Part III Actuarial Memorandum

Highmark Coverage Advantage

Individual Rate Filing

Effective January 1, 2023

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I. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Highmark Coverage Advantage's (HCA) individual block of business rate filing, for products with an effective date of January 1, 2023. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the Pennsylvania Insurance Department, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of HCA's rate filing. However, we recognize that this certification may become a public document. HCA makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum that would result in the creation of any duty or liability under any theory of law by HCA.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

I.1 Company Identifying Information:

- Company Legal Name: Highmark Coverage Advantage
- State: The Commonwealth of Pennsylvania has regulatory authority over these policies.
- HIOS Issuer ID: 79279
- Market: Individual
- Effective Date: January 1, 2023

I.2 Company Contact Information:

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

II. Proposed Rate Changes

For all rate changes by plan, see the 'Cumulative Rate Change % (over 12 mos prior)' found in Worksheet 2, line 1.11 of the URRT. The rate change varies by plan due to an update in several of our pricing factors and changes in cost sharing required to meet Actuarial Value and other cost sharing restrictions under the Affordable Care Act as well as mappings between discontinued and new plans.

The primary drivers of the rate increase are cost and utilization trend and changes to the reinsurance parameters.

In accordance with the Department's August 23, 2022 guidance, the impact of the state 1332 Reinsurance program is captured using the prescribed parameters of $60,000 attachment point, 53% coinsurance rate, and $100,000 reinsurance cap. If the final parameters should change from those described in this filing, a revised submission would be required.

Other assumptions in the filing account for the ongoing impact of the COVID-19 pandemic and the lack of Federal CSR funding. The continuation of American Rescue Plan Act (ARPA) level enhanced subsidies in the Inflation Reduction Act was considered in the rate development but no adjustment was included at this time. Finally, modifications to the rate development may be necessary if significant unforeseen events occur. Examples include, but are not limited to, changes in legislation/regulations (including rules, regulatory guidance, etc.), changes in the participation of QHP issuers that would materially impact risk adjustment transfer amounts, Medicaid redetermination policy impacts, or material developments in the course of the COVID-19 pandemic. As a result, HCA reserves the right to submit a revised filing.

III. Experience and Current Period Premium, Claims, and Enrollment

III.1 Paid through Date:

Experience Period claims were based on incurred calendar year 2021, paid through February 2022. This includes 2021 experience in Affordable Care Act compliant plans. HCA did not offer any transitional plans in 2021.

III.2 Current Date:

The current date shown represents a snapshot of February 1, 2022.

III.3 Allowed and Paid Claims Incurred During the Experience Period:

- Historical Experience: We chose HCA's current experience for the individual block of business for the period January 1, 2021 through December 31, 2021, with claims paid through February, 2022 as the basis for the 2023 projected individual market pricing.

- Claims Incurred During the 12-month Experience Period: Worksheet 1, Section I shows our best estimate of the amount of claims that were incurred during the 12-

month experience period for HCA's individual book-of-business. This section includes:

- The amount of claims which were processed through Company's claims system,
- Claims processed outside of the Company's claims system, and
- Our best estimate of claims incurred but not paid as of the paid through date stated above.

- Method for Determining Allowed Claims: For non-capitated claims, the allowed charges are summarized from The Company's detailed claim-level historical data. This experience includes 2021 claims for Affordable Care Act compliant business. For capitated and other off-system claims, historical capitations and experience were tabulated and added to the claims.

- Paid Claims: We also summarized the paid claims from detailed member records. The paid-to-allowed ratio for the experience period reflects the 2021 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: The Company is using a completion factor of 0.9783 to include IBNR claims in allowed charges. The IBNR completion factor was developed using our corporate reserving system for The Company's individual business. We applied it equally to both paid and allowed total claims (as a change to utilization) to complete the experience.

IV. Benefit Categories

The index rate of the experience period was summarized at the defined benefit categories included in Worksheet 1, Section II of the URRT.

The data provided in this section closely adheres to the preferred definitions of the Benefit Categories included in the URRT instructions, including the "Other Medical" category. The "Other Medical" category units reflect visits for PDN/home health, trips for ambulance and procedures for DME/prosthetics. Prescription drugs utilization were converted to a "per 30-day" script count.

V. Projection Factors

V.1 Trend Factors

This development of the CY2023 rates reflects an annual trend rate of 6.75% (4.0% cost, 2.6% utilization). These trends reflect HCA's expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and normalize for some of the more explainable variables such as high dollar claims, work days, provider contracting, demographics, and seasonality.

The trend represents a blended average for all types of service and is applied to the aggregate experience for pricing. These trends represent assumed community-wide expectations. Claim variations due to the specific projected enrolled population in this single risk pool are reflected in the morbidity adjustment.

V.2 Changes in the Morbidity of the Population Insured

The Change in Morbidity adjustment of 0.932 is comprised of the following: the morbidity impact from claims experience and an adjustment to account for the impact of Covid-19. In accordance with the Department's guidance, the morbidity change related to the Reinsurance program is set to 1.000. Each of the components is described in more detail below.

The Morbidity Impact from Claims Experience

This adjustment reflects the change in the population mix/claim levels from the experience period to the projection period. We continue to observe a high degree of membership churn from year-to-year, which impacts the morbidity. This factor also takes into consideration the effects of adverse selection inherent to guaranteed issue markets. The Individual ACA risk pool continues to have a significantly higher proportion of older members with a high prevalence of chronic conditions compared to group business, which adds to the uncertainty of any future claim projections.

Covid-19 Impact

In order to account for the impact of COVID-19 on projected claim costs, the Company took the following steps:

1. Adjusted the claims in the base experience period to a non-COVID-19 baseline. This was done to stabilize the base from which claims are being projected. The base period adjustment accounts for the impacts of testing, treatment, vaccines, and deferred/rescheduled/induced care. Claims in the base experience period were decreased by a factor of 0.953 to remove the impact of COVID-19.
2. Projected claims to the projection period using trends with the impact of COVID-19 excluded. Again, this provides for a more stable projection of future claims, before applying the anticipated impact of COVID-19 in the projection period. This was

accomplished by applying a trend of 6.75% (which excludes any impact from COVID-19) to our adjusted BEP claims.

3. The projected claims were then further adjusted by applying the anticipated impacts of COVID costs expected in the projection period. The following components were accounted for:
    a. COVID Testing (0.2% claims impact) – Proportional to new cases, which are assumed to diminish over time and be lower in the projection period than in previous years.
    b. COVID Treatment/Care (0.2% claims impact) – Proportional to new cases, which are assumed to diminish over time and be lower in the projection period than in previous years. Additionally, new variants are expected to be less severe.
    c. Vaccines (1.2% claims impact) – Assumes insurers will cover vial cost and administration cost; however, booster utilization is expected to diminish.
    d. Deferred/Rescheduled/Induced Care (1.1% claims impact) – Includes care that didn't happen because it wasn't necessary (like ER visits), because it couldn't get scheduled (like inpatient stays when the beds are filled with COVID patients), and care that patients chose to defer (like elective procedures). For the projection period, the primary driver of avoided care is displaced non-COVID care.
    e. Actuarial Judgement (-1.4% claims impact) – The Company reviewed the composite CY2023 COVID impact resulting from the components outlined above and elected to temper the adjustment in light of the inherent unpredictability of items such as deferred care and treatment costs.

The application of the above COVID claim adjustments to the rating period results in a COVID adjustment factor of 0.958.

V.3 Changes in Demographics

We project that the average rating factor (age, tobacco load and area combined) will increase by about 2.3% due to the change in the population. This is primarily due to the expectation that the new members from the group and/or uninsured populations to be slightly older than the population in the underlying experience. This increases the projected allowed claims (utilization) by the same amount.

V.4 Changes in Benefits

There is no change in benefits related to the essential health benefit (EHB) categories so the factor is set to 1.0. The cost sharing changes for the EHBs are captured in the paid to allowed ratio factors discussed in the AV and Cost Sharing Design of Plan section X.1.

V.5 Changes in Other

The 1.0004 factor represents the combined impact of changes in network, induced demand, pharmacy rebates, hospital/physician settlements, and state mandates/laws (when applicable).

VI. Manual Rate Adjustments

HCA's individual experience is fully credible. No manual rate is developed or used in this projection.

VII. Credibility of Experience

The experience is from HCA's individual book of business in 2021. It is large enough to be fully credible. Our results are based 100% on the experience rate, as adjusted.

VIII. Index Rate

The index rates as shown on Worksheet 1 of the URRT are simply the single risk pool average allowed claims for the Essential Health Benefits for the experience and projected populations, respectively, for HCA. For the experience period, only non-grandfathered plans are included. The projection period Index Rate is not adjusted for reinsurance or risk adjustment programs or any other fee.

IX. Market Adjusted Index Rate [MAIR]

The Market Adjusted Index Rate is the Projected Index Rate further adjusted for risk adjustment and the exchange fee.

IX.1 Projected Reinsurance PMPM

As outlined in the waiver application, the State is anticipating the Reinsurance Program will have the following parameters for 2023: an attachment point of $60,000, a coinsurance rate of 53%, and a cap of $100,000. HCA estimated the impact of the reinsurance program under these tentative parameters by trending Highmark PA individual ACA CY2021 incurred claims by member to the CY2023 rating period, applying the parameters, and calculating the amount of incurred claims expected to be reimbursed by the program. The modeling produced an estimated incurred claims savings of 4.8%. This percentage was converted to a PMPM and adjusted to an equivalent allowed claim basis by dividing the PMPM by the paid-to-allowed factor and the composite effect of catastrophic eligibility. This amount is reflected in worksheet 1 of the URRT.

IX.2 Projected Risk Adjustment PMPM

The estimated average risk score for HCA's projected 2023 population was developed by using HCA's 2021 claim diagnoses and the risk adjustment coefficients as finalized in the Notice of Benefit and Payment Parameters. Similarly, actuarial value factors and induced demand factors were estimated for HCA based upon its projected 2023 population.

We estimated the statewide average risk transfer factors based on current market assumptions. We estimated the statewide average premium using current market premium assumptions with adjustments for anticipated rate changes for 2023.

The actual calculation of the risk transfer followed the risk transfer methodology as prescribed.

The analysis resulted in HCA paying to the risk adjustment pool. The (35.22) PMPM value shown in worksheet 1 of the URRT is developed by taking the expected risk transfer amount plus the projected High Cost Risk Pool charge and adjusting it to an equivalent allowed claims basis by dividing it by the paid-to-allowed factor and the composite effect of catastrophic eligibility and benefits in addition to EHB.

For the purposes of this rate filing, HCA has assumed no adjustment to the projected risk adjustment transfer for the Risk Adjustment Data Validation (RADV) program.

IX.3 Exchange User Fee %

The 3.10% value shown in worksheet 1 of the URRT is developed by multiplying the 3% exchange user fee by the assumed percentage of on exchange membership. This calculated amount is then divided by the paid-to-allowed factor to bring it to an equivalent allowed claims basis and adjusted further for the composite effect of catastrophic eligibility and benefits in addition to EHB.

X. Plan Adjusted Index Rate [PAIR]

The Plan Adjusted Index Rates can be found on line 3.10, Worksheet 2 of the URRT. The PAIR rates are calculated by applying the allowable rating factors as described below to the Market Adjusted Index Rate.

X.1 AV and Cost Sharing Design of Plan

The AV and Cost Sharing allowable rating factor is comprised of the following components:

- The utilization due to differences in cost sharing is based on the factors calculated using a methodology prescribed in the Department's guidance relative to the weighted average. No differences due to health status are in these adjustments.

- The pricing AV for the benefits and cost sharing of the plan and a CSR load for the on exchange silver plans.

Impact of Non-Payment of Cost Sharing Reduction Subsidies

In accordance with the Department's guidance, we have applied an additional adjustment to our AV pricing values for those Silver plans not offered exclusively off-exchange. This adjustment factor was 1.22 and represents the non-payment of Cost Sharing Reduction subsidies.

X.2 Provider Network Adjustment

The provider network adjustments are developed by dividing the plan level network factors by the overall weighted average from all plans.

X.3 Benefits in Addition to EHB

Non-EHB benefits have been added to several plans. Six plans have an adult dental and vision benefit and four plans have a hearing, OTC, and personal assistance (i.e. Papa Pals) benefit.

X.4 Administrative Expense

The proposed rates reflect internal administrative costs including quality improvement administrative expenses. This cost was developed based on standard expense allocation methods.

X.5 Taxes and Fees:

The following fees were added:

- $0.22 PMPM for Risk Transfer User Fee
- $0.26 PMPM for Patient Centered Outcomes Research Insitute (PCORI) Fee
- 0.0% for the Health Insurance Provider Fee
- 0.0% for the PA Premium Tax

X.6 Profit (or Contribution to Surplus) & Risk Margin:

HCA has voluntarily refrained from including a risk and contingency factor in this filing. By this voluntary restraint, HCA is not waiving any right to include a risk and contingency factor which HCA believes is consistent with historical and legal interpretations of HCA and the Pennsylvania Insurance Department.

X.7 Catastrophic Adjustment

For catastrophic plans, we use a 0.92 factor for the specific eligibility adjustment.

XI. Calibration

XI.1 Age Curve Calibration:

The projected weighted average age factor for billable members is 1.7771. This factor is calculated by dividing the all members age factor of 1.7766 by the ratio of billable members to total members 0.9997. The age curve calibration factor is 1/1.7771 = 0.5627.

XI.2 Geographic Calibration Factor:

The projected weighted average geographic factor is 0.940. Each Plan Adjusted Index Rate represents the rate for an average member with a geographic factor of 0.940. The geographic calibration factor is 1/0.940 = 1.0638.

XI.3 Tobacco Calibration Factor:

The projected weighted average tobacco factor is 1.007. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of 1.007. The tobacco calibration factor is 1/1.007 = 0.9931.

XI.4 Consumer Adjusted Premium Rate Development:

The calibrated plan adjusted index rate represents the base rate for an age factor of 1.0, geographic rating factor of 1.0 and tobacco rating factor of 1.0. Thus, the approximate premium for a specific member can be derived by multiplying this rate by the HHS age curve factor, the rating area factor on Worksheet 3 of the URRT, and the appropriate tobacco factor. Please note that this method will only produce approximate rates due to URRT rounding constraints.

XII. Projected Loss Ratio

The projected loss ratio for 2023 using the federally-prescribed MLR methodology is 88.9%.

XIII. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based the Federal AV Calculator. Some plans did require an adjustment to the inputs entered into the AV calculator. Screen shots and certifications for these plans were submitted as part of HCA's QHP application. Per CMS's guidance, a dummy AV Metal Value was applied to any terminated plans that fell out of the new de minimis range.

XIV. Membership Projections

Membership projections reflect HCA's expectations for 2023. These projections reflect expected changes in market share due to market competition, relative price levels, and changes in plan offerings (where applicable).

HCA expects membership in 2023 to follow a similar metal level distribution as the Individual ACA experience period in the markets where plans will continue to be offered.

For the Silver level plans, the projected membership by cost sharing subsidy levels is based on the observed distribution of ACA members that were eligible under the federal poverty levels as determined by the federal health insurance exchange. The projected enrollment by plan and subsidy level is as follows:

CSR Silver Plan Membership Distribution			
FPL	**Subsidy Level**	**% of Silver Membership**	**% of Total Membership**
<150%	94%	31.1%	6.3%
150%-200%	87%	50.5%	10.3%
200%-250%	73%	5.8%	1.2 %
>250%	70%	12.6%	2.6%
Total		100.0%	20.3%

XV. Terminated Plans and Products

Plans in the 2021 experience period that will no longer be available in 2023 can be found in Exhibit I.

HCA also has some plans that were offered only in 2022 (not offered in the experience period or in the projection period). These plans are shown in Exhibit I.

XVI. Plan Type

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe HCA's plans adequately.

XVII. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. All statements in this actuarial certification are accurate to the best of my knowledge and understanding. This filing is prepared in compliance with applicable Actuarial Standards of Practice. In completing this filing, I relied on data/information from other sources which was reviewed for reasonableness. This filing is prepared on behalf of HCA to accompany its rate filing (for calendar year 2023) for the Individual Market on and off the Pennsylvania Exchange.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (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 the population anticipated to be covered
- Neither excessive nor deficient.

I certify that 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.

I certify that 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. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. If any adjustments were required outside of the AV Calculator, appropriate certification has been provided to CMS through the QHP application process.

I certify that the geographic rating reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

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

Signed: [redacted]

[redacted]

Title: [redacted]

Date: August 26, 2022

XVIII. Exhibit I

Highmark Coverage Advantage

Terminated Experience Period Plans

HIOS ID	Metal	Plan Name	2023 Mapping
79279PA0090003	Silver	Together Blue EPO Silver 1850 HSA	N/A
79279PA0080006	Gold	Together Blue EPO Gold 800	N/A
79279PA0130001	Gold	Together Blue EPO Gold 800 + Adult Dental and Vision	N/A
79279PA0120001	Gold	Together Blue Care Advantage EPO Gold 800	N/A
79279PA0110001	Gold	Together Blue Care Advantage EPO Gold 800 + Adult Dental and Vision	N/A
79279PA0090002	Silver	Together Blue EPO Silver 3250 HSA	79279PA0080012
79279PA0080004	Silver	Together Blue EPO Silver 2900	79279PA0140002
79279PA0130003	Silver	Together Blue EPO Silver 2900 + Adult Dental and Vision	79279PA0150002

Terminated Plans Offered in 2022 Only

HIOS ID	Metal	Plan Name	2023 Mapping
79279PA0160001	Gold	Together Blue Care Advantage EPO Premier Gold 0	79279PA0140001
79279PA0170001	Gold	Together Blue Care Advantage EPO Premier Gold 0 + Adult Dental and Vision	79279PA0150001