Part III Actuarial Memorandum

Highmark BCBSD, Inc.

d/b/a Highmark Blue Cross Blue Shield Delaware

Individual Rate Filing

Effective January 1, 2021

TABLE OF CONTENTS

I.	General Information	3
II.	Proposed Rate Changes	4
III.	Experience and Current Period Premium, Claims, and Enrollment	5
IV.	Benefit Categories	6
V.	Projection Factors	6
VI.	Manual Rate Adjustments	7
VII.	Credibility of Experience	8
VIII.	Index Rate	8
IX.	Market Adjusted Index Rate [MAIR]	8
X.	Plan Adjusted Index Rates [PAIR]	9
XI.	Calibration	10
XII.	Projected Loss Ratio	11
XIII.	AV Metal Values	11
XIV.	Membership Projections	11
XV.	Terminated Plans and Products	11
XVI.	Plan Type	11
XVII.	Actuarial Certification	11
XVIII.	Exhibit I	13

I. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Highmark Blue Cross Blue Shield Delaware's (Highmark DE) individual block of business rate filing, for products with an effective date of January 1, 2021. 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 Blue Cross Blue Shield Delaware.
- State: The State of Delaware has regulatory authority over these policies
- HIOS Issuer ID: 76168
- Market: Individual
- Effective Date: January 1, 2021

I.2 Company Contact Information:

- Primary Contact Name:
- Primary Contact Telephone Number:
- Primary Contact Email Address:

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 and 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 proposed average rate change is being driven by unanticipated improvement in the base claims experience, the implementation of the Delaware Health Insurance Individual Market Stabilization Reinsurance Program ("Reinsurance Program") and anticipated increase in utilization and unit cost medical trends for medical services.

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 Reinsurance Program in plan year 2021. This rate Filing also accounts for the Reinsurance Program operating in the Individual Market in 2021 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.

The rate development in this filing is based on certain assumptions we have had to make at this point in time. We have accounted for the elimination of the Individual Mandate penalty and the lack of CSR funding in 2021 by using adjustment factors outlined in this memorandum. Additional assumptions include that advance payment of premium credits (APTCs) will continue until the end of 2021, there will be no significant changes in legislation, regulations or otherwise (i.e. rules, regulatory guidance, etc.) impacting the ACA market, and that there are no significant changes in the participation of QHP issuers that would materially change risk adjustment transfer amounts. In addition, there are other uncertainties that may directly or indirectly affect an already unstable insurance market and ultimately, rates.

The COVID-19 pandemic has created new challenges for estimating utilization of health care services in 2021. In recent weeks many considerations have been presented to the National Association of Insurance Commissioners (NAIC) and put forth by the Society of Actuaries. As a result of these considerations we estimate that claim costs in 2021 will be higher than they otherwise would have been compared to a baseline non-COVID-19 impact environment.

Finally, modifications to the rate development may be necessary if significant unforeseen events occur. Examples include, but are not limited to, repeal or invalidation of the ACA or material developments in the course of the COVID-19 pandemic. 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 2019, paid through February 2020. This includes 2019 experience in Affordable Care Act compliant plans. Highmark DE did not offer any transitional plans in 2019.

III.2 Current Date:

The current date shown represents a snapshot of February 1, 2020.

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, 2019 through December 31, 2019, with claims paid through February, 2020 as the basis for the 2021 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 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 2019 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 2019 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: Highmark DE is using a completion factor of ████ to include IBNR claims in allowed charges. The IBNR completion factor was developed using our corporate reserving system for Highmark DE'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 CY2021 rates reflects an annual trend rate of ███% (██% cost, ██% utilization). These trends reflect Highmark DE's expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and normalize for benefit leverage, population aging, and historical changes for fee schedules, as well as company-wide utilization management programs, and external trend drivers.

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

We applied an adjustment factor of approximately ███% which combined the morbidity improvement from claims experience and an ███% for morbidity improvement due to DE reinsurance program to reflect the anticipated changes in the average morbidity of the covered population (beyond allowable rating factors). The morbidity adjustment from claims experience reflects multiple changes, including blending of the ACA pool with new members from multiple sources including uninsured and the employer markets.

V.3 Changes in Demographics

We project that the average rating factor (age, tobacco load and area combined) will increase by about ██% 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 [illegible]. 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 [illegible] factor represents the changes in utilization due to cost sharing requirements, network, pharmacy rebates, and hospital/physician settlements, insulin cost sharing cap, health insurance coverage mandate and covid 19 adjusments.

Impact of Health Insurance Coverage Mandate

The final Other factor included a [illegible]% adjustment to reflect the market uncertainty from the elimination of the health insurance coverage mandate.

Impact of Covid19 Pandemic

The final Other factor also included a [illegible]% adjustment to reflect the estimated impact of COVID-19 on 2021 claim costs, to arrive at the final Other factor of [illegible]. The drivers of the increase are costs directly related to COVID-19, such as a possible vaccine and continued cost sharing waivers, other care delivery changes and adverse selection. The components of the adjustment are discussed below.

COVID-19 Treatment Costs ([illegible]% increase in 2021 claims): The primary driver for 2021 is the cost of a potential new vaccine. We assume a vaccine is available and [illegible]% of members get it in 2021, either in the office or at a retail pharmacy. Additionally, we assume some vaccines will be administered in an additional office visit with waived cost sharing. Also, we assume COVID-19 testing will be required before any outpatient procedure.

Care Delivery Change ([illegible]% increase in 2021 claims): We assume some increase in cost of care due to member health deteriorating slightly. Additionally, we assume a higher intensity of services per visit as providers re-engage with their patients. Finally, we assume some care will be shifted to more expensive sites of service.

Adverse selection ([illegible]% increase in 2021 claims): We assume there will be some influx of new members in the Individual ACA market due to the loss of employer sponsored coverage. Newly eligible individuals on average will likely pay a higher premium than they were paying for previous coverage. This is expected to result in adverse selection as those with health conditions are more likely to purchase coverage than those who are generally healthy.

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 2019. 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 risk adjustment and the exchange fee.

IX.1 Projected Reinsurance PMPM

As outlined in the State of Delaware's Section 1332 State Innovation waiver application, the State is anticipating the reinsurance program with the following parameters for 2021:

- Attachment point of $65,000, a coinsurance rate of 80%, and a cap of $335,000.

The reinsurance PMPM in worksheet 1, section II of the URRT was derived by converting the reinsurance claims savings of [redacted]% to an equivalent allowed claims savings PMPM. The [redacted]% was selected in combination with the [redacted]% for reinsurance morbidity improvement to achieve a <u>total rate reduction</u> of [redacted]% (i.e., claims savings and morbidity improvement). As prescribed by the DE DOI, the [redacted]% rate reduction is calculated by comparing rates with reinsurance to rates with no reinsurance. Thus, the net rate change after reinsurance program is [redacted]%.

The [redacted]% morbidity improvement from reinsurance was incorporated in section V.2 Changes in the Morbidity of the Population insured above.

IX.2 Projected Risk Adjustments PMPM:

[redacted]

[redacted]

IX.3 The Exchange User Fee %

The ███% value shown in worksheet 1 of the URRT is developed by multiplying the ██% 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.

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 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 adopted by the risk adjustment methodology relative its weight 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 plan.

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 ███ 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 factor by the overall weighted average from all plans.

X.3 Benefits in Addition to EHB

Five plans have adult dental and vision benefits in addition to EHB.

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:

- PMPM for Risk Transfer User Fee
- PMPM for the Patient-Centered Outcomes Research Institute (PCORI) fee
- % for the Health Insurance Provider Fee
- % for the State Premium Tax
- % for State Premium Tax and Reinsurance Program Fee

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

The proposed rates reflect a % contribution to surplus margin for all products and plans Pursuant to the Delaware Insurance Department's review of the initial rate filing

X.7 Catastrophic Adjustment

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

XI. Calibration

XI.1 Age Curve Calibration:

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

XI.2 Geographic Calibration Factor:

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

XI.3 Tobacco Calibration Factor:

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

XI.4 Consumer Adjusted Premium Rate Developments:

The calibrated plan adjusted index rate represents the base rate for an age factor of , geographic rating factor of and tobacco rating factor of . 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 2021 using the federally prescribed MLR methodology is ██%.

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 Highmark DE's QHP application.

XIV. Membership Projections

Membership projections reflect Highmark DE's expectations for 2021. These projections reflect expected changes in market share due to market competition, relative price levels, and changes in plan offerings (where applicable).

Highmark DE expects membership in 2021 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:

FPL	Subsidy Level	% of Silver Membership	% of Total Membership
<150%	94.0%	██	██
150%-200%	87.0%	██	██
200%-250%	73.0%	██	██
>250%	70.0%	██	██
Total		██	██

XV. Terminated Plans and Products

Plans in the 2019 experience period that will no longer be available in 2021 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 Highmark DE's plans adequately.

XVII. Actuarial Certification

I, ██████████, 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. 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 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:

Title:

Date: August 26, 2020

XVIII. Exhibit I

Highmark Blue Cross Blue Shield Delaware