Part III Actuarial Memorandum

Highmark BCBSD Inc.

d/b/a Highmark Blue Cross Blue Shield Delaware

Individual Rate Filing

Effective January 1, 2027

TABLE OF CONTENTS

I.	General Information	2
II.	Proposed Rate Changes	3
III.	Experience and Current Period Premium, Claims, and Enrollment	3
IV.	Benefit Categories	4
V.	Projection Factors	5
VI.	Manual Rate Adjustments	6
VII.	Credibility of Experience	6
VIII.	Index Rate	6
IX.	Market Adjusted Index Rate [MAIR]	7
X.	Plan Adjusted Index Rates [PAIR]	8
XI.	Calibration	10
XII.	Projected Loss Ratio	10
XIII.	AV Metal Values	10
XIV.	Membership Projections	11
XV.	Terminated Plans and Products	11
XVI.	Plan Type	11
XVII.	Actuarial Certification	12
XVIII.	Exhibit I	13

I. General Information

Document Overview

This rate filing has been modified from the filing submitted on June 15, 2026 pursuant to the Delaware Department of Insurance's review. Please see the revised state actuarial memorandum dated August 14, 2026 for further details on the specific changes.

This document contains the Part III Actuarial Memorandum for Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware's ("Highmark DE", "Company") individual block of business rate filing, for products with an effective date of January 1, 2027. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of Delaware Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Highmark DE's rate filing. However, we recognize that this certification may become a public document. Highmark DE makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum that would result in the creation of any duty or liability under any theory of law by Highmark DE.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

I.1 Company Identifying Information:

- Company Legal Name: Highmark BCBSD Inc.
- State: The State of Delaware has regulatory authority over these policies.
- HIOS Issuer ID: 76168
- Market: Individual
- Effective Date: January 1, 2027

I.2 Company Contact Information:

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

II. Proposed Rate Changes

For all rate changes by plan, see the 'Cumulative Rate Change % (over 12 mos prior)' found in Worksheet 2, line 1.11 of the URRT. The rate change varies by plan due to an update in several of our pricing factors, changes in cost sharing required to meet Actuarial Value, and other cost sharing restrictions under the Affordable Care Act as well as mappings between discontinued and new plans.

The rate increase is primarily influenced by changes in base period claims data, evolving cost and usage patterns, updated reinsurance parameters, considerations related to regulations and the market, and the expiration of enhanced premium tax credits. This rate filing accounts for a State of Delaware health insurance tax/assessment on Highmark Delaware, pursuant to 18 Del. C. § 8703, to fund the Delaware Health Insurance Individual Market Stabilization Reinsurance Program ("Reinsurance Program") in Plan Year 2027. This rate filing also accounts for the Reinsurance Program operating in the Individual Market in 2027 pursuant to a waiver of certain provisions of the Affordable Care Act for the State of Delaware, as authorized by section 1332 of that Act and approved by the Centers for Medicare and Medicaid Services and the United States Department of Treasury.

Modifications to the rate development may be necessary if significant unforeseen events occur. Significant unknown outcomes that are under discussion at the federal level include restoration of enhanced premium subsidies, and modifications of Cost Share Reductions methodology. Some additional examples include, but are not limited to, other changes in legislation/regulations (including rules, regulatory guidance, etc.), material provider contracting changes, or changes in the participation of QHP issuers that would materially impact risk adjustment transfer amounts. As a result, Highmark DE reserves the right to submit a revised filing.

III. Experience and Current Period Premium, Claims, and Enrollment

III.1 Paid through Date:

Experience Period claims were based on incurred Calendar Year 2025, paid through February 2026. This includes 2025 experience in Affordable Care Act compliant plans. Highmark DE did not offer any transitional plans in 2025.

The experience period premium amount reflects the amount of premium dollars earned during the experience period and does not include any MLR rebates.

III.2 Current Date:

The current date shown represents a snapshot of February 1, 2026.

III.3 Allowed and Paid Claims Incurred During the Experience Period:

- Historical Experience: We chose Highmark DE's current experience for the individual block of business for the period January 1, 2025 through December 31, 2025, with claims paid through February 2026 as the basis for the 2027 projected individual market pricing.

- Claims Incurred During the 12-month Experience Period: Worksheet 1, Section I shows our best estimate of the amount of claims that were incurred during the 12-month experience period for Highmark DE's individual book-of-business. This section includes:

    - The amount of claims which were processed through the Company's claims system,

    - Claims processed outside of the Company's claims system, and

    - Our best estimate of claims incurred but not paid as of the paid through date stated above.

- Method for Determining Allowed Claims: For non-capitated claims, the allowed charges are summarized from Highmark DE's detailed claim-level historical data. This experience includes 2025 claims for Affordable Care Act compliant business. For capitated and other off-system claims, historical capitations and experience were tabulated and added to the claims.

- Paid Claims: We also summarized the paid claims from detailed member records. The paid-to-allowed ratio for the experience period reflects the 2025 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: Highmark DE is using a completion factor of [redacted] to include IBNR medical claims in allowed charges. The Company is using a completion factor of [redacted] to include IBNR pharmacy claims in allowed charges. The IBNR completion factors were developed using our corporate reserving system for the Company's individual business. We applied them equally to both paid and allowed total claims (as a change to utilization) to complete the experience.

IV. Benefit Categories

The index rate of the experience period was summarized at the defined benefit categories included in Worksheet 1, Section II of the URRT.

The data provided in this section closely adheres to the preferred definitions of the Benefit Categories included in the URRT instructions, including the "Other Medical" category. The "Other Medical" category units reflect visits for PDN/home health, trips for ambulance and

procedures for DME/prosthetics. Prescription drug utilization was converted to a “per 30-day” script count.

V. Projection Factors

V.1 Trend Factors

The development of the CY2027 rates reflects an annual trend rate of [redacted], which consist of [redacted] for unit cost changes and [redacted] for utilization. These trends reflect Highmark DE’s expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and adjust for some of the more explainable variables such as high dollar claims, work days, provider contracting, demographics, and seasonality.

The trend represents a blended average for all types of service and is applied to the aggregate experience for pricing. These trends represent assumed community-wide expectations. Claim variations due to the specific projected enrolled population in this single risk pool are reflected in the morbidity adjustment.

V.2 Changes in the Morbidity of the Population Insured

The Morbidity Adjustment of [redacted] is comprised of the following: the morbidity impact from claims experience, out-of-network benefit changes on the PPO plan designs, and membership movement driven by expiration of enhanced premium subsidies. Each of the components is described in more detail below.

Morbidity Impact from Claims Experience

This adjustment of [redacted] reflects the change in the population mix/claim levels from the experience period to the projection period. We continue to observe a high degree of membership churn from year-to-year, which impacts the morbidity. For Plan Year 2026, the shift is driven by members who have migrated to plans with lower actuarial values reducing the incentive for utilization. This factor also takes into consideration the effects of adverse selection inherent to guaranteed issue markets.

Out-of-network PPO Change Impact

[redacted]

Morbidity Impact from Market Dynamics and Population Shifts

This adjustment of [redacted] reflects the anticipated morbidity impact resulting from significant changes in market dynamics and population shifts beyond standard population mix impacts. This factor specifically incorporates changes due to the expiration of the enhanced federal premium subsidies implemented by the American Rescue Plan Act (ARPA), the impact of the Inflation Reduction Act (IRA), and the execution of the One Big Beautiful Bill Act (OBBBA).

Per *Cost Concerns and Coverage Changes: A Follow-Up Survey of ACA Marketplace Enrollees* (Lopes et al., Kaiser Family Foundation, 2026), there is anticipation of a "long tail" impact on enrollment and the risk pool into Year 2 due to the expiration of the enhanced federal premium subsidy rather than the impact limited to one year. There is additional risk due to federal regulatory uncertainty such as federal eligibility changes for lawfully present enrollees.

V.3 Changes in Demographics

We project that the average rating factor (age, tobacco load and area combined) will increase by about [redacted] due to the change in the population. This is primarily due to the expectation that the new members from the group and/or uninsured populations will be older than the population in the underlying experience. This increases the projected allowed claims (utilization) by the same amount.

V.4 Changes in Benefits

There is no change in benefits related to the essential health benefit (EHB) categories so the factor is set to [redacted]. The cost sharing changes for the EHBs are captured in the paid to allowed ratio factors discussed in the AV and Cost Sharing Design of Plan section X.1.

V.5 Changes in Other

The [redacted] factor represents the combined impact of induced demand, pharmacy rebates, claim add-ons, and any state/federal mandates.

VI. Manual Rate Adjustments

Highmark DE's individual experience is fully credible. No manual rate is developed or used in this projection.

VII. Credibility of Experience

The experience is from Highmark DE's individual book of business in 2025. It is large enough to be fully credible. Our results are based [redacted] on the experience rate, as adjusted.

VIII. Index Rate

The Index Rates as shown on Worksheet 1 of the URRT are simply the single risk pool average allowed claims for the Essential Health Benefits for the experience and projected populations, respectively, for Highmark DE. For the experience period, only non-grandfathered plans are

included. The projection period Index Rate is not adjusted for reinsurance or risk adjustment programs or any other fee.

IX. Market Adjusted Index Rate [MAIR]

The Market Adjusted Index Rate is the Projected Index Rate further adjusted for reinsurance, risk adjustment, and the exchange fee.

IX.1 Projected Reinsurance PMPM

Based on the guidance provided by the State of Delaware, the State is anticipating the reinsurance program will have the following parameters for 2027:

- Attachment point of $62,000, a coinsurance rate of 35%, and a cap of $340,000.

The reinsurance PMPM in Worksheet 1, section II of the URRT was derived by converting the estimated reinsurance claims savings of [redacted] to an equivalent allowed claims savings PMPM.

IX.2 Projected Risk Adjustments PMPM:

[redacted]

IX.3 Exchange User Fee %

The [redacted] value shown in Worksheet 1 of the URRT is developed by multiplying the [redacted] exchange user fee by the assumed percentage of on-exchange membership. This calculated amount is then divided by the paid-to-allowed factor to bring it to an equivalent allowed claims basis and adjusted further for the composite effect of catastrophic eligibility and benefits in addition to EHB.

X. Plan Adjusted Index Rates [PAIR]

The Plan Adjusted Index Rates can be found on line 3.11, Worksheet 2 of the URRT. The PAIR rates are calculated by applying the allowable rating factors as described below to the Market Adjusted Index Rate.

X.1 AV and Cost Sharing Design of Plan

The AV and cost sharing allowable rating factor is comprised of the following components:

- The utilization due to differences in cost sharing is based on anticipated utilization differences between plans primarily driven by metal levels. No differences due to health status are in these adjustments.

- The pricing AV for the benefits and cost sharing of the plan and a CSR load for the on-exchange Silver plans.

Impact of Non-Payment of Cost Sharing Reduction Subsidies

We have applied an additional adjustment to our AV pricing values for those Silver plans not offered exclusively off-exchange. This adjustment factor was [redacted] and represents the non-payment of Cost Sharing Reduction subsidies.

In accordance with the May 2, 2025 CMS bulletin notice and the May 27, 2025 CMS FAQ, the Company estimated the CSRs paid for enrollees in Plan Year 2025 to be [redacted]. A modified version of the example method released in the CMS FAQ related to comparing EHB paid-to-allowed ratios was used since the actual CSRs paid cannot be quantified in the limited timeframe provided. The Company compared EHB paid-to-allowed ratios between each CSR plan variant to the standard plan and applied the differential to the actual EHB allowed claims in that variant. The Company relied on credible experience paid-to-allowed ratios for the CSR 87 and CSR 94 plan variants, and a blend of historical Pricing AVs with HHS-calculated AV for the standard plan, because its experience was not credible.

The same methodology was used to estimate CSR payments and recoveries for the projection year. In Plan Year 2027, the Company expects to collect [redacted] in additional revenue due to the CSR load factor. We also expect to pay out [redacted] on behalf of eligible enrollees. The projection of CSR payments was based on the same methodology that was used to estimate 2025 payments. The projection was adjusted for the expected mix shift in population between the silver variants from 2025 to 2027. These percentages were then applied to 2027 projected

claims to determine the projected CSR payments. [redacted]

X.2 Provider Network Adjustment

The provider network adjustments are developed by dividing the plan level network factor by the overall weighted average from all plans.

X.3 Benefits in Addition to EHB

Non-EHB benefits are offered in several plans. Eight plans have adult dental and vision benefits, one plan has an adult vision exam benefit, and eight plans have a hearing benefit.

Additionally, $1 per enrollee per month (PEPM) is added for non-Hyde abortion services in accordance with 45 CFR § 156.280. [redacted]

X.4 Administrative Expense

The proposed rates reflect internal administrative costs including quality improvement administrative expenses. This cost was developed based on standard expense allocation methods.

X.5 Taxes and Fees:

The following fees were added:

- [redacted] PMPM for the Risk Adjustment User Fee
- [redacted] PMPM for the Patient-Centered Outcomes Research Institute (PCORI) Fee
- [redacted] for the Health Insurance Provider Fee
- [redacted] for State Premium Tax and Reinsurance Program Fee

X.6 Profit (or Contribution to Surplus) & Risk Margin:

The proposed rates reflect a [redacted] contribution to surplus margin for all products and plans.

X.7 Catastrophic Adjustment

For catastrophic plans, we use a [redacted] factor for the specific eligibility adjustment.

XI. Calibration

XI.1 Age Curve Calibration:

The projected weighted average age factor for billable members is [redacted]. This factor is calculated by dividing the age factor for all members of [redacted] by the ratio of billable members to total members [redacted]. The age curve calibration factor is [redacted] = [redacted].

XI.2 Geographic Calibration Factor:

The projected weighted average geographic factor is [redacted]. Each Plan Adjusted Index Rate represents the rate for an average member with a geographic factor of [redacted]. The geographic calibration factor is [redacted] = [redacted].

XI.3 Tobacco Calibration Factor:

The projected weighted average tobacco factor is [redacted]. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of [redacted]. The tobacco calibration factor is [redacted] = [redacted].

XI.4 Consumer Adjusted Premium Rate Developments:

The calibrated plan adjusted index rate represents the base rate for an age factor of [redacted], geographic rating factor of [redacted] and tobacco rating factor of [redacted]. Thus, the approximate premium for a specific member can be derived by multiplying this rate by the HHS age curve factor, the rating area factor on Worksheet 3 of the URRT, and the appropriate tobacco factor. Please note that this method will only produce approximate rates due to URRT rounding constraints.

XII. Projected Loss Ratio

The projected loss ratio for 2027 using the federally prescribed MLR methodology is [redacted].

XIII. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. Some plans did require an adjustment to the inputs entered into the AV calculator. Screenshots and certifications for these plans were submitted as part of Highmark DE's QHP application. When applicable and per CMS's guidance, a dummy AV Metal Value was applied to any terminated plans that fell out of the new de minimis range.

XIV. Membership Projections

Membership projections reflect Highmark DE's expectations for 2027. These projections reflect expected changes in market share due to market competition, relative price levels, the impact of the expiration of the enhanced advanced premium tax credits, and changes in plan offerings (where applicable).

Highmark DE expects membership in 2027 to follow a similar metal level distribution as the 2026 Individual ACA enrollment distribution.

For the Silver level plans, the projected membership by cost sharing subsidy levels is based on the observed distribution of ACA members that were eligible under the federal poverty levels as determined by the federal health insurance exchange. The projected enrollment by plan and subsidy level is as follows:

CSR Silver Plan Membership Distribution			
FPL	**Subsidy Level**	**% of Silver Membership**	**% of Total Membership**
<150%	94.0%	[redacted]	
150%-200%	87.0%		
200%-250%	73.0%		
>250%	70.0%		
Total			

XV. Terminated Plans and Products

Plans in the 2025 experience period that will no longer be available in 2027 can be found in Exhibit I.

Highmark DE had one plan that was offered only in 2026 (not offered in the experience period or in the projection period). This plan is shown in Exhibit I.

XVI. Plan Type

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe Highmark DE's plans adequately.

XVII. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. All statements in this actuarial certification are accurate to the best of my knowledge and understanding. This filing is prepared in compliance with applicable Actuarial Standards of Practice. In completing this filing, I relied on data/information from other sources which were reviewed for reasonableness. This filing is prepared to accompany Highmark DE's rate filing for the individual combined market on and off the Delaware Exchange.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. If any adjustments were required outside of the AV Calculator, appropriate certification has been provided to CMS through the QHP application process.

I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

The Part I Unified Rate Review Template does not demonstrate the process used by Highmark DE to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed: [redacted]

Title: [redacted]

Date: August 14, 2026

XVIII. Exhibit I

Highmark Blue Cross Blue Shield Delaware

Terminated Experience Period Plans

[redacted]

Terminated Plans Offered in 2026 Only

[redacted]