Scope and Range of the Rate Change

This is the Part II preliminary justification for Health Alliance Medical Plans' small group comprehensive medical rate increase effective January 1, 2025.

This justification is intended to comply with the requirements of Section 2794 of the Public Health Service Act as added by Section 1003 of the Patient Protection and Affordable Care Act. This justification may not be appropriate for purposes or scope beyond those described above and, therefore, should not be used for other purposes.

We are requesting a 16.18% average premium rate increase on our small group ACA groups for the 12-month period from January 2025 through December 2025. Groups renewing in the first quarter (January through March) of 2025 will receive this level of premium rate change. The largest rate change is a 24.40% increase on plan 77638IA0070055 (2025 POS 8900 Bronze).

As of March 2024, we have 22 active members that will be affected by these changes.

Financial Experience of the Product

A 3-year summary of our financial results after risk adjustment transfers is shown in the table below. Having only around 22 members, our annual experience is volatile. For the three-year period, we started with a low loss ratio in 2021 largely due to a favorable risk adjustment transfer result, however, 2022 came in way over target after paying over $24,000 for risk adjustment transfer, and 2023 is looking similar despite an anticipated $32,000 risk transfer receipt. Starting in 2022, we have been seeing elevated prescription drug costs across all our blocks of business due largely to high-cost drugs. We anticipate these elevated drug trends to continue for a while yet, but eventually level off.

	2021	2022	2023
Filed Rate Change	12.5%	8.1%	2.4%
Member Months	319	276	268
Earned Premium	184,809	185,439	162,006
Risk Adjustment	35,011	(24,678)	32,000
Risk Adjusted Premium	219,819	160,761	194,006
Incurred Claims	91,832	188,072	217,545
Loss Ratio	41.8%	117.0%	112.1%

Changes in Medical Service Costs

We are using an annualized allowed claim trend of 7.5% to project our 2023 allowed claims forward to 2025. This trend assumption includes medical and prescription drug inflation as well as changes in utilization. The paid claim trend incorporates the additional component of plan benefit leveraging and directly affects our financial results. This additional component adds 1.2 points to the trend bring total paid claims trend to 8.8%. This trend was estimated based on internal data and other industry information. Over the past year and a half, we have been seeing elevated trends driven primarily by prescription drug cost increases and increased utilization of high-cost drugs.

Changes in Benefits

There were no substantial changes to our covered benefits for 2025.

Administration and Profit Assumptions

Our estimate for non-benefit costs have increased by $19.04 PMPM to $130.02 since our prior rate filing. This represents 15.87% of premium. The remaining 84.13% of premium is allocated to cover anticipated 2025 claims.

Summary

The overall impact of this rate change results in our projecting a loss ratio of 87.20% using the methodology prescribed for calculation of the federal ACA loss ratio.

Health Alliance Midwest, Inc.
Small Group Comprehensive Medical Business
Rate Filing Justification
Part III – Actuarial Memorandum and Certification

Overview

This document contains the Part III Actuarial Memorandum for Health Alliance Midwest, Inc.'s (HAMI's) small group comprehensive medical block of business, effective January 1, 2025. These revised small group rates are guaranteed through December 31, 2025. All products are only offered off of the SHOP. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the Actuarial Memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This memorandum may not be appropriate for other purposes.

The information in this Actuarial Memorandum is intended for use by the Iowa Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of this small group rate filing. However, we recognize that this certification may become a public document. The results included in this rate filing are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

Health Alliance Midwest, Inc.
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I. General Information

Company Identifying Information

Company Legal Name:	Health Alliance Midwest, Inc.
State:	Iowa
HIOS Issuer ID:	77638
Market:	Small Group
Effective Date:	January 1, 2025

Company Contact Information

Primary Contact Name:	Brandie DeLahr
Primary Contact Telephone Number:	(217)902-9142
Primary Contact Email Address:	Brandie.DeLahr@healthalliance.org

II. Proposed Rate Changes

The purpose of this filing is to file our proposed Health Alliance Midwest, Inc. (HAMI) small group ACA rates effective for the period January 1, 2025, through December 31, 2025. For 2025, we are renewing 17 plans and adding two new plans. The experience basis, benefit plans, rating factors, and other projection assumptions were updated for this filing.

Our 2025 renewal plans may include copay and other benefit changes from their existing 2024 plans. Premium rates were developed using our Health Alliance Medical Plans (HAMP) 2023 Illinois small group ACA experience. Starting with this base experience, a number of items were considered when developing the premium rates, including but not necessarily limited to the following:

- Projected morbidity level of the population anticipated to purchase products,
- Projected differences in provider reimbursement levels,
- Proposed benefit plan designs,
- Anticipated risk adjustment payments or receipts,
- Medical and prescription drug inflation,
- Changes in benefit utilization, and
- Administrative costs, taxes, and fees including those under the ACA.

The requested composite 12-month rate change for renewing plans, as calculated in the URRT, is [redacted]. Exhibit 1 shows our requested rate changes by plan. The maximum quarter 1 renewing plan change of [redacted] occurs for members on plan 77638IA0070055.

Reason for Rate Change

The following are the primary considerations that went into the determination of our 2025 proposed rate change:

- Base Experience – HAMP's 2023 Illinois Small Group ACA experience forms the basis for HAMI's 2025 premium rates. Section VI discusses the adjustments made to this data in developing the manual rate used in the premium rate development.

- Trend – A [redacted] annualized allowed claim trend assumption was used to project HAMP Illinois small group allowed claims from 2023 to 2025. This assumption includes medical and drug unit cost inflation and changes in utilization. Our paid claim trend, or insurance trend, which includes leveraging of fixed benefits is [redacted] and is used in setting the quarterly premiums rates for the 2nd, 3rd, and 4th quarters.

- Risk Adjustment – We adjust the starting 2023 base experience for risk adjustment program transfer amounts to move our single risk pool morbidity cost to the statewide average.

- Provider Contract Changes – We adjust for provider reimbursement differences between our IL experience period data and our IA marketing area.

- Administrative costs, taxes and fees, profit, and risk loads – Our total retention [redacted] PMPM for this filing period.

- Other Factors – Other factors include changes in plan benefits, plan design behavior factors, and pricing model updates. These changes are applied at the benefit plan level resulting in different rate changes by plan and product.

Table 1 below shows the rating factors and calculation of the average renewal increase. Adjustments to the base experience shown in this exhibit are also included on Exhibits 3 and 4 and are explained in Section VI below.

Table 1 - Redacted

III. Market Experience

HAMI is a managed care organization contracting with providers and networks to provide medical and pharmacy care to its members. We contract with a few providers on a capitated basis but contract primarily on a fee-for-service basis. Our contractual arrangements for capitated services and actual claims for non-capitated services were directly incorporated in the development of the 2025 rates.

Claims Paid Through Date

The claims incurred in the experience for both non-capitated and capitated services reflect payments through March 31, 2024.

Premiums (net of MLR rebate) in Experience Period

The earned premium reported in Worksheet 1 of the URRT reflects the HAMI non-grandfathered premium for the experience period of calendar year 2023. Our small group loss ratio exceeds the MLR requirement therefore an adjustment for MLR rebates was not included.

Allowed and Incurred Claims Incurred During the Experience Period

HAMI's incurred claims represent the sum of two items: 1) fee-for-service claims and 2) prescription drug claims. The allowed claims were provided directly from our claim records. We provided the 2023 claims on a completed basis by using lag development factors for lags across all commercial services. This method estimates the portion of claims that have been paid to date for each incurred month based on past claim lag data, which reflects historic time lags in our medical and prescription drug claim data between the month of service (i.e., the incurred month) and the month of claim processing (i.e., the processed month).

Table 2 displays a breakdown of the 2023 small group allowed and paid claims:

Table 2
Health Alliance Midwest, Inc.
2023 Iowa Small Group NGF Claims

	Allowed	Paid
Claims Paid through March 2024	313,779	279,947
Incurred But Not Reported (IBNR)	4,146	3,699
Total Claims	**317,925**	**283,646**

IV. Benefit Categories in Worksheet 1, Section II of the URRT

Our fee-for-service medical claims are included by service category:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.
- Prescription drugs represent drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

V. Projection Factors Applied to Experience

Our Iowa non-grandfathered business has 268 member months in the experience period, all of which are ACA. Given the minimal volume of experience, we are developing our 2025 premium rates using a manual rate methodology discussed below in Section VI.

Trend Factors

Not applicable since we are not projecting IA experience.

Morbidity Adjustment

Not applicable since we are not projecting IA experience.

Demographic Shift

Not applicable since we are not projecting IA experience.

Plan Design Changes

Not applicable since we are not projecting IA experience.

Other Adjustments

Not applicable since we are not projecting IA experience.

VI. Manual Rate Adjustments

We are basing our 2025 premium rates 100% on a manual rate development.

Source and Appropriateness of Experience Data Used

The credibility manual rate PMPM shown in Worksheet 1, Section II of the URRT is based on our 2023 HAMP Illinois small group ACA experience and developed as shown in Exhibits 2 through 4. Our 2023 Illinois small group experience was adjusted for an estimated 2023 risk adjustment payment to bring experience to the statewide morbidity level. Further adjustments were made for differences in state-specific morbidity, regional cost differences including geographic cost and provider reimbursement levels between this Illinois small group experience and our 2025 Iowa assumptions. Exhibit 3 outlines the factors used to adjust the 2023 Illinois experience to a 2025 manual rate calibrated to Iowa.

HAMP Illinois allowed claims were provided directly from our claim records. We review large claims but do not make a specific adjustment for them since our claims volume is sufficiently large such that this adjustment does not have a material impact on the average allowed claims per member per month (PMPM).

The 2023 claims are on a completed basis using lag development factors for lags across all commercial services. This method estimates the portion of claims that have been paid to date for each incurred month based on past claim lag data, which reflects historic time lags in our medical and prescription drug claim data between the month of service (i.e., the incurred month) and the month of claim processing (i.e., the processed month).

Table 3 displays a breakdown of HAMP's 2023 Illinois small group ACA allowed and paid claims:

Table 3
Health Alliance Medical Plans
2023 Illinois Small Group ACA Claims

	Allowed	Paid
Claims Paid through March 2024	98,922,856	82,097,186
Incurred But Not Reported (IBNR)	1,292,807	1,073,989
Total Claims	**100,215,663**	**83,171,175**

Adjustments Made to the Data

This section includes a description of each factor used to adjust the experience of the manual rates and supporting information related to the development of those factors. These adjustments are summarized on Exhibit 3.

- For 2023, we are expecting [redacted] This is reflected by a [redacted] factor on Exhibit 3 and adjusts our 2023 experience to the Illinois statewide morbidity level.

- An estimate of the difference in statewide morbidity from Illinois to Iowa is calculated using CMS's historic Interim and Final Summary Reports on the risk adjustment program. To develop this adjustment factor, we divide the state average PLRS by the respective state average AV and ARF for Illinois and Iowa. The difference in these state results is our assumed difference in statewide risk morbidity between these two states.

  Exhibit 2 summarizes the results of Risk Adjustment Interim and Final reports over plan years 2016 - 2022. This exhibit also includes the Interim 2023 report released in March 2024, and a projection of the final 2023 risk adjustment statistics which are used to calculate this factor. Using this historic data and a projected Final 2023 PLRS, I arrive at a [redacted] relative risk for IA versus IL, as shown on Exhibit 3.

- We adjust for the difference in our demographic mix from the IL experience period to the expected mix in our IA projected period. The member weighted average ARF of our 2023 IL ACA experience period is [redacted], while for our IA small group projection period is [redacted] as seen on Exhibit 9. The adjustment calculates to [redacted] and is necessary to bring the Illinois experience to the same age basis that is being used to calibrate the premium rates in Section XI, below. This adjustment shows as a [redacted] factor on Exhibit 3.

- We adjust for the difference in the utilization of the mix of benefit plans from the IL experience period to the projected plan mix in our IA projection period. We use our benefit pricing model to calculate the member-weighted average utilization factor of each period. The result of this calculation is no real difference in plan utilization from IL to IA. This adjustment shows as a 1.000 factor on Exhibit 3.

- While there are some negligible EHB differences between Illinois and Iowa, they are very small and difficult to valuate. We are assuming a net equivalence in our manual rate development as indicated by the 1.000 factor on Exhibit 3.

- [redacted].

- All of our Iowa plans are on our HMO/POS network while our Illinois base experience includes plans on other provider networks including narrow networks and a PPO network. Normalizing the provider network factors across our Illinois base experience business to 1.000 results in the HMO/POS network having a relative cost of [redacted]. Since the base experience is normalized to 1.000 and our Iowa plans only have the HMO/POS network, we need to build this relative cost into our projection. The [redacted] factor is reflected on Exhibit 3.

Trend Factors

We reviewed our own experience as well as other industry information to determine appropriate cost and utilization trend assumptions for our 2025 projections. A 3-year history of our raw allowed trends is shown in the Table 4, below.

Table 4 - Redacted

We are setting our allowed trend assumption at [redacted] as shown in Table 5 below. This trend is used to project our experience to the projection period and accounts for unit cost inflation as well as anticipated changes in utilization.

Our filed premium rates include quarterly adjusted rate tables based on an annual premium trend of [redacted] each quarter. This premium trend is comprised of our allowed trend assumption of [redacted] an average assumption for plan benefit leveraging [redacted] and an assumed [redacted] trend on the portion of premium allocated to administrative expenses.

Table 5 - Redacted

Inclusion of Capitation Payments

Not applicable

VII. Credibility of Experience

The CMS guidelines used for Medicare Advantage / Prescription Drug Plans (MA/PD) were used to determine the credibility of the experience. These guidelines specify 24,000 member months as 100% credible for medical and specify the following formula for determination of partial credibility:

(n / 24,000) ^ (1/2) for medical and
(n / 18,000) ^ (1/2) for prescription drugs

where n = member months in the experience period

Since prescription drug and medical coverage are both covered, and medical services make up a significantly larger portion of the costs, the above medical formula was used for the determination of partial credibility. The use of the CMS MA/PD credibility is appropriate given that both MA/PD and Commercial cover similar benefit categories.

Resulting Credibility Level Assigned to the Base Period Experience

The credibility assigned to the Illinois base period experience is 100%. Table 6 summarizes the adjusted credibility of the base period experience.

Table 6
Health Alliance Medical Plans
Credibility of Base Experience

Description	ACA	Annotation
Member Months – Base Experience	89,210	(a)
Full Credibility Threshold – Member Months	24,000	(b)
% Base Experience in the Manual Rate	0%	(c)
Credibility of Base Experience (no adjustment)	100%	(d) = Min {sqrt[(a)/(b)], 1}
Adjusted Credibility of Base Period	**100%**	(e) = [(d) - (c)] / [1 - (c)]

VIII. Establishing the Index Rate

Index Rate Development

The Iowa experience period index rate shown on Worksheet 1 of the URRT is not credible and is not used in determining premium rates for 2025. As discussed above, we developed a Manual EHB Allowed Claims PMPM from our 2023 Illinois ACA experience that we use to set our premium rates. This manual allowed EHB PMPM of [redacted] is shown on Worksheet 1, Section II of the URRT. It has not been adjusted for risk adjustment transfers, reinsurance fees / recoveries, or Exchange fees.

IX. Development of the Market-wide Adjusted Index Rate (MAIR)

The market-adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 CFR Part 156, §156.80(d)(1).

Reinsurance

We are assuming a net federal reinsurance recovery of $0.

Risk Adjustment Payment/Charge

As discussed above, our 2023 Illinois experience was adjusted to the 2023 Illinois statewide morbidity level by [redacted] An assumption for the change in statewide morbidity from Illinois to Iowa was also made in determining the manual EHB PMPM. This results in our average risk and premium rates being set at the anticipated state average risk level with the expectation that no significant portion of this premium will be either received from or paid to the Risk Adjustment transfer program in 2025.

Exchange User Fees

We are not on the SHOP so do not incur this fee.

These adjustments are shown in Worksheet 1, Section II of the URRT and result in a Market Adjusted Index Rate of [redacted].

X. Plan Adjusted Index Rate

The market-adjusted index rate is adjusted to compute the plan-adjusted index rates using the following allowable adjustments. The development of the plan adjusted index rates is shown in Appendix A.

Actuarial Value and Cost Sharing Adjustment

The Actuarial Value and cost-sharing factors were developed with an internally developed benefit pricing model using our own Health Alliance claims data. This model uses a fixed claims data set and adjudicates claims based on the plan design entered. Since the same claims data is used to price all plans, expected differences in the morbidity of members assumed to select the plan do not affect the resulting relativities.

Appendix A column 3 represents the plan design behavior factor for each plan normalized to the composite plan design behavior factor, and follows the development of these factor through to our AV and Cost Sharing factors and to our Actuarial Pricing Values.

Provider Network, Delivery System and Utilization Management Adjustment

All of our Iowa products are only offered on our HMO network, which is set to a 1.000 factor.

Adjustment for Benefits in Addition to the EHBs

We cover adult eye exams, acupuncture, routine foot care, and nutrition counseling as benefits in addition to EHB. These benefits are small and some, like acupuncture, may save costs by lowering utilization of other more expensive pain services. We believe they have a negligible cost impact.

Adjustment for Distribution and Administrative Costs

Exhibit 5 displays the total expenses, profit, taxes, and fees.

We have projected our 2025 administrative expenses to be [redacted] of premium. This estimate is entered as a percent of premium that does not vary by plan in Worksheet 2, Section III of the URRT. This amount includes an allocation of corporate overhead and operational expenses, commissions, net commercial reinsurance, and quality

improvement expenses but does not include any profit, risk load, taxes, or fees discussed below. Table 7 below shows breakdown of our administrative costs.

Table 7 - Redacted

Our projected assessment for taxes and fees is [redacted] of premium. This estimate is entered as a percent of premium that does not vary by plan in Worksheet 2, Section III of the URRT. This amount includes an estimate for the Health Insurer Tax, state premium tax, risk adjustment program fee, and federal and state Income taxes. The Exchange User Fee is not included in this assessment. Table 8 below shows a breakdown of our taxes and fees.

Table 8 - Redacted

We build [redacted] of premium for a target net contribution to surplus that does not vary by product or plan. We consider the uncertainty of estimated claims in the 2025 market and federal MLR requirements in the target.

Exhibit 6 demonstrates the reconciliation of the pre-tax and post-tax profit margin while Exhibit 7 demonstrates the development of the Federal Income Tax PMPM.

Impact of Specific Eligibility Categories for the Catastrophic Plan

Not applicable

XI. Calibration

The calibrated plan adjusted index rates are developed in Appendix C.

Age Curve Calibration

We composite the CMS-approved premium age factors by the projected membership at each age based on emerging 2024 Illinois membership. Using this membership mix, the average age of the single risk pool is [redacted] and the average age calibration factor is [redacted]. This calibration factor is applied uniformly to all plans. Our development of the weighted average age calibration complies with the standard age curve methodology and with applicable rating rules. Exhibit 9 displays the development of the age calibration factor. The reciprocal of this factor, [redacted], is entered on the URRT Worksheet 2, Section III as part of the Calibrated Plan Adjusted Index Rate calculation.

Geographic Factor Calibration

For 2025, we are only selling in rating areas 5 and 6. Our area factor is 1.000 for both regions and is unchanged from last year.

Tobacco Use Rating Factor Calibration

We do not rate for tobacco use so the calibration factor is 1.000.

XII. Consumer Adjusted Premium Rate Development

The consumer-adjusted premium rate is the final premium rate for a plan charged to a small group utilizing the rating and premium adjustments as articulated in the applicable market reform rating rules. It is the product of the calibrated plan adjusted index rate, the geographic rating factor, the age rating factor, the tobacco rating factor (which is 1.000 for all ages on small group), and the quarterly trend factor.

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XIII. Projected Loss Ratio

The projected loss ratio based on federally prescribed MLR methodology is [redacted] as shown in Exhibit 8.

XIV. AV Metal Values

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed entirely using the CMS Actuarial Value calculator.

XV. Membership Projections

Our projected membership of 1,200 member months is shown by plan in Worksheet 2, Section IV of the URRT. This projection is based on the current distribution of our Illinois membership on a similar plan portfolio as being offered in Iowa for 2025, as well as anticipated new business for 2025.

XVI. Terminated Plans and Products

Exhibit 10 shows our 2023 and 2024 terminated plans and plan mappings through to 2025.

XVII. Plan Type

For 2025, we will be offering HMO and POS plan types as noted in Worksheet 2, Section I of the URRT.

XVIII. Effective Rate Review Information

Additional information is available upon request.

XIX. Reliance

There is no notable reliance to report.

XX. Actuarial Certification

I, Pasquale Reda, Jr. am an Actuary at Health Alliance Medical Plans. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries in good standing. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify 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, and
   - Neither excessive nor deficient based on my best estimates of the 2025 small group market.

2. The index rate and only 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 (e.g., unit costs, provider practice pattern differences) and do not include differences for population morbidity by geographic area.

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4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.

The information provided in this Actuarial Memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

The results are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

Respectfully submitted,

Pasquale Reda, Jr., FSA, MAAA
Director, Actuarial Services
Health Alliance Medical Plans