these new ACA policy holders, rates are also driven extreme cases of adverse selection. Adverse selection is basically getting a mix of policy holders that has higher risk than what was expected. This can occur in many ways with health insurance

- For example, there were close to 250 Individual ACA policy holders in PA that incurred over $100,000 each in claims and then cancelled coverage before the end of the year.

- This behavior drives up the cost to insure the entire pool, because people use insurance benefits and then discontinue paying for coverage once their individual health care needs have been temporarily met.

- Insurance does not work if people only buy it when they know that they are going to have a big claim. It's often been compared to buying homeowner's insurance after your house starts burning down. The system obviously can't work that way.

- In addition to utilization, the underlying cost of health care is another factor that continues to drive up premiums.

- While Alexis talked about the new initiatives that we are instituting at Highmark to transform the way health care is delivered and paid for, the underlying cost of providing services continues to go up, forcing health insurance companies to raise rates in order to cover the costs of the services.

- One of the most notable causes of escalating health care costs is the explosion in prescription and specialty drug prices.

- On average, a specialty drug costs about $5,500 per prescription and is becoming a larger proportion of a product's overall pharmacy expenses.

    - According to a 2015 report from Express Scripts, spending on specialty medications increased by more than 20 percent last year.

        - This same study shows that specialty drugs now represent approximately 50 percent of the total spend on prescription medications for ACA business sold on the Exchanges.

    - Hepatitis C drugs have received a lot of attention because the average cost per year is over $70,000, but other examples include new drugs for Pulmonary Fibrosis which are over $90,000 per year, and new drugs for certain cancers that cost over $100,000 per year.

- These examples underscore the most important point in these remarks. That is, the rates that we are requesting reflect what it actually costs to pay claims for these policy holders and administer the products

- To put this in perspective, we are currently paying out more in claims than we receive in premium.

- Our 2017 rates are set using actual claims data for the people that we cover in these ACA programs.

- In order to better understand 2017, it's important to recognize how we got to this point.

- There was no actual ACA experience when we set our rates for 2014 and 2015. Our ACA plans were brand-new products, with prices established far in advance of their effective date, so there was no knowledge of what the policy holder base would look like. The 2016 rates were based on limited data, since only partial claims data was available for a

large portion of the covered lives. For the 2017 rate development, actual claim experience is available for over 80% of the expected population.

- That actual claims data from the ACA marketplace helps us to better understand the health needs of this population, as these enrollees tend to be older and often managing multiple chronic conditions.

- We must price products to reflect the rising cost of providing care to these individuals and families so Highmark can continue to offer financially sustainable plans to all of our customers.

- When the Marketplaces first launched, the government put in place programs to ease the transition to a marketplace where everyone can obtain health insurance, regardless of their medical conditions, including programs to stabilize premiums for consumers.

- These programs are being phased out, and the elimination of the temporary reinsurance program is putting upward pressure on premiums again in 2017

- All of these factors plus changes in benefit designs and administrative costs come together to create the rate increase request for our individual ACA products.

- I also want to point out that consumers have many choices in ACA products, offered by Highmark and by other health insurers in Pennsylvania.

- Based on the information made publicly available by the Department, our proposed 2017 rates will be competitive in the marketplace when compared to other insurers.

- We understand that our requested rate increase is significant. At the same time, it is important to reemphasize that these rates reflect what it actually costs to insure the new ACA population and to administer these products.

- It is also important to note that the ACA contains specific consumer protections to insulate policy holders from rates that are too high. The main protection is based on our Medical Loss Ratio, or MLR.

- MLR is based on the share of each premium dollar that an insurer spends on patient care and quality improvement activities. When an insurer doesn't spend at least 80 cents of each premium dollar on those items in the Individual and Small Group markets, it is required to issue rebates to its policy holders.

- In summary, Highmark's requested rates reflect the expected costs to provide coverage to this population. Our filings were developed in accordance with professional and

regulatory standards and clearly demonstrate that the requested rates are supported by actual experience and reasonable assumptions for 2017.

Thank you for the opportunity to discuss the process we followed to develop the rate filings. I hope this background has been helpful in understanding why the requested rate increases are needed.