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 **Highmark BCBSD Inc.**
- Market for which proposed rates apply (Individual or Small Group) **Individual Market**
- Total proposed rate change (increase/decrease) **9.0%**
- Effective date of proposed rate change **January 1, 2025**

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 9.0% will affect 34,272 members. The rate change will vary by product ranging from a minimum of 1.0% to a maximum of 12.0%.

- 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.

  Attachment B - Supplemental Health Care Exhibit contains a summary of revenue, claims, and expenses. Revenue is expected to increase with the rate change, claims are expected to increase with trend.

- 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).

  Please see table on the following page.

BEP claims relative to projected 2023 claims in 2024 filing	2.8%
Projected Rx rebates and provider settlements	-0.4%
2023 to 2024 Trend	-1.1%
2024 to 2025 Trend	7.6%
Retention	-1.2%
Risk Adjustment	-1.8%
Reinsurance	2.2%
Morbidity, including morbidity impact of reinsurance program	1.7%
Plan Design/Miscellaneous	-0.8%
Average Rate Change	**9.0%**

- 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 9.0%

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

  Base Experience – increase in CMS required starting claim base for rate development.

  Trend – unit cost and utilization changes from the prior year's pricing as well as the impact of projecting an additional year into the future.

  Retention – net change in retention components including administrative expense, taxes, licenses and fees, and profit and risk.

  Risk Adjustment – decrease in costs due to an updated assessment of the risk transfer dollars associated with the ACA risk adjustment program.

  Reinsurance – increase in costs due to parameter changes and an updated assessment of the State of Delaware's 1332 State Innovation Waiver for the state reinsurance program.

  Morbidity – reflects multiple changes, including blending of the ACA pool and new members from multiple sources including uninsured and the employer markets.

  Product Design / Miscellaneous – the projected weighting of member purchases by plan and other miscellaneous factors in the rating process make up the remainder of the rate impact.

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.

State and Federal mandates contribute approximately 1.8% to the rate increase primarily consisting of Senate Bill 120 and House Bill 303.

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

- Provide the period for which the rates will apply.

  January 1, 2025 – December 31, 2025

- Provide the number of members affected by the proposed rate change.

  34,272 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.

  At the request of the Centers for Medicare & Medicaid Services (CMS), Highmark is consolidating several of its HIOS Product IDs. As a result, eight existing plans are being non-renewed and eight new plans are being introduced. Members in the non-renewed plans will be mapped to the equivalent new plans, and their effective rate changes are captured in the proposed average rate change.

  Highmark is introducing eight new plans:

76168DE0730003	**my Blue Access PPO Premier Platinum 0**
76168DE0740004	**my Blue Access PPO Premier Platinum 0 + Adult Dental and Vision**
76168DE0690011	**my Blue Access PPO Standard Platinum 0**
76168DE0690010	**my Blue Access PPO Standard Gold 1500**
76168DE0690009	**my Blue Access PPO Standard Silver 5000**
76168DE0700006	**my Blue Access PPO Standard Silver 5000 + Adult Dental and Vision**
76168DE0690012	**my Blue Access PPO Standard Bronze 7500**
76168DE0690013	**my Blue Access Major Events PPO Catastrophic 9200 - 3 Free PCP Visits**

  Non-Renewed Plans:

76168DE0690005	**my Blue Access PPO Platinum 0**

76168DE0700005	**my Blue Access PPO Platinum 0 + Adult Dental and Vision**
76168DE0760004	**my Blue Access PPO Standard Platinum 0**
76168DE0760003	**my Blue Access PPO Standard Gold 1500**
76168DE0760002	**my Blue Access PPO Standard Silver 5900**
76168DE0770001	**my Blue Access PPO Standard Silver 5900 + Adult Dental and Vision**
76168DE0760005	**my Blue Access PPO Standard Bronze 7500**
76168DE0720001	**my Blue Access Major Events PPO Catastrophic 9450 - 3 Free PCP Visits**

- Discuss why the rate changes vary and how they vary.

  Rate changes vary depending on actuarial value, benefit richness and eligibility for catastrophic coverage.

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 anticipated medical loss ratio is about 92% relative to total premium less taxes and fees. This loss ratio is calculated consistently with the federally prescribed MLR methodology.

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

  The anticipated medical loss ratio is about 92% relative to total premium less taxes and fees. This loss ratio is calculated consistently with the federally prescribed MLR methodology.

- 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?

  Highmark Delaware continues to focus efforts on care management activities in order to lower the future medical cost for its members. Clinical teams, led by experienced doctors and nurses, analyse claim data to identify opportunities for more efficient care delivery and lower medical cost trends.

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

  Highmark Delaware products are aimed at improving the quality, effectiveness, and efficiency of care. As health care continues to evolve, Highmark Delaware remains committed to providing a variety of product offerings like telehealth visits, to meet the needs of individuals and families.