Oscar Health Plan of Pennsylvania, Inc. – Individual Plans

Rate request filing ID # OHIN-131948291 - 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:	N/A
Revised requested average rate change:	N/A
Range of requested rate change:	N/A
Effective date:	January 1, 2020
Mapped members:	N/A
Available in:	Rating Area 8

Key Information

Jan. 2018-Dec. 2018 financial experience

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

The insurer expects its annual medical costs to increase **N/A**.

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

Claims:	88.2%
Administrative:	8.5%
Taxes & fees:	3.3%
Profit:	0.0%

Our Decision

This is a new filing with no enrollment in the individual market. Hence there is no rate change. The statewide average rate increase request across all insurers was originally 4.9% and was reduced to 4.0%. 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.

Process and Considerations for the 2020 Plan Year

Consistent with plan year 2019, the Department instructed insurers to file requested rates for 2020 Affordable Care Act (ACA)-compliant plans assuming the individual mandate would not be enforced, and the federal government would not make Cost-Sharing Reduction (CSR) payments. The requested changes assumed a 6% morbidity load to reflect that healthier people may not renew ACA coverage in the individual market as well as other expected market changes proposed by the federal administration.

The individual mandate required individuals to maintain health insurance or pay a fee with their federal income tax. This created an incentive for healthier people to buy health insurance, which reduced costs for everyone. Due to changes made by the federal government, the federal tax penalty for not being enrolled in health insurance was reduced to $0 starting in 2019. The lack of an incentive for people to

buy health insurance may cause healthier individuals to forgo insurance, resulting in premiums being higher than they have been previously.

Additionally, a 20% load for CSR defunding was applied to on-exchange silver plans. Cost-Sharing Reductions apply to certain out-of-pocket costs, like deductibles and copayments, for low- and middle-income enrollees. Although the federal government has stopped making CSR payments, insurers are still required by federal law to reduce out-of-pocket costs for low- and middle-income enrollees.

The impact of market changes remains and therefore the Department continued to allow insurers to include appropriate adjustments to rates. Insurers offering on-exchange silver plans adjusted premiums for those plans in order to compensate for the ending of federal CSR payments. This means that premiums for on-exchange silver plans are greater than the premiums for off-exchange silver plans. Many on-exchange consumers who receive the Advanced Premium Tax Credit (APTC) will not experience the full effect of the premium increase because this subsidy will increase as well. Consumers who have an on-exchange silver plan and do not qualify for a subsidy may want to consider purchasing an off-exchange silver plan or switching to an on-exchange bronze plan, because these plans will likely have lower premiums.

Examples of other changes impacting rates include the expansion of access to short-term limited duration plans and association health plans offered outside of the ACA markets. Both of these types of plans may provide less expensive coverage options that may not necessarily offer the full patient protections and benefits assured under the ACA. These policies could destabilize the ACA risk pool by enticing healthier risks into lower-cost substandard coverage while leaving consumers who require more comprehensive health care in the ACA risk pool.

For each requested plan, the Department 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 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 2020 change will have on Pennsylvania consumers.

In approving rates for 2020, the Department focused on making sure that Pennsylvanians in every county in the state continue to have access to health care coverage. In 2020, the number of counties with just one health insurer offering coverage in the individual market has decreased from 2019. Ensuring that affordable options remain available to Pennsylvania consumers is a top priority for the Department.

Finally, the Insurance Department will launch an outreach and marketing campaign during the 2020 open enrollment season. The Department continues to facilitate enrollment in the most appropriate plan through educational resources available at www.insurance.pa.gov.

General Note: An insurer may not increase your rates more than once in a calendar year. The change in premium for a specific individual or employer 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, as well as 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 insurers 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' 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 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