Federal Rate Filing Justification Part III
Actuarial Memorandum and Certification

Optimum Choice, Inc.
NAIC: 0707-96940
FEIN: 52-1518174

State of Delaware Rate Review

Table of Contents

Section 1: Purpose

The following is a rate filing prepared by Optimum Choice, Inc.. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of Delaware. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold off the Small Business Health Options Program in Delaware for the 2024 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the Delaware Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by the Delaware Freedom of Information Act, 29 Del. C. § 10001 et seq., and the Delaware Uniform Trade Secret Act, 6 Del. C. § 2001 et seq. If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

Section 2: General Information

<u>Company Identifying Information</u>

Company Legal Name:	Optimum Choice, Inc.
State:	Delaware
HIOS Issuer ID:	97569
Market:	Small Business, 1-50
Proposed Effective Date:	January 01, 2024

<u>Primary Contact Information</u>

Name:	[redacted]
Telephone Number:	[redacted]
Email Address:	[redacted]

Section 3: Proposed Rate Changes

The proposed change in rates for this filing is 5.8% compared to the prior filing. These changes are applied uniformly to all plans. The proposed pricing trend is 11.6% annually.

The primary drivers of the proposed rate changes are the following:

- Changes in medical service costs
  - Increasing Cost of Medical Services – Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
  - Increased Utilization – The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
  - Higher Costs from Deductible Leveraging – Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
  - Cost shifting from the public to the private sector – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost difference is being shifted to private health plans. Hospitals typically make up this difference by charging private health plans more.
  - Impact of New Technology – Improvements to medical technology and clinical practice often result in the use of more expensive services - leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
  - UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
  - Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.
  - State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.
- Changes that vary by plan
  - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
  - The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

Section 4: Experience and Current Period Premium, Claims and Enrollment

Paid Through Date

The experience period is 1/1/2022 through 12/31/2022, with claims paid through 2/28/2023.

Current Date

The current enrollment and premium is reported as of 12/31/2022.

Allowed and Incurred Claims Incurred During the Experience Period

Claims Description	Allowed Claims	Incurred Claims
Claims Paid as of February 28,2023	$ 1,329,276	$ 1,095,269
Claims Incurred but Not Reported as of February 28,2023	$ 32,373	$ 31,831

The claims data was available directly from company claims records.

Support for Estimate of Incurred but not Reported Claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors. The same completion factors are applied to both incurred and allowed claim amounts.

Experience Period Risk Adjustment

Final CMS 2022 risk adjustments for the experience period were not known in time for development of rate filing.

Our 2022 risk adjustment transfer PMPM is estimated based on the 2021 actual results, proportional to incurred claims. This results in an approximate adjustment of $96,161 to the experience period premium. The premium in Worksheet 1, Section 1 is net of the risk adjustment transfer.

Experience Period Index Rates

Experience Period Index Rates are defined as the allowed claims PMPM for Essential Health Benefits during the Experience Period. With the breakout of service level EHB claims, the information provided reflects a reasonable estimate of the EHBs.

Section 5: Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

Inpatient Hospital

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

Capitation

Includes all services provided under one or more capitated agreements.

Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

Section 6: Projection Factors

Trend

Two years of annual trend were applied to our 2022 experience to project it to the 2024 rating period. Our most recent analysis indicates annual trend in the state of Delaware for the 2023 and 2024 calendar years will be 10.04% and 10.04%, respectively. The table below details the components of each trend factor.

Trend Component	2023	2024
Unit Cost	4.90%	4.90%
Utilization	4.90%	4.90%
Total	10.04%	10.04%

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component. In addition, the costs associated with future treatment, vaccination and testing due to COVID-19 are included in the future trends used in the claims projection.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Demographic Shift

The total Demographic Shift Adjustment is 0.4%. It is comprised of the following factors:

Age Shift:

An Adjustment was made to account for the difference in the experience period age distribution to the expected age distribution in the rating period. The claims were adjusted by

0.4%, which was calculated using the HHS standard age curve (Avg. Age Factor projected / Avg. Age Factor experience – 1) to align with the rating period expected age distribution.

The HHS-specified age curve was used in rating.

Plan Design Changes

The total Plan Design Adjustment is -0.5%. It is comprised of the following factors:

Shift in Benefit Plan Distribution:

An adjustment of -0.5% was made to account for the expected change in allowed claims due to the shift in the distribution of benefit plans between the experience period and the rating period.

Other Adjustments

The total other adjustments are -4.4%, and it is comprised of the following factors:

Catastrophic Claims Adjustment:

An adjustment was made to account for catastrophic claims experience in the experience period. The claims were adjusted by 8.3% to align with expected catastrophic claim levels in the rating period.

Trend Adjustment

An additional trend adjustment of 0.8% is applied to trend our rates to the mid-point of the quarter rather than the beginning of the quarter

All Other Adjustments:

All other adjustments resulted in an adjustment of -12.4%.

Section 7: Credibility Manual Rate Development

Source and Appropriateness of Data Used

- The fully credible experience period source data used to develop manual rates is the actual small group combined ACA experience for Pennsylvania for UnitedHealthcare Insurance Company and UnitedHealthcare of Pennsylvania.

Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

An adjustment to the credibility manual was made to account for catastrophic claims experience in the experience period.

Inclusion of Capitation Payments

Capitation payments are included in both the experience and projections.

Section 8: Credibility of Experience

The DE experience by license or even the combined DE Small Group experience of both UnitedHealthcare Insurance Company and Optimum Choice, Inc. is not credible. To get fully credible experience we combined the experience of Pennsylvania UnitedHealthcare Insurance Company and UnitedHealthcare of Pennsylvania with the combined experience of DE UnitedHealthcare Insurance Company and Optimum Choice, Inc.

Based on internal studies, which considers the requirements set forth by ASOP #25, we have determined that it is appropriate to set the credibility of Optimum Choice, Inc. to 0%, and the credibility manual – which is the combined experience of DE and PA – is set to 100%.

Section 9: Development of Projected Index Rate

The experience period index rate is $604.19 PMPM.

The Index Rate For the experience period is approximately 99.66% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly. The Index Rate in the projection period represents 99.66% of allowed claims due to the benefits in excess of EHBs.

The projected index rate of $573.62 was calculated by trending and adjusting the experience period index rate to the projection period, including blending the experience with a manual rate if the experience was not fully credible. It is established in accordance with the requirements of 45 CFR §156.80(d). See sections 6, 7, and 8 of this memo for more details.

Section 10: Development of the Market Adjusted Index Rate

Reinsurance

There is no reinsurance program in force for this business, and as a result there are no reinsurance recoveries to report.

Risk Adjustment Payment/Charge

Optimum Choice, Inc. anticipates paying an average of $40.50 PMPM for risk adjustment transfers in the state of Delaware for the 2024 plan year, which has been grossed up to -$49.15 PMPM on an allowed basis for purposes of calculating the Market Adjusted Index Rate. We are assuming the risk level of our business relative to that of our competitors for the 2024 plan year will be similar to what it was in the 2022 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2024 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2022 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market.

Exchange User Fees

There are no plans included in this filing that are offered on the exchange. Therefore there are no exchange user fees.

The market adjusted index rate includes market-wide adjustments for reinsurance, risk adjustment transfers and exchange user fees (if any).

Index Rate	Net Federal or State Reinsurance (allowed basis)	Risk Adjustment Payment/Charge (allowed basis)	Exchange Fee Adjustment (allowed basis)	Market Adjusted Index Rate
$573.62	$0.00	($49.15)	0.00%	$622.77

The figures above may not tally exactly due to rounding of the display.

Section 11: Plan Adjusted Index Rate

Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

UnitedHealthcare does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of UnitedHealthcare's nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

Distribution and Administrative Costs

Distribution and administrative costs include premium tax, risk adjustment user fees, SG&A, quality improvements, federal income tax, and after-tax income. Risk adjustment transfers, net reinsurance recoveries and exchange fees are excluded because they are accounted for in the market adjusted index rate.

Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results for 2022 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

Profit and Risk Margin

The profit and risk margin is shown in Worksheet 2, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the administrative expenses, taxes and fees, and 1 minus the target loss ratio and the administrative expenses, taxes and fees.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

Taxes and Fees

Taxes and fees are expected to be 6.07% and include premium tax, exchange fees (if any), risk adjustment user fees, and federal income tax. The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
Federal / State Income Tax on Profit & Risk Load	1.26%
Premium Tax	1.80%
ACA Taxes: PCORI Fee	0.04%
ACA Taxes: Risk Adjustment User Fee	0.03%
ACA Taxes: Exchange User Fee	0.00%
All Other Taxes & Fees	2.94%
Total	**6.07%**

Section 12: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

Age Calibration

The calculated age curve calibration is 0.6738, which equals one divided by the average age factor of the expected member distribution by age. The age factors used in this calculation are the HHS-specified age curve.

Geographic Calibration

The geographic factor calibration is 1, which equals one divided by the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2024 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Tobacco Calibration

Tobacco factors are not used in the rating of these products, and no calibration is needed.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

Section 13: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate
x Age Calibration Factor
x Geographic Calibration Factor
x Consumer Specific Age Rating Factor
x Consumer Specific Geographic Rating Factor
<u>x Small Group Trend Adjustment</u>
= Consumer Adjusted Premium Rate

Section 14: Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2023 is 83.3%. Optimum Choice, Inc. agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Section 15: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

<u>Benefits that Vary Based on Place of Service</u>

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Physician Tiering

Select plan designs include lower cost sharing when members utilize providers we designate as meeting cost and efficiency standards. The tiered network functionality of the AV calculator was utilized to account for the cost sharing differences. The utilization of providers was based on a UnitedHealthcare study of differences in cost sharing and their effectiveness at driving utilization patterns.

Employer Contributions to HSAs and HRAs

The following plans are offered in conjunction with HSAs or HRAs. The table shows the metal level of each plan and the range of annual employer contribution amounts, as well as the resulting range of AV Metal Values, that allow the plan to achieve the stated metal level. Note that because URRT Worksheet 2 allows only a single AV Metal Value for each plan, the AV Metal Values displayed on Worksheet 2 for these HSA/HRA plans correspond to the upper bound of the AV Metal Value range in the table below.

HIOS Plan ID	Metal	Employer	AV Meal Value Range
97569DE0030010	Silver	[$0,$0]	[71.8%, 71.8%]

AV Calculator Workaround for UnitedHealthcare Rewards

Plans include UnitedHealthcare Rewards, a program that rewards enrollees completing certain wellness criteria with various financial incentives. These incentives are expected to impact member cost-sharing in a manner similar to employer contributions to a participant's Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) Account. To account for the impact on AV, the employer HRA/HSA contribution field in the AV Calculator was increased by the expected incentive, estimated using UHC historical experience.

Section 16: Membership Projections

The April 2023 membership for OCI of 73 was annualized. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2024. Strictly for purposes of the URRT, we have projected membership by plan.

Section 17: Terminated Plans and Products

Terminated plans will be mapped to another plan in the projection period for purposes of completing the URRT.

Section 18: Plan Type

A plan type of HMO has been selected, which describes the plans exactly.

Section 19: Reliance

In my professional judgment, the assumptions or methods described in the memorandum do not conflict with what I believe to be reasonable. Therefore, I have not included any reliances.

Section 20: Actuarial Certification

I, [redacted], and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
  - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 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 population anticipated to be covered.
  - Neither excessive, deficient, nor unfairly discriminatory.

- 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.

- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

- 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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. The unique plan design actuarial certification required by 45 CFR Part 156.135 has been separately attached.

- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop their 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.

[redacted]

08/04/2023

Date