# ACTUARIAL MEMORANDUM – TRADE SECRET
# AMERIHEALTH CARITAS VIP NEXT, INC.
# INDIVIDUAL MARKET RATES EFFECTIVE 1/1/2024
# HIOS ISSUER ID 72760

## GENERAL INFORMATION SECTION

I, Kara Clark, am a Partner with Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman), and have been retained by AmeriHealth Caritas VIP Next, Inc. (AHC) to assist in the review and development of their single risk pool plans to be offered for calendar year 2024 in the individual market. The plans associated with this filing will be offered both on and off the Federally Facilitated Marketplace (FFM) in Delaware. The effective date of the proposed rates is January 1, 2024.

This actuarial memorandum supports a rate filing for AHC's individual market business. The scope of this memorandum is limited to supporting the development of the individual market rates. The rates were developed in compliance with the applicable laws and regulations of the State of Delaware as well as the Affordable Care Act and its implementing regulations. This memorandum should not be used for any purpose other than those expressly stated.

This actuarial memorandum supports an updating filing submission relative to the initial filing. Below is a summary of the updates that were implemented:

1. As requested in the objections received on June 23, we have updated the estimated impact of the reinsurance program to reflect the 2024 reinsurance parameters.

Below is a summary of the company identifying information and company contact information.

| **Company Identifying Information** | |
|---|---|
| Company Legal Name | AmeriHealth Caritas VIP Next, Inc. |
| State | Delaware |
| HIOS Issuer ID | 72760 |
| Market | Individual |
| Effective Date | 1/1/2024 |

| **Company Contact Information** | [redacted] |
|---|---|
| Primary Contact Name | |
| Primary Contact Telephone Number | |
| Primary Contact Email Address | |

## Proposed Rate Changes

This filing contains the proposed rates for one existing ACA-compliant product that AHC will offer in the individual market. A summary of the rate change is as follows:

**Rate Increase by Product**

| Product ID | Product Name | Min | Max | Average |
|---|---|---|---|---|
| 72760DE001 | AmeriHealth Caritas VIP Next | -7.97% | -2.67% | -4.52% |

Note: The average rate changes shown in the table above are based on current enrollment and do not account for the impact of aging, consistent with the Unified Rate Review Template. The min, max, and average rate changes shown in the table above are based on the plan-level rate changes shown in the Unified Rate Review Template.

### REASON FOR RATE INCREASE(S)

The proposed rate changes are the result of updated experience utilized for the manual rate development, revised projection factors, plan factors, and changes in non-benefit expense amounts.

# MARKET EXPERIENCE

AHC had no products in effect in Delaware in 2022, so there is no experience to report. The 2024 premium rates are based on a manual rate as described within this actuarial memorandum.

## A. Experience and Current Period Premium, Claims, and Enrollment

**Paid Through Date:**
AHC had no products in effect in Delaware in 2022, so there is no experience to report.

**Current Date:**
AHC had no products in effect in Delaware in 2022, so there is no experience to report.

**Experience Period Premium:**
AHC had no products in effect in Delaware in 2022, so there is no experience to report.

**Allowed and Incurred Claims Incurred During the Experience Period:**
AHC had no products in effect in Delaware in 2022, so there is no experience to report.

## B. Benefit Categories

AHC had no products in effect in Delaware in 2022, so there is no experience to group to each service category. Claims underlying the manual rate were grouped into the benefit categories using claim line level characteristics such as place of service, provider type, revenue codes, procedure codes, etc. The definitions used to bucket the claims into benefit categories are consistent with the preferred definitions in the URRT instructions.

Inpatient hospital claims are claims associated with an inpatient facility stay. These include claims associated with medical, surgical, maternity, mental health, and substance abuse admissions, as well as admissions at skilled nursing facilities.

Outpatient hospital claims are claims associated with outpatient facility services. These include claims associated with emergency room visits, surgeries, lab and radiology services, therapies, etc.

Professional claims are claims associated with services rendered by primary care physicians and specialists, therapy services, the professional component of lab and radiology services, and other professional services.

Other Medical claims are claims associated with ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, Part B drugs dispensed or administered by a provider, and other items.

Prescription drugs include all drugs dispensed by a retail pharmacy. Pharmacy costs are net of pharmacy rebates.

AHC does not have any capitation arrangements.

### C. Projection Factors

The premium rates were developed using a manual rate.

**Medical and Pharmacy Trends:**
Not applicable.

**Morbidity Adjustment:**
Not applicable.

**Demographic Shift:**
Not applicable.

**Plan Design Changes:**
Not applicable.

**Other Adjustments:**
Not applicable.

## MANUAL RATE ADJUSTMENTS

AHC had no products in effect in Delaware in 2022, so a manual rate was used to develop the projected 2024 premium rates.

### A. Source and Appropriateness of Experience Data Used

[redacted]

### B. Adjustments Made to the Data

The following adjustments were made to the manual rate to project 2024 claim cost.

**Demographic Adjustment**

An adjustment of [redacted] was applied to account for differences in the demographic mix between the projected population and the population underlying the manual rate experience. [redacted] The table below demonstrates the development of the demographic adjustment.

[redacted]

**Morbidity Adjustment**

[redacted]

[redacted]

[redacted]

**Induced Demand Adjustment**

An induced demand factor of [redacted] was applied to account for [redacted]

[redacted]

The table below summarizes the development of the induced demand adjustment.

[redacted]

**HMO Adjustment**

An adjustment of [redacted] was applied to account for differences between the network mix underlying the manual rate and the projected population. [redacted] The HMO adjustment translates the manual rate experience to an HMO-only basis. [redacted]

[redacted] The table below summarizes the development of the HMO adjustment.

[redacted]

[redacted]

**Provider Contract Adjustment**

An adjustment of [redacted] was applied to account for differences in the provider contracts between the projected population and the population underlying the manual rate experience. [redacted]

**Trend Adjustment**

An adjustment of [redacted] was applied to trend the calendar year 2021 experience underlying the manual rate forward to the projected period. [redacted]

To develop the assumed trend rates, historical Delaware medical and pharmacy trends assumed in individual ACA pricing were analyzed. Additionally, we compared the results of our trend analysis to a comprehensive trend survey produced by Oliver Wyman. The survey reflects responses from carriers and HMOs insuring over 5.5 million individual members as of July 2022. The following trends represent the results for individual HMO policies. Prescription drug trends are shown separately from medical trends. Overall, the assumed trends are reasonable when compared to the carrier trend survey.

[redacted]

[redacted]

**COVID-19**

[redacted]

**Regulatory Framework**

[redacted]

**Inclusion of Capitation Payments**

AHC will not have any capitated arrangements in the projection period.

## CREDIBILITY OF EXPERIENCE

[redacted]

## ESTABLISHING THE INDEX RATE

The projected allowed cost PMPM was adjusted to reflect the population expected to be insured in 2024, including an adjustment for claims trend. With these adjustments, the projected Index Rate PMPM is [redacted]. The table below summarizes the build-up of the projected Index Rate PMPM for benefit year 2024.

[redacted]

[redacted]

# DEVELOPMENT OF THE MARKET ADJUSTED INDEX RATE

In order to determine the Market Adjusted Index Rate (MAIR), the Index Rate must be adjusted to account for all allowable market-wide modifiers (i.e., reinsurance, risk adjustment transfers, and exchange user fees), with the impact of these items spread evenly across the single risk pool. The MAIR shown in the URRT reflects the impact of reinsurance, risk adjustment transfers, and exchange user fees.

The impact of exchange user fees, reinsurance, and risk adjustment transfers has been calculated such that after the application of the average cost sharing factors, the necessary dollar amount is realized (i.e., the amounts are grossed up to an allowed claim cost basis). As shown in the table below, the adjustment applied to the Index Rate to arrive at the MAIR [redacted] A description of each market level adjustment is summarized in the sub-sections below.

[redacted]

The Average Cost Sharing Factor shown in the table above reflects the average actuarial value and cost sharing adjustment developed using Oliver Wyman's MarVAL™ model. MarVAL™ utilizes data from a large commercial dataset and was calibrated to produce paid claim costs that are consistent with those expected to be observed in 2024. The cost sharing parameters for each plan were applied to the applicable service categories to determine the paid to allowed ratio for each plan. MarVAL™ does not reflect differences in selection between populations with different morbidities. The Average Cost Sharing Factor is consistent with the ratio of projected incurred claims to projected allowed claims across all plans shown on Worksheet 2, Section IV of the URRT.

## A. Reinsurance

There is no federal reinsurance program to consider; however, it is expected that Delaware will operate a state-based reinsurance program in 2024. We have utilized the previous year's reinsurance parameters consistent with the guidance provided by the Delaware Department of Insurance (i.e., $65,000 attachment point, 78% coinsurance, and $340,000 cap). [redacted]

[redacted]

## B. Risk Adjustment Payment/Charge

There are three components of the risk adjustment payment/charge: the risk adjustment transfer payment/charge, the high cost risk pool receipt, and the high cost risk pool assessment. [redacted]

[redacted]

## C. Exchange User Fees

[redacted]

# PLAN ADJUSTED INDEX RATES

The PAIRs are developed by applying all allowable plan level modifiers to the MAIR. Two plan level adjustments are applied to the MAIR to develop the PAIRs: an actuarial value and cost sharing adjustment and an adjustment for administrative costs. Since AHC only offers one network, a plan level adjustment for network is not applicable. AHC will not offer a catastrophic plan in 2024, so the catastrophic adjustment does not apply. Each applicable plan level adjustment is described further in the following sub-sections.

Please note that while Worksheet 2, Section III of the URRT summarizes the calculation of each PAIR; the actual PAIR will vary slightly relative to those shown in the URRT due to differences in rounding. Appendix A summarizes the calculation of each PAIR used to calculate consumer premium rates for individuals with effective dates of coverage in 2024.

## A. Actuarial Value and Cost Sharing Adjustments

The actuarial value and cost sharing adjustments were developed using Oliver Wyman's MarVAL™ model. The model was calibrated to produce paid claim costs PMPM that are consistent with those expected to be observed in 2024, and the cost sharing parameters for each plan were applied to the appropriate service categories to determine the paid to allowed ratio for each plan. The actuarial value and cost sharing adjustment includes an estimate of induced utilization related to cost sharing but does not reflect any difference due to the health status of the individuals expected to select a given plan. The

induced utilization assumptions underlying the actuarial value and cost sharing adjustment follow the HHS induced demand assumptions underlying the risk adjustment transfer formula.

[redacted]

## B. Benefits in Excess of EHBs

[redacted]

## C. Administrative Costs

Administrative costs, except for the risk adjustment user and PCORI fees, are applied equally to each plan as a fixed percent of premium. The risk adjustment user and PCORI fees are applied equally to each plan as a PMPM amount, which will result in slight differences for the taxes and fees assumption by plan as a percent of premium. The administrative costs are summarized below for each of the administrative cost categories shown on Worksheet 2, Section III of the URRT. While exchange user fees are reflected as a market level adjustment and reflected as an administrative cost adjustment on Worksheet 2, Section III, they are reflected in the tables below for completeness.

[redacted]

The taxes and fees included in the rate development are summarized in the table below. As noted above, exchange user fees are listed in the table below. They are reflected on Worksheet 1, Section II of the URRT as a market level adjustment and not as an administrative cost on Worksheet 2, Section III of the URRT.

[redacted]

[redacted]

# CALIBRATION

Issuers are required to apply a single calibration factor to all PAIRs so that the allowable rating factors for age, geography, and tobacco use are applied appropriately to arrive at consumer adjusted premium rates. As such, all PAIRs will be adjusted by a factor of [redacted] to calibrate for age, geography, and tobacco use. The table below summarizes each component of the calibration factor.

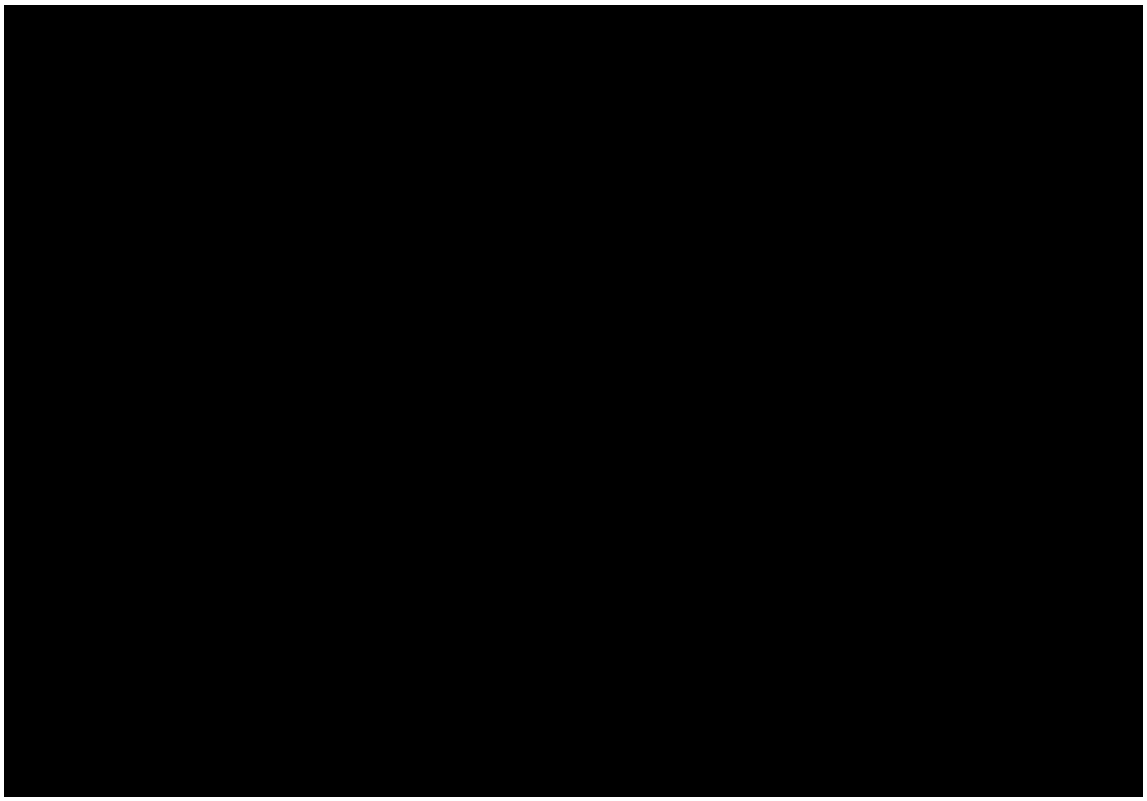
[redacted]

A description of how each component was determined is included in the sub-sections that follow. A demonstration of how the calibration factor is applied to the PAIRs is shown in Appendix B.

## A. Age Calibration Factor

The age curve calibration applied to the PAIRs represents the relativity of the 21 year-old age rating factor to the average age rating factor produced using the distribution of members for the rating period. This is approximately equal to [redacted]. The weighted average age rating factor corresponds with an age rating factor for a [redacted] year-old, approximately. The methodology to determine the age curve calibration is based on the projected distribution of members by age and the HHS standard age curve. The age curve calibration was applied to all plans uniformly. The table below summarizes the projected distribution by age along with the anticipated average age rating factor.

[redacted]



## B. Geographic Calibration Factor

There is only one rating region in Delaware, so AHC will not rate by geography.

## C. Tobacco Use Rating Factor Calibration

The tobacco use rating factor calibration applied to the PAIRs represents the relativity of a "1.0" tobacco use rating factor to the average tobacco use rating factor based on the expected membership distribution by tobacco use status for the projection period. Based on the expected membership distribution by tobacco use status, the tobacco calibration factor is . The table below summarizes the tobacco use rating factors along with the projected membership by tobacco use status.

AHC will not rate for tobacco use for individuals under the age of 21.

# CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

Consumer adjusted premium rates for non-tobacco users for each age are developed by applying the standard age curve to the calibrated PAIRs and multiplying by the geographic rating factor for the applicable region. Rates for tobacco users can be derived by multiplying the tobacco load by the resulting non-tobacco premium rate.

Individual premiums are calculated for each member in a family unit, with a family unit defined as a primary, spouse, and any child dependents of the primary. The premium for a family unit is calculated by summing the individual premiums for all individuals age 21 and over and the premiums for the three oldest dependent children under the age of 21 for a given primary. Appendix B summarizes all rating factors and includes a sample premium rate calculation.

# PROJECTED LOSS RATIO

The target loss ratio using the federal MLR definition is estimated to be [redacted] The traditional loss ratio, calculated as one minus non-benefit expenses when stated as a percent of premium, and treating risk adjustment transfer payments/receipts as a claims expense, is projected to be [redacted].

[redacted]

# AV METAL VALUES

The AV Metal Values on Worksheet 2 of the URRT are based on the AV Calculator. All plans offered by AHC are non-unique plan designs, and as such, no adjustments to inputs or adjustments outside the AV Calculator were necessary for determining the AV Metal Values.

## MEMBERSHIP PROJECTIONS

The membership projections shown on Worksheet 2 of the URRT were based on an estimate of expected market share in 2024. [redacted] The table below summarizes the projected member months by metal level:

[redacted]

This filing assumes that there will be no Federal funding for CSRs in 2024.

## TERMINATED PLANS AND PRODUCTS

No plans are being terminated.

## PLAN TYPE

The plan types selected in the drop-down box on Worksheet 2, Section I of the URRT are representative of the proposed plans included with this filing. [redacted].

## RELIANCE

In preparing this filing, I have relied upon AHC staff for non-benefit expense assumptions and information related to provider contracts.

## ACTUARIAL CERTIFICATION

I, Kara Clark, Partner at Oliver Wyman Actuarial Consulting, have been engaged by AmeriHealth Caritas VIP Next, Inc. (AHC) to prepare this actuarial memorandum and corresponding rates. Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman), is an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

The information included in this actuarial memorandum has been prepared for use by AHC. Oliver Wyman makes no representation or warranty to any third party regarding the content of this actuarial memorandum and no third party may rely on the information included in this actuarial memorandum that would create any legal duty by Oliver Wyman to any third party.

The analysis underlying the development of the rates included in this actuarial memorandum is based on our interpretation of current State and Federal laws and regulations. Should these laws and/or

regulations be modified our results could be subject to change. It should be noted that Oliver Wyman is an actuarial consulting firm and is not engaged in the practice of law. Therefore, nothing in this actuarial memorandum should be interpreted as legal advice.

The rates developed in this filing reflect estimates of future contingent events; actual results will likely vary. The magnitude of differences between projections in this filing and actual observed experience will depend on the extent to which actual experience in the future conforms to the assumptions made in this analysis. It is certain that actual experience will not conform exactly to the assumptions made in this filing.

The URRT does not demonstrate the process used 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 Marketplaces, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I am a member of the American Academy of Actuaries (Academy), and I meet the Academy qualification standards for rendering this opinion. I certify that, to the best of my knowledge and judgment:

1. The projected Index Rate 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, including the following:
        i. ASOP No. 5, Incurred Health and Disability Claims
        ii. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
        iii. ASOP No. 12, Risk Classification
        iv. ASOP No. 23, Data Quality
        v. ASOP No. 25, Credibility Procedures
        vi. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
        vii. ASOP No. 41, Actuarial Communications
        viii. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered
    d. Neither excessive nor deficient
2. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

3. The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
4. The AV Calculator was used to determine the AV Metal Values shown in Part I of Worksheet II in the URRT for all plans.

Kara Clark, FSA, MAAA
Oliver Wyman Actuarial Consulting, Inc.

7/5/2023

Date