Highmark Benefits Group (HBG) – Small Group Plans

Rate request filing ID # HGHM-131937056 – This document is prepared by the insurer 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/Pages/2020-ACA-Health-Rate-Filings.aspx

Overview

Initial requested average rate change:	2.76%
Revised requested average rate change:	2.76%
Range of requested rate change:	-2.31% to 3.95%[1]
Effective date:	January 1, 2020
Mapped members:	12,583
Available in:	Rating Areas 6, 7, and 9

Key Information

Jan. 2018-Dec. 2018 financial experience

Premiums	$47,126,475
Claims	$37,847,140
Administrative expenses	$5,519,713
Taxes & fees	$697,207
Insurer made (after taxes)	**$3,062,415**

How it plans to spend your premium
This is how the insurer plans to spend the premium it collects in 2020:

Claims:	86.8%
Administrative:	10.4%
Taxes & fees:	2.8%
Profit:	0%

The insurer expects its annual medical costs to increase **6.80%**.

Our Decision

The insurer requested an average 2.76% rate change in the small group market for enrollees in current 2019 plans who continue coverage with the insurer in 2020. The statewide average rate increase request across all insurers was originally 9.6% and increased to 9.7%. One of the factors contributing to the rate increase is the reinstitution of the federal Health Insurance Tax which contributed approximately 2 percentage points to the rate increase.

For each requested plan, we 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

[1] This range includes a) rate changes for people in 2019 plans that are continuing in 2020, and b) rate changes for people whose 2019 plans are ending in 2020 and who are being moved into new 2020 plans. An example of the latter scenario would be a consumer in a 2019 bronze plan who is being moved ("mapped") into a silver plan in 2020 because the insurer is no longer offering bronze plans. In this case, the rate change that the consumer experiences is due to both the insurer'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 plan into which they are mapped.

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 change will have on Pennsylvania consumers.

The Department notes that the 2020 rates have increased by an average of 9.7% compared to the 2.6% average increase approved in 2019. Insurers have cited the following as key drivers of rate increases in addition to the reinstitution of the federal Health Insurance Tax as indicated above:

- Increased hospital, physician and prescription drug costs;
- Increased subscriber usage;
- Changes in anticipated risk adjustment amounts (money from a federal program that redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees);
- Increased administrative expenses;
- Uncertainty of the impact non-ACA coverage options may have on the ACA single risk pool; and
- The base experience claims were more adverse than expected.

Insurers particularly highlighted the impact of non-ACA compliant coverage options, including a movement of small groups towards options that allow them to self-fund their health insurance needs. Cognizant of the impact these rate changes have on the Commonwealth's small businesses, the Department will continue to monitor these trends to determine if regulatory or policy changes may be necessary to ensure the ongoing affordability of health insurance for small businesses.

After our review of the insurer's benefit design and the reasonableness of its rates, the Department approved the requested rate change. 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 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 insurer'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 insurer's office and equipment, customer service, appeals costs, taxes, agent commissions, etc.

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

Federal law requires health insurers to have a medical loss ratio (MLR) of at least 80%. This means that your insurer must spend at least 80% of your premium dollars on medical care and activities that improve the quality of care. If your insurer spends less than 80% on medical care and quality improvement, then the insurer 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: Insurers 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' ages, the employer's location, their employees' family sizes, 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 insurer for yourself and/or your dependents; not insurance you get from your employer.

Premium: Under federal law, insurers 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 do not 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 insurer's claims, administrative expenses, and taxes and fees are paid.

Rate: The rate is the base amount that an insurer charges a person. An insurer 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 insurers may use to adjust how much they charge consumers. When insurers 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 insurer 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