

State: Arkansas **Filing Company:** HMO Partners, Inc. d/b/a Health Advantage
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only
- Other
Product Name: 2024 HA SG Off Exchange Rates
Project Name/Number: 2024 HA SG Off Exchange Rates/31-24, 31-26

Filing at a Glance

Company: HMO Partners, Inc. d/b/a Health Advantage
Product Name: 2024 HA SG Off Exchange Rates
State: Arkansas
TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI: HOrg02G.004E Small Group Only - Other
Filing Type: Rate
Date Submitted: 06/13/2023
SERFF Tr Num: HLAD-133656426
SERFF Status: Closed-Approved
State Tr Num: ACA OFF EXCHANGE ONLY
State Status: Approved-Closed
Co Tr Num: HLAD-133656426 2024 HA SG OFF EXCHANGE RATES
Effective: 01/01/2024
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Sammytra Williams, Katrina Higgins, Melissa Jowers, Tocarra Hampton
Reviewer(s): Donna Lambert (primary), Johnny Flippo, David Dillon
Disposition Date: 08/11/2023
Disposition Status: Approved
Effective Date: 01/01/2024

State Filing Description:

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company HMO Partners, Inc. d/b/a Health Advantage

SERFF tracking number HLAD-133656426

Submission Date 6/8/2023

Product Name Small Group Major Medical POS

Market Type Individual Small Group

Rate Filing Type Rate Increase New Filing

Scope and Range of the Increase:

The 8.33% increase is requested because:

HA is requesting an overall rate increase of 8.33% for the 2024 plan year. This request is primarily based on (1) changes in utilization and cost trends from the 2022 experience period to the 2024 plan year, (2) benefit adjustments HA made for the 2024 plan year, and (3) adjustments to 2022 experience period claims to account for various legislative items that will impact claims. Other adjustments include changing demographics, morbidity assumptions, expense trend, etc. The 8.33% requested increase will ensure HA's individual product is adequately and competitively priced for the 2024 plan year.

This filing will impact:

of Arkansas policyholder's 847 # of Arkansas covered lives 2,403

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 8.33%
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 7.26%
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 9.37%

Individuals within the group may vary from the aggregate of the above increase components as a result of:

Rate increases may vary for individuals primarily due to changes in benefits and other factors relative to their 2023 benchmarks.

Financial Experience of Product

The overall financial experience of the product includes:

The overall financial experience of this product is based on claims experience incurred in plan year 2022 and paid as of 3/31/2023, with an additional estimate for claims incurred but not paid (IBNP).

The rate increase will affect the projected financial experience of the product by:

The 2024 requested rate increase will allow HA to provide competitively priced premiums that adequately cover the financial risks associated with this type of product, as well as allowing HA to meet the federally-mandated Minimum Loss Ratio (MLR) requirement (based on HA's financial

Components of Increase

The request is made up of the following components:

Trend Increases – -7.5% of the 8.33% total filed increase

1. Medical Utilization Changes – Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 0.13% of the 8.33% total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is -7.7% of the 8.33% total filed increase.

Other Increases – 107. % of the 8.33% total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is 18.1% of the 8.33% total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is 20.3% of the 8.33% total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is -17.0% of the 8.33% total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is 0 % of the 8.33% total filed increase.

5. Other – Defined as:

The other category includes adjustments for IBNP claims, demographic factors, tobacco usage factors, morbidity factors, taxes, fees, and net risk adjustment.

This component is 86.5% of the 8.33% total filed increase.

Actuarial Memorandum (Redacted Version)

HMO Partners, Inc. d/b/a Health Advantage

Premium Rate Filing
for
Small Group Off-Exchange Health Insurance Products

Effective January 1, 2024

Redacted, Public Version

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1. General Information

As required by 45 CFR § 154.215, this Actuarial Memorandum documents the development and justification for HMO Partners, Inc. d/b/a Health Advantage (HMOP) Affordable Care Act (ACA) Small Group Off-Exchange health insurance premium rates effective January 1, 2024.

The required company identifying information and company contact information can be found below:

Company Identifying Information

- Company Legal Name: HMO Partners, Inc. d/b/a Health Advantage
- State: Arkansas
- HIOS Issuer ID: 13262
- Market: Small Group
- Effective Date: 1/1/2024

Company Contact Information

- Primary Contact Name: [REDACTED]
- Primary Contact Telephone Number: [REDACTED]
- Primary Contact E-mail Address: [REDACTED]

2. Proposed Rate Changes

HMOP is requesting a [REDACTED] average rate [REDACTED] weighted across all renewing plans, which ranges from [REDACTED]. The rating impact by plan ID can be found in the Unified Rate Review Template (URRT), specifically Worksheet 2, Section 1.11.

To review the quantitative impact of significant factors driving the proposed rate change, please refer to the “Relationship of Proposed Rate Scale to Current Rate Scale” exhibit in the “Actuarial Memo Dataset.” This dataset is included with the 2024 rate filing.

The reasons for the requested rating impact include the following:

- Updated benefit factors for the 2022 experience period plans and 2024 projection period plans
- Claims trend from the 2022 experience period to the 2024 projection period
- Changes in morbidity from the 2022 experience period to the 2024 projection period
- Changes in the expected risk adjustment position from the 2022 experience period to the 2024 projection period
- Disruption to provider reimbursement as a result of the Federal “No Surprises Act”
 - Emerging 2023 claims experience shows that this law has increased air ambulance claim costs in particular
- Expanded benefits and reduced member cost-sharing mandates due to legislative bills passed and signed into law during the 2023 Arkansas legislative session, many of which do not take effect until August 1, 2023 or later (which means their expected impact was not accounted for in the 2022 experience period)

3. Market Experience

This section of the Actuarial Memorandum includes details that support the single risk pool calculations for HMOP’s product in the Arkansas Small Group market. Such calculations are the basis for the 2024 plan year membership, claims, and premium projections and the requested rating action.

The experience period used for this Actuarial Memorandum is plan year 2022 experience for the single risk pool only. As allowed by the URRT instructions, [REDACTED].

3.1 Experience and Current Period Premium, Claims, and Enrollment

A. Paid Through Date

The experience period claims represented in the URRT are claims incurred 1/1/2022 through 12/31/2022 and paid between 1/1/2022 and 3/31/2023. Runout factors have been applied so that the experience period claims reflect an incurred view of the claims.

A summary of the allowed and paid claims can be found below. These are also included in Worksheet 1, Section 1 of the URRT.

- Allowed Claims: [REDACTED]
- Paid Claims: [REDACTED]

B. Current Date

The current date enrollment and premium information in the URRT is current as of 3/31/2023. This information is also included in Worksheet 2, Section 2 of the URRT.

- Enrollment: [REDACTED]
- Premiums: [REDACTED]

C. Allowed and Incurred Claims Incurred During the Experience Period

All medical claims were processed through HMOP’s internal claims processing system and all pharmacy claims were processed through HMOP’s pharmacy benefits manager (PBM), [REDACTED]. In order to better identify cost trends from the 2022 experience period to the 2024 projection period, claims have been broken down by claim category. The claim category designations come from [REDACTED].

Allowed claims are calculated as the sum of total claims paid by HMOP plus member cost-sharing.

The IBNP estimate is based on completion factors that were calculated from HA’s ACA Small Group product paid claims data. [REDACTED].

3.2 Benefit Categories

As noted in the previous section, [REDACTED] was used to classify experience period claims experience into the URRT benefit categories.

- All inpatient-related claims were mapped to the “Inpatient Hospital” category
- All outpatient-related claims were mapped to the “Outpatient Hospital” category

- PCP, specialist, therapy (OT/PT/ST) and other professional-related claims were mapped to the “Professional” category
- Home health, ambulance, DME, and prosthetics were mapped to the “Other Medical” category
- Incentive program payments and other capitation-related payments were mapped to the “Capitation” category
- Prescription drug claims (net of any Rx rebates) were mapped to the “Prescription Drug” category

3.3 Projection Factors

This section includes information about the adjustments used to convert 2022 experience period claims to the 2024 projection period.

A. Trend Factors (Cost/Utilization)

A trend adjustment was applied to the 2022 experience period claims to account for allowed cost and utilization changes from the experience period to the projection period. As demonstrated in Worksheet 1, Section II, the trend factor is [REDACTED].

This is also captured in the following exhibit:

Exhibit 1: [REDACTED]

Exhibit Redacted

[REDACTED]

[REDACTED]

[REDACTED]

B. Morbidity Adjustment

[REDACTED]

[REDACTED]

Taking these into account, UMIC’s modeling shows a morbidity factor of [REDACTED].

Exhibit 2: [REDACTED]

Exhibit Redacted

C. Demographic Shift

The demographic shift from the 2022 experience period to the 2024 projection period is expected to be [REDACTED].

[REDACTED]

[REDACTED]

The exhibit below summarizes how the overall demographic adjustment in the URRT was calculated.

Exhibit 3: [REDACTED]

Exhibit Redacted

D. Plan Design Changes

[REDACTED]

The additional coverage refers to the costs HMOP expects to incur in the 2024 projection period as a result new laws stemming from the 2023 Arkansas legislative session. Note that these new laws were not effective during the 2022 experience period.

During the 2023 Arkansas legislative session, multiple bills were passed that enhance benefits and reduce member cost-sharing for certain services. The additional costs considered in the 2024 rate filing include the following:

- Act 333
 - Requires member deductible and coinsurance cost-sharing to be calculated based on prescription drug costs net of Rx Rebates. This will increase claims paid by HMOP because Rx Rebates will be used to reduce member cost-sharing basis.
- Act 429
 - Requires coverage for biomarker cancer screenings, which include certain types of genetic testing. This will cause HMOP to broaden the types and/or frequency of screenings for which they currently cover today.
- Act 480
 - Adds coverage for non-emergency ambulance encounters if certain conditions are met. These conditions include coordinating care for the individual via a 911-initiated request and telemedicine, among others. The encounter may or may not lead to transport to an alternative site of care (e.g., urgent care facility, physician office, mental healthcare facility). Reimbursement is based on lesser of contracted local government rate or Workers' Compensation Commission schedule.
- Act 575

- Exempts providers from being subject to prior authorization requirements if those providers received approval for at least 90% of requests for a particular service during a particular time period. Providers that meet the criteria for baseline, historical data will not be subject to future prior approval requirements.
- Acts 578 and 597
 - Act 578 sets the minimum provider reimbursement for in-network (INN) ground ambulance reimbursement at 250% of rural Medicare rates. Act 597 sets the minimum provider reimbursement for out-of-network (OON) ground ambulance at the lesser of the Worker’s Compensation Commission (per the ambulance provider annual survey that’s based on responding providers’ billed rates) or the ambulance provider’s billed rate for that service. Both Acts are expected to increase HMOP ground ambulance paid claims at levels unseen in any previous plan years.
- Act 805
 - Requires coverage at 80% of Medicare for prosthetic devices and eliminates HMOP’s ability to deny such claims under certain circumstances.
- Act 876
 - Adds coverage for off-label intravenous immunoglobulin (IVIG) treatment for children that are diagnosed with pediatric acute-onset neuropsychiatric syndrome (PANS) or pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS). Prior to this law, HMOP generally denied any requests for off-label IVIG treatment.

The exhibit below summarizes how the overall plan design changes adjustment in the URRT was calculated.

Exhibit 4: [REDACTED]

Exhibit Redacted

[E. Manual Rate Adjustments](#)

No manual rate was necessary, as the experience period claims are fully credible.

[F. Credibility of Experience](#)

Given that the base period experience includes [REDACTED], the credibility assigned to the base period experience for the purposes of this rate filing is 100%.

[G. Establishing the Index Rate](#)

The index rate for HMOP’s 2024 Off-Exchange Small Group rate filing is [REDACTED]. This is demonstrated in the exhibit below.

The index rate only includes allowed EHB claims. All non-EHB claims were excluded from the experience period by filtering and removing any claims with HCPCS codes and ICD-10 codes associated with the non-EHB benefits. The non-EHB benefits include the following:

- Treatment of craniofacial anomaly
 - Coverage of craniofacial anomaly is a state mandated benefit adopted after December 31, 2011 by the State of Arkansas.¹

¹ Ark. Code Ann. §§23-79-1501 et seq.

- Adult vision exams
- Newborn screenings

Please note that any PMPM differences between the exhibit below and the URRT are due to rounding limitations in the URRT.

Exhibit 5: [REDACTED]
Exhibit Redacted

H. Development of the Market-Wide Adjusted Index Rate (MAIR)

The development of the projection period MAIR can be viewed in the exhibit below. Additional information regarding risk adjustment and exchange user fee modifiers can also be found in this section.

Please note that any PMPM differences between the exhibit below and the URRT are due to rounding limitations in the URRT.

Exhibit 6: [REDACTED]
Exhibit Redacted

(1) Reinsurance

[REDACTED]

(2) Risk Adjustment Payment/Charge

The expected risk adjustment transfer can be found in Worksheet 1, Section II of the URRT.

[REDACTED]

The basis for this calculation was [REDACTED] risk adjustment information from the following sources:

- [REDACTED]
 - [REDACTED]
- [REDACTED]
 - [REDACTED]
 - [REDACTED]
- [REDACTED]
 - [REDACTED]

When estimating the risk adjustment transfer for the 2024 projection period, key variables in the risk adjustment transfer were estimated and applied against the Federal risk adjustment transfer formula. These variables include the following:

- [REDACTED]
 - [REDACTED]
 - [REDACTED]
- [REDACTED]
 - [REDACTED]
 - [REDACTED]
- [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
- [REDACTED]
 - [REDACTED]
 - [REDACTED]

Other variables used in the risk adjustment transfer formula were carried over from 2022 into 2024 with [REDACTED]. These factors include the following:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Finally, the HCRP was estimated by [REDACTED]

The overall expected HCRP PMPM [REDACTED]

The following exhibit below demonstrates how the risk adjustment, HCRP, and combined estimates (in total) were calculated. This is being presented on a paid basis. Risk adjustment transfer factors for

other insurers operating in the Arkansas small group market are included for calculation purposes, but their totals are not included in the risk adjustment and HCRP totals.

Exhibit 7: [REDACTED]
Exhibit Redacted

(3) Exchange User Fees

The small group plans are only being offered off-exchange, so no user fees are assumed.

3.4 Plan Adjusted Index Rate

The plan adjusted index rate (PAIR) was calculated by applying all allowable adjustments to the MAIR as outlined in the 2024 URRT instructions. All factors outlined below can be found in Worksheet 2, Section III of the URRT.

A. Actuarial Value (AV) and Cost-Sharing Design Adjustment

The weighted average AV and cost-sharing design factor for the 2024 projection period is [REDACTED].

Benefit factors to adjust experience period claims to the projection period were developed using [REDACTED].

Plan benefits were modified in order to maintain compliance with the 2024 Federal AV Calculator and ensure plan benefits and premiums were in line with HMOP's perceived market expectations. Also, all plan designs were compatible with the Federal AV Calculator.

B. Changes to Network, Delivery System, and Utilization Management Practices

The weighted average factor for changes to network, delivery system, and UM practices is [REDACTED].

C. Benefits in Addition to EHB Benefits

The weighted average factor for benefits covered in addition to EHB benefits is [REDACTED].

As described in Section 3.3(G) of this memorandum, the non-EHB benefits included in the "Benefits in Addition to EHB" factor are as follows:

- Treatment of craniofacial anomaly
- Adult vision exams
- Newborn screenings

D. Administrative Costs

The following administrative costs include all expenses other than EUF and reinsurance fees, which have already been factored into the MAIR.

(1) Administrative Expense

The weighted average factor for administrative expenses is [REDACTED]. Administrative expense assumptions were developed using [REDACTED].

(2) Taxes and Fees

The weighted average factor for taxes and fees in the projection period

The weighted average factor for taxes and fees in the projection period is [REDACTED]. This percentage does not include EUF, but does include the following:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

(3) Profit and Risk Load

The weighted profit and risk load for the projection period is [REDACTED].

E. Development of Plan Adjusted Index Rate

Exhibits 8 and 9 demonstrate how the plan adjusted index rate was developed for each plan ID being offered in 2024. This includes an exhibit that ties the administrative expenses, taxes and fees, and profit and risk loads for each Plan ID to Worksheet 2, Section III of the URRT.

Please note that any PMPM differences between the exhibits below and the URRT are due to rounding limitations in the URRT.

Exhibit 8: [REDACTED]
Exhibit Redacted

Exhibit 9: [REDACTED]
Exhibit Redacted

3.5 Calibration

The following calibrations are used to make the PAIR calibrated to a 1.000 factor. All of the calibration factors can be found in Worksheet 2, Section III of the URRT.

A. Age Curve Calibration

The age calibration factor for the 2024 projection period is [REDACTED]. This was found using the most recent Federal age curve and applying it to the 2024 projection period enrollment by age, which resulted in an average age curve factor of [REDACTED].

The age curve calibration factor is used to help calibrate the PAIR to a normalized value, which can then be applied to consumer-level adjustments. The age curve is one of three factors used to normalize (see sections B and C below). Once the PAIR is normalized to the calibrated PAIR and ready to be priced at the consumer-level, HMOP will apply the appropriate age factor based on a consumer's age per the Federal age curve (see Appendix A).

B. Geographic Factor Calibration

[REDACTED]

C. Tobacco Use Rating Factor Calibration

[REDACTED]

D. Combined Calibration Factors

The combined calibration factors used in the 2024 rate filing is [REDACTED]. It is used uniformly for all plans in the single risk pool. The exhibit below demonstrates how the calibrated plan adjusted index rate is calculated, using the plan adjusted index rate and calibration factors.

Please note that any PMPM differences between the exhibit below and the URRT are due to rounding limitations in the URRT.

Exhibit 10: [REDACTED]
Exhibit Redacted

3.6 Consumer Adjusted Premium Rate Development

The exhibit on the next page shows how to calculate the premium rate for a non-smoking 35 year-old on the 13262AR0220006 plan (Gold 1500-Elite). The exhibit starts with the PAIR, applies the calibration factors from Section 3.5 of this memorandum, and then applies the appropriate consumer-level adjustments based on the consumer's age, rating area, and tobacco status.

Please note that any PMPM differences between the exhibit below and the URRT are due to rounding limitations in the URRT.

Exhibit 11: [REDACTED]
Exhibit Redacted

4. Projected Loss Ratio

The projected loss ratio for the 2024 projection period was calculated based on the federally prescribed MLR methodology. In addition to the 2024 projection period, 2022 and 2023 MLR projections have been provided in order to calculate the three-year average MLR for the 2024 projection period. This can be found in the exhibit below.

Exhibit 12: [REDACTED]

Exhibit Redacted

5. Plan Product Information

5.1 AV Metal Value

All plan AV metal values were based on the Federal AV Calculator methodology and tool. These values by plan can be found in Worksheet 2, Section I of the URRT.

5.2 Membership Projections

The membership projections used for the 2024 projection period [REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]

5.3 Terminated Plans and Products

The exhibit below includes a list of terminated plans for plan years 2022 through 2024.

Exhibit 13: [REDACTED]

Exhibit Redacted

5.4 Plan Type

All plans in Worksheet 2, Section 1 of the URRT were described accurately by the available drop-down box in this section of the URRT.

6. Miscellaneous

6.1 Effective Rate Review Information

HMOP has elected to provide additional information in order to better assist regulators with their Rate Review activities. Most of the information contained in this section was requested during prior Rate Review requests. HMOP hopes that by including this information, it will allow for a more transparent, expedient review of their filing.

A.

[REDACTED]

Exhibit 14: [REDACTED]
Exhibit Redacted

B.

[REDACTED]

Exhibit 15: [REDACTED]
Exhibit Redacted

C.

[REDACTED]

Exhibit 16: [REDACTED]
Exhibit Redacted

D.

[REDACTED]

Exhibit 17: [REDACTED]
Exhibit Redacted

E.

[REDACTED]

[REDACTED]

Exhibit 18: [REDACTED]
Exhibit Redacted

F.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Exhibit 19: [REDACTED]
Exhibit Redacted

G.

[REDACTED]

Exhibit 20: [REDACTED]
Exhibit Redacted

H.

[REDACTED]

[REDACTED]

Exhibit 21: [REDACTED]
Exhibit Redacted

1. [REDACTED]

Exhibit 22: [REDACTED]
Exhibit Redacted

6.2 Actuarial Certification

I, [REDACTED], am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries. I meet the Qualification Standards of Actuarial Opinions as adopted by the American Academy of Actuaries and have the education and experience necessary to complete this rate filing for HMO Partners Inc., d/b/a Health Advantage (HMOP). [REDACTED].

I certify the rates in this filing 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. 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 judgment:

1. The projected Index Rate is:
 - 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
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 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.
4. The AV Calculator was used to determine the AV Metal Values shown in Part I of Worksheet 2 in the URRT for all plans.

The URRT does not demonstrate the process used by the issuer 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.

The 2024 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 at the Federal and State levels. Changes have the potential to greatly impact the 2024 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Appendix A



Exhibit Redacted