

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 **Celtic Insurance Company**
- Market for which proposed rates apply (Individual or Small Group) **Individual Market**
- Total proposed rate change (increase/decrease) **31.8%**
- Effective date of proposed rate change **January 1, 2026**

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 31.8% will affect 10,619 individual members. The rate change will vary by product and plan, ranging from a 29.3% increase to a 41.9% increase.

- 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.

Year	MMs	Revenue	Claims	Expenses	Profit
2024	12,766	\$470.10	\$234.05	\$59.96	\$176.09

- 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
Experience & Morbidity	27.3%
Unit Cost Trend	2.2%
Utilization	-0.6%
Non-Benefit Expenses	1.9%
Total	31.8%

- 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 a 31.8% increase.

- Provide a brief explanation for the rate change in each of the factors shown in the chart.
 - **Experience & Morbidity** – 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 2024 to 2026), including anticipated changes in the average morbidity of the single risk pool.
 - **Unit Cost Trend** – Unit costs and provider reimbursement agreements have been updated to reflect changes in the rating year.
 - **Utilization** – The projected utilization trends are consistent with observed historical trends based on internal analysis of our marketplace experience, supplemented by the Milliman Health Cost Guidelines.
 - **Non-Benefit Expenses** – Changes in general administrative expenses have been incorporated into 2026 rates are resulting in a rate increase due to differences from prior year expense assumptions.

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 factors discussed in the proposed rate change section above.

Due to changes in the projected provider reimbursement level and utilization, the assumed trend is a necessary component of the rate change.

Legally required benefit changes had minimal impacts on rates.

Administrative costs and anticipated profits increased rates by 1.9%.

eAPTC expiration will shift statewide average morbidity, and expected to increase the index rate by 21.8% between the base and projection periods.

1332 Reinsurance parameters were updated to an attachment point of \$55,000, reinsurance cap of \$340,000 and coinsurance rate of 35%, as released by DHSS on 7/15/25.

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

- Provide the period for which the rates will apply.

January 1, 2026 – December 31, 2026

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

The proposed rate change applies to 10,619 individual 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.

There are no new or non-renewing plans in 2026.

Plan Name	Plan ID	Cumulative Rate Change % (over 12 mos prior)
Clear Gold	64004DE0090011	37.6%
Complete Gold	64004DE0090009	41.9%
Elite Silver	64004DE0090013	35.2%
Everyday Bronze	64004DE0090002	34.8%
Focused Silver	64004DE0090007	29.6%
Principal Bronze HSA	64004DE0090001	41.3%
Standard Expanded Bronze	64004DE0090004	36.2%
Standard Gold	64004DE0090012	39.5%
Standard Silver	64004DE0090008	29.3%
Clear Gold + Vision + Adult Dental	64004DE0100011	37.4%
Complete Gold + Vision + Adult Dental	64004DE0100009	41.7%
Elite Silver + Vision + Adult Dental	64004DE0100013	35.0%
Everyday Bronze + Vision + Adult Dental	64004DE0100002	34.6%
Focused Silver + Vision + Adult Dental	64004DE0100007	29.4%
Premier Bronze HSA + Vision + Adult Dental	64004DE0100001	41.0%
Standard Expanded Bronze + Vision + Adult Dental	64004DE0100004	36.0%
Standard Gold + Vision + Adult Dental	64004DE0100012	39.3%

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

Rate changes vary by product and plan due to differences in actuarial value, benefit richness, and induced utilization.

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 medical loss ratio (MLR) is 85.1%. The projected MLR is based on the prescribed calculation from 45 CFR 158, but solely reflects the projection year single risk pool experience, rather than the three-year combined period that is used for determining MLR rebates.

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

The projected medical loss ratio (MLR) includes the proposed 31.8% rate increase for 2026.

- 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?

Celtic Insurance Company engages in several programs to help improve the health care quality for members. My Health Pays is a program that rewards members for completing health activities. We are also continuing to set incentives for providers to achieve pre-determined quality metrics and provide more efficient care.

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

In building our product, we keep in mind our target population, which includes lower income, uninsured, and former Medicaid members. To meet these members' needs, we take deliberate network, product, and marketing actions to provide an attractive product at low cost.