Delaware Health Insurance Rate Filing Requirements

Part II Preliminary Justification—Content and Format Requirements

The Delaware Insurance Department (DOI) requires all health insurance companies, also referred to as "Issuers", who submit Rate Filings for products offered in the single risk pool in the individual and small group market to submit a Part II Preliminary Justification*, regardless of whether the rate filing reflects a positive, negative or neutral rate change.*

Beginning with Rate Filings for Coverage Year 2017, the DOI is implementing the following content requirements and format guidelines to enhance transparency for consumers and to ensure consistency of information across Issuers. The DOI requests that companies address each item within each section and in the sequence outlined below. ***Issuers are reminded to use clear, consumer-friendly language to promote broad public understanding****.*

General Information

- Company Legal Name: **Aetna Health Inc. (a PA corp.)**
- Market for which proposed rates apply (Individual or Small Group): **Individual**
- Total proposed rate change (increase/decrease): **2.0%**
- Effective date of proposed rate change: **January 1, 2024**

Summary

- Provide a brief narrative summary of the scope and range of the rate change (i.e., increase or decrease) as well as the number of people impacted. Include how the rate change varies across products/plans.

  The overall rate increase of 2.0% will affect 1,245 members. The rate change will vary by plan design ranging from a minimum of -8.2% for a renewing on-exchange gold plan with 14 current members to a maximum of 2.2% for a renewing on-exchange silver plan with 610 members. The off-exchange product has a silver plan with a rate increase of 4.7%, and no current enrollment.

- Provide a summary of the historical revenue, claims, expenses and profit on the product(s), and how the rate change should impact these in the future.

  Aetna does not have any historical experience in this product to summarize since the carrier is new to the market in 2023. However, compared to the current 2023 rates, Aetna expects that this rate change will increase premium revenue by 2.0% from renewing members. An increase in expected claims cost, net of risk adjustment and reinsurance, is causing a need for a 5.0% increase in premium. Part of that 5.0% required increase is being offset by decreases in administrative expenses and profit, which cause 1.1% and 1.8% decreases to the premium, respectively. Those three components aggregate to the 2.0% required increase to premium.

- Provide a chart (example below) listing all components of the proposed rate change (increase/decrease). Please note the factors used in this chart are for illustrative purposes only and the Company should use factors pertaining to their proposed rate change. All factors should multiply to the Total Proposed Rate Change (increase/decrease).

Factor	Rate Change
2022 Base Experience vs Expectation	-9.6%
Trend – Increase in Expected Claim Cost	4.5%
Individual ACA Morbidity vs Manual Experience	1.2%
Network Adjustment	-0.1%
Reinsurance	3.1%
Risk Adjustment	0.5%
Exchange Fees	-0.5%
Plan Design Changes	6.7%
Administrative Expenses	-2.1%
Taxes and Fees	0.4%
Profit Load	-1.1%
Total	**2.0%**

- State the proposed average rate change (increase/decrease). *(Must match the proposed average rate change as indicated in HIOS, Actuarial Memorandum and Company Rate Information Page in SERFF. Please note that the average rate change reported in all three locations should match.)*

  The proposed average rate change is 2.0%.

- Provide a brief explanation for the rate change in each of the factors shown in the chart.

  - **2022 Base Experience vs Expectation:** The difference between actual 2022 manual experience normalized for pricing factors and 2021 manual experience normalized for pricing factors, trended to 2022 with the trend assumed in the 2023 rate filing.

  - **Trend:** The difference in the trend rate (changes in cost and utilization of claims) assumed for 2022 to 2023 between rate filings, in addition to the trend from 2023 to 2024 assumed in this rate filing.

  - **Morbidity:** The change in the factor used to adjust the manual experience to the morbidity level expected in the Individual market in the rating period.

  - **Network Adjustment:** The change in the factor used to adjust the manual experience to the network cost and utilization level expected in the Individual market in the rating period.

  - **Reinsurance:** The change in the impact of the reinsurance program on expected claims.

  - **Risk Adjustment:** The change in the impact of the federal risk adjustment and high cost risk pool programs on net expected claims.

- **Exchange Fees:** The change in expected exchange fees.
- **Plan Design Changes:** The change in the average actuarial valuation of benefit designs.
- **Administrative Expenses:** The change in Aetna's internal expenses related to these policies.
- **Taxes and Fees:** The change in the cost of taxes and fees owed to government entities for these policies.
- **Profit Load:** The change in rates due to changes in Aetna's profit targets.

Reason for Proposed Rate Change (Increase/Decrease)

- Provide a brief narrative discussing all the reasons for the proposed rate change in Delaware, including, but not limited to:
  - How provider costs and utilization contribute to the need for the rate change
  - How legally required benefit changes contribute to the need for the rate change
  - How administrative costs and anticipated profits contribute to the need for the rate change

The proposed rate change is due to the items discussed in the above proposed rate chart.

Due to changes in provider costs and additional utilization of the population, the assumed trend is a necessary component of the change.

Administrative costs and profits are reducing rates by 1.1% and 1.8% as described in the above two sections.

Effect of the Average Proposed Rate Change (Increase/Decrease) on Policyholders

- Provide the period for which the rates will apply.
  - **January 1, 2024 – December 31, 2024**
- Provide the number of members affected by the proposed rate change.
  - **1,245 current members**
- Provide a brief narrative discussing new plans, plans that are not renewed and whether the proposed rate change applies to all plans. If no, provide a listing of all proposed rate changes by product/plan.
  - **New plans and non-renewed plans are not included in the overall average rate change calculation. New and discontinued plans are listed in the URRT. There are 3 renewing plans (1 gold, 2 silver) and 3 new plans (1 gold, 2 silver). There are 6 plans being terminated (3 bronze, 2 silver, 1 gold). The above plan counts apply to both on-exchange and off-exchange only plans.**
- Discuss why the rate changes vary and how they vary.

- **Rate changes vary due to changes in the valuation of each plan's actuarial value and induced demand of benefit richness.**

Medical Loss Ratio (MLR)

Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR falls below 80%, the insurance company will issue rebates to members in accordance with the law.

- What is the projected MLR for the proposed rate(s)?

  The projected MLR based on the federal formula is 92.4%

- How does the proposed rate change (increase/decrease) align with the projected MLR?

  The projected MLR would be 94.3% without the rate increase.

- What types of activities does the Company conduct to improve the health care quality for members that are included as part of the 80% (or greater) share?

  Aetna is committed to improving health care quality for members, including engaging providers in care benchmarked to quality metrics, providing virtual services, and various care management programs.

- Discuss specifically what the Company is doing to keep premiums affordable.

  Aetna is taking a number of steps to keep our products as affordable as possible and to address the underlying cost of health care. These actions include:

  - **Developing new agreements, arrangements, and partnerships with health care providers**
  - **Creating programs that address potential health issuers for members earlier, improving health outcomes and reducing the need for high cost health care services**
  - **Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide**