Part III: Actuarial Memorandum

Redacted
Celtic Insurance Company
Annual Individual Health Rate Filing
Delaware
Assuming CSR Subsidies are Unfunded
Effective January 1, 2025
Forms: 64004DE009, 64004DE010

Contents

1. General Information

Scope and Purpose:
This document contains the Part III Actuarial Memorandum for Celtic Insurance Company's individual health block of business annual rate filing, effective January 1, 2025. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT). This is a renewal rate filing.

The purpose of this Actuarial Memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT. In combination, these documents support compliance with the market reform rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

Consistent with the October 12, 2017 payment memo from the U.S. Department of Health and Human Services (HHS)[1], the premium rates developed and supported by this Actuarial Memorandum assume that cost-sharing reduction (CSR) subsidies will not be funded. Future modifications in legislation, regulation and/or court decisions regarding the funding of CSR payments may affect the extent which the premium rates are sufficient and neither excessive nor deficient.

This actuarial memorandum reflects the estimated impact of the Section 1332 State Relief and Empowerment Waiver for benefit year 2025. Future modifications to the operation and parameters of the State Relief and Empowerment Waiver may affect the extent to which the premium rates are neither excessive nor deficient.

Celtic Insurance Company asserts that the premium rates developed and supported by this Actuarial Memorandum are based on legislative and regulatory provisions in effect at the time of submission.

Celtic Insurance Company reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed to ensure rates are appropriate. In addition to CSR payments and risk adjustment program payments and disruption, material rating impacts could arise from changes to various factors, including but not limited to:

- Advance Premium Tax Credits, including extension of Advanced Premium Tax Credits as provisioned in the Inflation Reduction Act
- Medicaid Redeterminations that were suspended during the COVID-19 public health emergency (PHE)
- Constraints on age rating factors
- Open enrollment and grace periods
- Enrollment of other populations, such as Medicare, Medicaid, and high risk pools
- Taxes and fees, notably the suspension of the ACA Insurer Fee
- Emerging experience as it relates to both claims and risk adjustment, notably the updated HCC coefficients in the 2025 model as laid out in the Final Rule for the 2025 Annual Notice of Benefit and Payment Parameters

[1] https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

If there are material deviations in market level premiums from our projected statewide average premium (SWAP) assumption for 2025 - for example, based on changes in the number of carriers in the market or carriers' pricing assumptions for 2025 - we would like to work with the Delaware Department of Insurance after initial submissions to revise our filing to update our estimated risk adjustment transfer. Market disruption, resulting from changes or carriers' perceived changes in the risk adjustment program, could also necessitate working with the Department to update other critical pricing assumptions such as market morbidity and relative risk.

This information is intended for the sole use by the Delaware Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of the Celtic Insurance Company individual rate filing. However, we recognize that this certification may become a public document.

These results are actuarial projections. Actual results will vary from those projected in the filing for a number of reasons, including but not limited to changes in membership, claims experience, and random variation from selected assumptions.

Company Identifying Information:

- Company Legal Name: Celtic Insurance Company
- State: The State of Delaware has regulatory authority over these policies
- HIOS Issuer ID: 64004
- Market: Individual
- Effective Date: January 1, 2025

Company Contact Information:

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

Description of Benefits:
These products are issued by Celtic Insurance Company as EPO health policies. The major provisions of this form for each plan design and product can be found in Appendix 1.1.

Rate Guarantees:
Rates are guaranteed not to change through December 31, 2025.

Renewability:
Each policy is renewable by paying the applicable renewal premiums, unless the policyholder no longer meets the eligibility requirements of the policy or Celtic Insurance Company decides to discontinue that specific policy.

Applicability:
These rates will apply to both new and renewing business.

General Marketing Method:
This product will be sold through agents, direct mailings, the internet, and the Federally Facilitated Marketplace (FFM).

Estimated Average Annual Premium:
The estimated average annual premium per policy in calendar year 2025 is [redacted]

Distribution of Business:
See Appendix 1.2 for the expected age and geographic distributions for these products.

Rate Tables:
See Appendix 1.3 for allowable rating factors and Appendices 1.3b and 1.3c for clarification on service area definitions. Appendix 1.4 also includes an example of how rating factors will be applied. Note that for family coverage, rates for children are charged to no more than the three oldest covered children under age 21 consistent with the Family Structure rules of the Patient Protection and Affordable Care Act (ACA).

2. Proposed Rate Changes

The rate increases for each product offered in the single risk pool by Celtic Insurance Company in the state of Delaware are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):
The rate projections for 2025 have been updated from the previous year's projections to reflect the most recent assumptions and information available.

The following provides a narrative description of the significant factors driving the proposed rate increase for 2025.

- [redacted]

  The individual single risk pool experience underlying the rate projections has been updated. The current model reflects the projected utilization trend applied to adjusted experience (from 2023 to 2025), including anticipated changes in the average morbidity of the single risk pool. There is a full description of utilization trend and other projection factors applied to experience in Section 6, "Trend Factors".

  Risk adjustment transfer experience for 2025 includes consideration of changes to the statewide average premium, the Risk Adjustment program, and Celtic Insurance Company enrollee population morbidity relative to the Delaware single risk pool.

- [redacted]

- [redacted]

- [redacted]

Note that the requested rate change may not be the same across all plans within a product due to changes to the member cost sharing amounts by plan. Additionally, the defunding of CSR subsidies has contributed to the rate levels being higher than if the subsidies were to be funded.

3. Single Risk Pool

The 2025 rate development is based on the single risk pool set by the State of Delaware, which was established according to the requirements in 45 CFR Part 156.80. The single risk pool is defined as the non-grandfathered individual business in Delaware.

The single risk pool for the projection period does not include members who are eligible to remain enrolled in transitional plans.

4. Experience and Current Period Premium, Claims and Enrollment

Not applicable. This product is new in 2024 and therefore has no 2023 experience.

5. Benefit Categories

The algorithm used to assign both the experience and manual utilization data and cost information is summarized as follows.

Inpatient Hospital
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
Outpatient hospital includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional
Professional includes non-capitated primary care, specialist, therapy, 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
Other medical includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.

Capitation
Capitation includes all services provided under one or more capitated arrangements.

Prescription Drug
Prescription drug includes drugs dispensed by a pharmacy and is net of rebates.

6. Trend Factors

Not applicable. This is a filing based on manual rate projections, as we did not have credible experience on which to rely. Please see Section 8, “Manual Rate Adjustments”, for details regarding the development of the Manual EHB Allowed Claims PMPM, which is on a 2025 calendar year basis.

7. Adjustments to Trended EHB Allowed Claims PMPM

Not applicable. This is a filing based on manual rate projections, as we did not have credible experience on which to rely. Please see Section 8, “Manual Rate Adjustments”, for details regarding the development of the Manual EHB Allowed Claims PMPM, which is on a 2025 calendar year basis.

8. Manual Rate Adjustments

Source and Appropriateness of Experience Data Used
The manual rate development is based on relevant internal QHP experience in other states as well as the Milliman Health Cost Guidelines (HCGs). The manual rate is developed to be consistent with and appropriate for the expected individual population that will be in enrolled, including morbidity, geographic area utilization relativities, expected provider reimbursement, and utilization management programs.

Where additional manual adjustments to claims are required to model changes in Celtic Insurance Company's population and coverage over time, most notably utilization trend, these adjustments are based on internal analysis of relevant QHP data in other states with supplemental support from Milliman Health Cost Guidelines (HCGs).

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience, and establish interrelationships between different health coverage levels.

The Milliman HCGs are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as they use them in measuring the experience or evaluating the rates of their clients and as they compare them to other data sources.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing these guidelines including published and unpublished data. In most instances, cost assumptions are based on their evaluation of several data sources and, therefore, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

Manual Morbidity Basis
The morbidity for Celtic Insurance Company's 2025 membership is assumed to equal the projected morbidity for Delaware single risk pool multiplied by an adjustment for the assumed morbidity of Celtic Insurance Company's membership relative to the single risk pool.

The historical single risk pool morbidity is calibrated using data from relevant CMS Risk Adjustment reports. We then projected this historical morbidity forward to account for changes in the risk pool composition over time.

The relative morbidity assumption used for projecting claims reflects Celtic Insurance Company's expectations regarding the morbidity of its 2025 membership relative to the single risk pool and is consistent with the relative morbidity assumption used to estimate Celtic Insurance Company's risk transfer payment/receivable, which is informed by historically observed relationships in our other markets.

Adjustments Made to the Data

- Cost trend and provider reimbursement

- Rating region
- Expected demographics
- Utilization trend
- Discounts off AWP
- Expected morbidity
- Benefit plan design
- Calibration based on relevant QHP experience

See Appendix 8.1 for a demonstration of these adjustments. The adjustments, which are discussed above, are appropriate and necessary to reflect the anticipated population, region, provider network, and benefits anticipated for the 2025 single risk pool.

Inclusion of Capitation Payments
Capitated payments for services are accounted for through a PMPM allocation to claims, where the average capitation amount replaces the projected claims amount.

9. Credibility of Experience

[redacted]

10. Establishing the Index Rate

Celtic Insurance Company did not offer products in 2023, so the Index Rate for the Experience Period does not apply.

The Index Rate for the Projection Period (calendar year 2025) is reflected in Worksheet 1, Section II of the URRT. It was developed following the specifications of 45 CFR part 156.80(d) (1). The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for Essential Health Benefits (EHB) for calendar year 2025 only and has not been adjusted for payments and charges under the risk adjustment program or for Exchange user fees. The index rate differs from the total allowed claims in that the total allowed claims include benefits in excess of EHBs (adult vision and adult dental).

[redacted]

The Index Rate for the Projection Period will remain unchanged until a renewal filing effective January 1, 2026.

The development of the Index Rate for the Projection Period is shown in Worksheet 1, Section II. This reflects:

- The 12-month projection period shown in Worksheet 1, Section II
- The anticipated claim level of the projection period with respect to trend, benefits, and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix 10.1 demonstrates the calculation of the Projected Index Rate by blending the Experience Period Index Rate with the Credibility Manual Index Rate, as applicable. The next two sections further describe the steps taken to develop the Market Adjusted Index Rate and Plan Adjusted Index Rate.

11. Development of the Market-Wide Adjusted Index Rate

The Index Rate for the projection period is adjusted to arrive at the Market Adjusted Index Rate (MAIR) based on the following, as outlined in 45 CFR 156.80(d):

- Adjustment for the Risk Adjustment Program
- Exchange user fee adjustment

The risk adjustment payment/charge is described below. Since the Index Rate is on an allowed claims basis, the market-level adjustments are also performed on an allowed basis.

[redacted]

For further detail on the development of the MAIR, please refer to Appendix 11.1.

Reinsurance: No federal reinsurance recoveries are expected in the projection period. The reinsurance that was entered in the field for projected reinsurance on URRT Worksheet 1, Section II reflects a reduction in the index rate due to the Section 1332 State Relief and Empowerment Waiver. On Appendix 11.1, the reinsurance adjustment is shown on an allowed basis as a multiplicativef actor, and this factor is 0.821.

Risk Adjustment Payment/Charge:

[redacted]

The Risk Transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below:

$$T_i = \left[\frac{(PLRS_i \times IDF_i \times GCF_i)}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{(AV_i \times ARF_i \times IDF_i \times GCF_i)}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)}\right] \times \overline{P}_s$$

Where:

$\overline{P}_s =$ statewide average premium $\times$ 0.86 (to reflect the admin reduction adjustment);

$PLRS_i =$ plan i's plan liability risk score;

$AV_i =$ plan i's metal level AV;

$ARF_i =$ plan i's allowable rating factor;

$IDF_i =$ plan i's induced demand factor;

GCF_i = plan i's geographic cost factor;

S_i = plan i's share of state enrollment as measured in member months.

The denominator is summed across all plans in the risk pool in the market in the state.

We project the portfolio average for each factor in the risk adjustment transfer formula using a combination of (i) actual historical risk adjustment factors adjusted to the projected population and (ii) adjustments for market and risk adjustment program changes. The resulting aggregate payment or receivable is then proportionally allocated to all plans in the portfolio.

For the purposes of stable modeling, each factor was approximated as follows:

Based on the Final Rule for the 2025 Annual Notice of Benefit and Payment Parameters, HHS's proposed 2023 and 2025 HCC model and coefficient changes for 2025 (including partial year adjustment factors, prescription drug condition categories, and model recalibration) were considered in the development of the projected risk adjustment transfer. The demographic, plan mix, and morbidity assumptions were used to project claims costs.

IDF: The statewide average IDF is projected based on the average IDF of the single risk pool in 2025. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Delaware.

The average IDF for Celtic Insurance Company is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to Celtic Insurance Company's projected population. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver, 1.03, Gold 1.08, and Platinum 1.15.

AV: The statewide average actuarial value (AV) is projected based on the average metal level AV of the single risk pool in 2023. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Delaware. The average AV for Celtic Insurance Company is calculated by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to Celtic Insurance Company's projected population. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor (ARF) adjustment accounts only for age rating.

The statewide average ARF was set equal to the average ARF of the single risk pool in 2023. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Delaware.

The average ARF for Celtic Insurance Company is projected by applying the proposed 2025 HHS age rating factors to Celtic Insurance Company's projected population. An equal distribution across ages within each age band was assumed.

GCF: The average Geographic Cost Factors for Celtic Insurance Company's membership is projected based on the 2022 GCFs, as reported by HHS, adjusted for projected changes caused by carrier rate actions from 2022 to 2025.

Outliers were reflected in our calculations to the extent that outliers are reflected in historical risk scores used as the starting point of the 2025 risk transfer projection and via the calculation of the net High Risk Pool receivable or payment. Otherwise, there were no "potential outlier assumptions" that would have an impact on transfers.

The projected transfer amount assumes no impact under the Risk Adjustment Data Validation (RADV) process.

The risk adjustment transfer amounts shown on Worksheet 1 of the URRT are the actual PMPM amounts expected in the projection period. The risk adjustment transfer amount applied to the Index Rate in the development of the Market Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and the morbidity assumptions used to project claims costs.

Exchange User Fees: Exchange user fees have been applied as an adjustment to the Index Rate at the market level. In Appendix 11.1, the user fee is shown on an allowed basis as a multiplicative factor. Note, we assumed 100.00% of members would enroll through the Exchange and 0.00% would enroll outside of the Exchange.

12. Plan Adjusted Index Rate

The Plan Adjusted Index Rate (PAIR) is included in Worksheet 2, Section III of the URRT. The PAIR is the MAIR adjusted for only the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- Actuarial value and cost-sharing design of the plan.
  - [redacted]
    - [redacted]
    - [redacted]
    - [redacted]
  - [redacted]
- The plan's provider network, delivery system characteristics, and utilization management adjustment practices.
- Benefits provided under the plan that are in addition to the EHBs.
  - [redacted]
- Administrative costs, excluding the Exchange user fees (which are already accounted for in the Market Adjusted Index Rate).
  - [redacted]

There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

Administrative costs and non-EHB benefits common to all plans are added to the Market Adjusted Index Rate. Then, factors for actuarial value and cost-sharing and non-EHBs by plan are applied to reach the Plan Adjusted Index Rate for each plan.

The development and values of the Plan Adjusted Index Rates are shown in Appendix 12.1 and are not calibrated.

On Worksheet 2, Section II, the Plan Adjusted Index Rate of the Experience Period is reported.

Administrative Expense Load:

[redacted]

[redacted]

The administrative expenses are allocated proportionally by plan on a constant percentage of premium basis.

Profit (or Contribution to Surplus) & Risk Margin:
This load was applied proportionally to all products and plans and can be found in Appendix 12.2.

Taxes and Fees:
The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in Appendix 12.2. The Risk Adjustment User Fee has been included as part of this adjustment. See Section 11, "Development of the Market-Wide Adjusted Index Rate", for a discussion on how the Exchange user fee was calculated and applied to the Market Adjusted Index Rate.

13. Calibration

[redacted]

Age Curve Calibration:

[redacted]

Appendix 13.1 of the Actuarial Memorandum demonstrates the calibration of the Plan Adjusted Index Rate for age. The distribution of members by age is in Appendix 1.2 and the corresponding age factors are included in Appendix 1.3.

Geographic Factor Calibration:

[redacted]

[redacted]

Tobacco Use Rating Factor Calibration:

[redacted]

Calibration adjustments are applied uniformly to all plans:
The calibration adjustment does not vary by plan and this is demonstrated in Appendix 13.1. Member-level adjustments as described in 45 CFR 147.102 are applied uniformly to all plans in the single risk pool, and these adjustments do not vary by plan.

[redacted]

The distribution of members by rating area is included in Appendix 1.2. Furthermore, Appendix 1.4 provides a sample calculation of premium rates.

14. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Calibrated Plan Adjusted Index Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Calibrated Plan Adjusted Index Rate to determine the rate that is charged to the health insurance subscriber:

- Rating Area
  - The area factors are listed in Appendix 1.3. The methodology for developing geographic factors is included in Section 13, "Calibration".
- Age
  - The prescribed standard age factors were used.
- Tobacco Status
  - 
- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21.

Appendix 1.3 lists the allowable rating factors and Appendix 1.4 contains an example walking through the calculation of a theoretical family’s rates.

15. Projected Loss Ratio

The projected medical loss ratio (MLR) for Celtic Insurance Company in 2025 in Delaware is [redacted], which satisfies the state of Delaware's minimum MLR requirement of 80%. This projected MLR is calculated according to 45 CFR 158. The projected MLR is the projected 2025 calendar year single risk pool experience rather than the three-year period used for determining rebates. No credibility adjustment based on projected enrollment and average deductible was estimated. See Appendix 15.1 for the detail underlying the calculation.

16. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were calculated using the Final 2025 Federal AV Calculator for the plan provisions that fit within the calculator parameters and making appropriate adjustments to the AV identified by the calculator for plan design features that are not compatible with the parameters of the AV Calculator.

The Unique Plan Design Supporting Documentation and Justification for applicable plans is included as part of the QHP filing.

Please refer to Appendix 16.1 for screenshots documenting the outcomes of the AV Calculator for each plan.

17. Membership Projections

18. Terminated Plans and Products

A list of the plans being terminated and the plans to which these are being mapped is included in the appendices as Appendix 18.1.

19. Plan Type

[redacted]

20. Effective Rate Review Information

See Appendix 20.1 for documents summarizing the capital and surplus position of Celtic.

21. Reliance

See Appendix 21.1 for a detailed listing of items received and relied upon for rate development.

22. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries in good standing and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work.

I certify the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis was placed on the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 50, Determining minimum value and Actuarial Value under the Affordable Care Act
- ASOP No. 56, Modeling

I certify that to the best of my knowledge and judgement:

1. The Index Rate for the Projection Period is:
   (a) In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102);
   (b) Developed in compliance with the applicable Actuarial Standards of Practice;
   (c) Reasonable in relation to the benefits provided and the population anticipated to be covered;
   (d) Neither excessive nor deficient based on my best estimate of the 2025 individual market
2. 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.

3. The geographic rating factors reflect only difference in the cost of delivery and do not include differences for population morbidity by geographic area.
4. The CMS Actuarial Value Calculator, with appropriate adjustments, was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans. This rate filing was prepared in compliance with all applicable state and federal statutes and regulations.

The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The 2025 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2025 plan year premium rates provided in this Actuarial Memorandum and the alignment of these premium rates with incurred costs. Changes include, but are not limited to, any legislative or regulatory amendment, court decision, or a decision by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director to adjust funding of CSR subsidies or advance premium tax credits, the operation and parameters of the state Section 1332 waiver reinsurance program. In the event that a material provision is impacted, a revision to the rates will be needed.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Signed: [redacted]

Name: [redacted]

Date: 06/12/2024

All Appendices have been redacted.