

**Part III Actuarial Memorandum**  
**Highmark Benefits Group**  
**Individual Rate Filing**  
**Effective January 1, 2024**

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# **I. General Information**

## **Document Overview**

This document contains the Part III Actuarial Memorandum for Highmark Benefits Group’s (HBG) individual block of business rate filing, for products with an effective date of January 1, 2024. 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 Pennsylvania Insurance Department (“Department”), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of HBG’s rate filing. However, we recognize that this certification may become a public document. HBG 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 HBG.

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 Benefits Group
- State: The Commonwealth of Pennsylvania has regulatory authority over these policies.
- HIOS Issuer ID: 79962
- Market: Individual
- Effective Date: January 1, 2024

### **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 increases by plan, see the ‘Cumulative Rate Change % (over 12 mos prior)’ found in Worksheet 2, line 1.11 of the URRT. The rate increase varies by plan due to an update in several of our pricing factors and changes in cost sharing required to meet Actuarial Value and other cost sharing restrictions under the Affordable Care Act.

The primary drivers of the rate increase are cost and utilization trend.

In accordance with the Department’s updated recent rate filing guidance, the impact of the state 1332 Reinsurance program is captured using the prescribed parameters of \$60,000 attachment point, 50% coinsurance rate, and \$100,000 reinsurance cap. If the finalized parameters differ from those described in this filing, a revised submission would be required.

Other assumptions in the filing account for the ongoing impact of COVID-19 and the lack of Federal CSR funding. Finally, modifications to the rate development may be necessary if significant unforeseen events occur. Examples include, but are not limited to, changes in legislation/regulations (including rules, regulatory guidance, etc.), changes in the participation of QHP issuers that would materially impact risk adjustment transfer amounts, Medicaid redetermination policy impacts, or material developments COVID-19. As a result, HBG 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 2022, paid through February 2023. This includes 2022 experience in Affordable Care Act compliant plans. HBG did not offer any transitional plans in 2022.

### **III.2 Current Date:**

The current date shown represents a snapshot of February 1, 2023.

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

- Historical Experience: We chose HBG’s current experience for the individual block of business for the period January 1, 2022 through December 31, 2022, with claims paid through February, 2023 as the basis for the 2024 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 HBG’s individual book-of-business. This section includes:
  - The amount of claims which were processed through 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 The Company's detailed claim-level historical data. This experience includes 2022 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 2022 plan designs chosen by each member.
  - **Incurred but Not Paid (IBNR) Claims Estimate:** The Company is using a completion factor of 0.9688 to include IBNR claims in allowed charges. The IBNR completion factor was developed using our corporate reserving system for The Company's individual business. We applied it 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 drugs utilization were converted to a "per 30-day" script count.

## V. Projection Factors

### V.1 Trend Factors

This development of the CY2024 rates reflects an annual trend rate of 12.00% (5.0% cost, 6.7% utilization). These trends reflect HBG's expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and normalize 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 Change in Morbidity adjustment of 0.971 is comprised of the following: the morbidity impact from claims experience and an adjustment to account for the impact of Covid-19. In accordance with the Department's guidance, the morbidity change related to the Reinsurance program is set to 1.000. Each of the components is described in more detail below.

#### The Morbidity Impact from Claims Experience

This adjustment 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. This factor also takes into consideration the effects of adverse selection inherent to guaranteed issue markets. The Individual ACA risk pool continues to have a significantly higher proportion of older members with a high prevalence of chronic conditions compared to group business, which adds to the uncertainty of any future claim projections.

#### Covid-19 Impact

In order to account for the impact of COVID-19 on projected claim costs, the Company took the following steps:

1. Adjusted the claims in the base experience period to a non-COVID-19 baseline. This was done to stabilize the base from which claims are being projected. The base period adjustment accounts for the impacts of testing, treatment, vaccines, capacity constraints, and deferred/rescheduled/induced care. Claims in the base experience period were increased by a factor of 1.002 to remove the impact of COVID-19.
2. Projected claims to the projection period using trends with the impact of COVID-19 excluded. Again, this provides for a more stable projection of future claims, before applying the anticipated impact of COVID-19 in the projection period. This was

accomplished by applying a trend of 12.00% (which excludes any impact from COVID-19) to our adjusted BEP claims.

3. The projected claims were then further adjusted by applying the anticipated impacts of COVID costs expected in the projection period. The following components were accounted for:
  - a. COVID Testing (0.7% medical claims impact) – Proportional to new cases, which are assumed to diminish over time and be lower in the projection period than in previous years.
  - b. Vaccines (0.1% medical and 1.4% drug claims impact) – The federal public health emergency ended on May 11, 2023, resulting in a shift in costs for the COVID-19 vaccine to the private market. Since COVID-19 vaccines will remain free as long as federally purchased supply is available, we expect costs to increase over time, starting at the end of 2023 and grading upward through 2025. Due to a decline in demand, we also assumed utilization will decrease through 2024.
  - c. Actuarial Judgement (-0.4% claims impact) – The Company reviewed the composite CY2024 COVID impact resulting from the components outlined above and elected to temper the adjustment in light of the inherent unpredictability of these estimates.

The application of the above COVID claim adjustments to the rating period results in a COVID adjustment factor of 1.007.

### **V.3 Changes in Demographics**

We project that the average rating factor (age, tobacco load and area combined) will increase by about 1.7% 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 to be slightly 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 1.0. 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 0.987 factor represents the combined impact of changes in network, induced demand, pharmacy rebates, hospital/physician settlements, and state mandates/laws (when applicable).

## **VI. Manual Rate Adjustments**

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

## **VII. Credibility of Experience**

The experience is from HBG's individual book of business in 2022. It is large enough to be fully credible. Our results are based 100% 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 HBG. 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 risk adjustment and the exchange fee.

### **IX.1 Projected Reinsurance PMPM**

In accordance with the Department's updated recent rate filing guidance, the impact of the state 1332 Reinsurance Program is captured using the following parameters for 2024: an attachment point of \$60,000, a coinsurance rate of 50%, and a cap of \$100,000. HBG estimated the impact of the reinsurance program under these tentative parameters by trending Highmark PA individual ACA CY2022 incurred claims by member to the CY2024 rating period, applying the parameters, and calculating the amount of incurred claims expected to be reimbursed by the program. The modeling produced an estimated incurred claims savings of 4.5%. This percentage was converted to a PMPM and adjusted to an equivalent allowed claim basis by dividing the PMPM by the paid-to-allowed factor and the composite effect of catastrophic eligibility. This amount is reflected in worksheet 1 of the URRT.

### **IX.2 Projected Risk Adjustment PMPM:**

The estimated average risk score for HBG's projected 2024 population was developed by using HBG's 2022 claim diagnoses and the risk adjustment coefficients as finalized in the Notice of Benefit and Payment Parameters. Similarly, actuarial value factors and induced demand factors were estimated for HBG based upon its projected 2024 population.

We estimated the statewide average risk transfer factors based on current market assumptions. We estimated the statewide average premium using current market premium assumptions with adjustments for anticipated rate changes for 2024.



The actual calculation of the risk transfer followed the risk transfer methodology as prescribed.

The analysis resulted in HBG paying to the risk adjustment pool. The (\$30.91) PMPM value shown in worksheet 1 of the URRT is developed by taking the expected risk transfer amount plus the projected High Cost Risk Pool charge and adjusting it to an equivalent allowed claims basis by dividing it by the paid-to-allowed factor and the composite effect of catastrophic eligibility and benefits in addition to EHB.

For the purposes of this rate filing, HBG has assumed no adjustment to the projected risk adjustment transfer for the Risk Adjustment Data Validation (RADV) program.

### **IX.3 Exchange User Fee %**

The 2.92% value shown in worksheet 1 of the URRT is developed by multiplying the 3% 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 3.10, 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 the factors calculated using a methodology prescribed in the Department's guidance relative to the weighted average. 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**

In accordance with the Department's guidance, we have applied an additional adjustment to our AV pricing values for those Silver plans not offered exclusively off-exchange. This adjustment factor was 1.23 and represents the non-payment of Cost Sharing Reduction subsidies.

### **X.2 Provider Network Adjustment**

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

### **X.3 Benefits in Addition to EHB**

Non-EHB benefits have been added to several plans. Ten plans have an adult dental and vision benefit and eight plans have a hearing and an OTC benefit.

### **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:

- \$0.21 PMPM for Risk Transfer User Fee
- \$0.29 PMPM for Patient Centered Outcomes Research Institute (PCORI) Fee
- 0.0% for the Health Insurance Provider Fee
- 0.0% for the PA Premium Tax

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

HBG has voluntarily refrained from including a risk and contingency factor in this filing. By this voluntary restraint, HBG is not waiving any right to include a risk and contingency factor which HBG believes is consistent with historical and legal interpretations of HBG and the Pennsylvania Insurance Department.

### **X.7 Catastrophic Adjustment**

For catastrophic plans, we use a 0.92 factor for the specific eligibility adjustment.

## **XI. Calibration**

### **XI.1 Age Curve Calibration:**

The projected weighted average age factor for billable members is 1.935. This factor is calculated by dividing the all members age factor of 1.933 by the ratio of billable members to total members 0.9992. The age curve calibration factor is  $1/1.935 = 0.5168$ .

### **XI.2 Geographic Calibration Factor:**

The projected weighted average geographic factor is 1.000. Each Plan Adjusted Index Rate represents the rate for an average member with a geographic factor of 1.000. The geographic calibration factor is  $1/1.000 = 1.000$ .

### **XI.3 Tobacco Calibration Factor:**

The projected weighted average tobacco factor is 1.008. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of 1.008. The tobacco calibration factor is  $1/1.008 = 0.9920$ .

#### **XI.4 Consumer Adjusted Premium Rate Development:**

The calibrated plan adjusted index rate represents the base rate for an age factor of 1.0, geographic rating factor of 1.0 and tobacco rating factor of 1.0. 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 2024 using the federally-prescribed MLR methodology is 93.0%.

### **XIII. AV Metal Values**

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based the Federal AV Calculator. Some plans did require an adjustment to the inputs entered into the AV calculator. Screen shots and certifications for these plans were submitted as part of HBG's QHP application. 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 HBG's expectations for 2024. These projections reflect expected changes in market share due to market competition, relative price levels, and changes in plan offerings (where applicable).

HBG expects membership in 2024 to follow a similar metal level distribution as the Individual ACA experience period in the markets where plans will continue to be offered.

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%	38.7%	5.8%
150%-200%	87%	44.7%	6.7%
200%-250%	73%	5.5%	0.8%
>250%	<u>70%</u>	<u>11.1%</u>	<u>1.7%</u>
Total		100.0%	15.0%

**XV. Terminated Plans and Products**

Plans in the 2022 experience period that will no longer be available in 2024 can be found in Exhibit I.

**XVI. Plan Type**

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe HBG’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 was reviewed for reasonableness. This filing is prepared on behalf of HBG to accompany its rate filing for the Individual Market on and off the Pennsylvania 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.

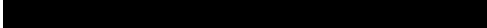
I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The AV Metal Values

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 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 HBG 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: 

  
Title: Actuarial Director, Individual Markets

Date: August 17, 2023

**XVIII.****Exhibit I****Highmark Benefits Group****Terminated Plans Offered in 2022 Only**

<b>HIOS ID</b>	<b>Metal</b>	<b>Plan Name</b>	<b>2023 Mapping</b>
79962PA0190001	Bronze	my Priority Blue Flex EPO Bronze 3800	79962PA0270001
79962PA0190005	Silver	my Priority Blue Flex EPO Silver 2900	79962PA0300001
79962PA0190007	Gold	my Priority Blue Flex EPO Gold 0	79962PA0270005
79962PA0190009	Silver	my Priority Blue Flex EPO Silver 2600	79962PA0270004
79962PA0200001	Bronze	my Priority Blue Flex EPO Bronze 6900 HSA	79962PA0290001
79962PA0200002	Silver	my Priority Blue Flex EPO Silver 3250 HSA	79962PA0270003
79962PA0200004	Gold	my Priority Blue Flex EPO Gold 1400 HSA	79962PA0290002
79962PA0210001	Catastrophic	my Priority Blue Major Events EPO 8700 - 3 Free PCP Visits	79962PA0320001
79962PA0220001	Bronze	my Priority Blue Flex EPO Bronze 3800 + Adult Dental and Vision	79962PA0280001
79962PA0220002	Silver	my Priority Blue Flex EPO Silver 2900 + Adult Dental and Vision	79962PA0310001
79962PA0220003	Silver	my Priority Blue Flex EPO Silver 2600 + Adult Dental and Vision	79962PA0280002
79962PA0220005	Gold	my Priority Blue Flex EPO Gold 0 + Adult Dental and Vision	79962PA0280003
79962PA0230001	Gold	my Priority Blue Flex EPO Premier Gold 0	79962PA0300002
79962PA0240001	Gold	my Priority Blue Flex EPO Premier Gold 0 + Adult Dental and Vision	79962PA0310002