Delaware Health Insurance Rate Filing Requirements

Part II Preliminary Justification—Content and Format Requirements

The Delaware Insurance Department (DOI) requires all health insurance companies, (also referred to as' Issuers', who submit Rate Filings for products offered in the single risk pool in the individual and small group market to submit a Part II Preliminary Justification*, regardless of whether the rate filing reflects a positive, negative or neutral rate change.*

Beginning with Rate Filings for Coverage Year 2017, the DOI is implementing the following content requirements and format guidelines to enhance transparency for consumers and to ensure consistency of information across Issuers. The DOI requests that companies address each item within each section and in the sequence outlined below. ***Issuers are reminded to use clear, consumer-friendly language to promote broad public understanding****.*

General Information

- Company Legal Name **Celtic Insurance Company**
- Market for which proposed rates apply (Individual or Small Group) **Individual Market**
- Total proposed rate change (increase/decrease) **n/a**
- Effective date of proposed rate change **n/a**

Summary

- Provide a brief narrative summary of the scope and range of the rate change (i.e., increase or decrease) as well as the number of people impacted. Include how the rate change varies across products/plans.

  Not applicable. This is an initial rate filing; there is no proposed rate increase. Subsequent rate increases beginning with effective dates of January 1, 2025 will be filed in the future.

- Provide a summary of the historical revenue, claims, expenses and profit on the product(s), and how the rate change should impact these in the future.

  Not applicable. This is an initial rate filing; there is no historical revenue, claims, expenses, or profit.

- Provide a chart (example below) listing all components of the proposed rate change (increase/decrease). Please note the factors used in this chart are for illustrative purposes only and the Company should use factors pertaining to their proposed rate change. All factors should multiply to the Total Proposed Rate Change (increase/decrease).

  Not applicable. This is an initial rate filing; there is no proposed rate change.

- State the proposed average rate change (increase/decrease). *(Must match the proposed average rate change as indicated in HIOS, Actuarial Memorandum and Company Rate Information Page in SERFF. Please note that the average rate change reported in all three locations should match.)*

  Not applicable. This is an initial rate filing; there is no proposed rate change.

- Provide a brief explanation for the rate change in each of the factors shown in the chart.

  Not applicable. This is an initial rate filing; there is no proposed rate increase.

Reason for Proposed Rate Change (Increase/Decrease)

- Provide a brief narrative discussing all the reasons for the proposed rate change in Delaware, including, but not limited to:
  - How provider costs and utilization contribute to the need for the rate change
  - How legally required benefit changes contribute to the need for the rate change
  - How administrative costs and anticipated profits contribute to the need for the rate change

  Not applicable. This is an initial rate filing; there is no proposed rate change.

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

- Provide the period for which the rates will apply.

  January 1, 2024 – December 31, 2024

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

  Not applicable. This is an initial rate filing; there is no proposed rate increase.

- Provide a brief narrative discussing new plans, plans that are not renewed and whether the proposed rate change applies to all plans. If no, provide a listing of all proposed rate changes by product/plan.

  Celtic Insurance Company is introducing 24 new plans:

64004DE0090012	**Standard Gold**
64004DE0090011	**Clear Gold**
64004DE0090009	**Complete Gold**
64004DE0090010	**Everyday Gold**
64004DE0090008	**Standard Silver**
64004DE0090006	**Clear Silver**
64004DE0090005	**Everyday Silver**
64004DE0090007	**Focused Silver**
64004DE0090003	**Elite Bronze**
64004DE0090002	**Everyday Bronze**
64004DE0090001	**Premier Bronze HSA**
64004DE0090004	**Standard Expanded Bronze**
64004DE0100012	**Standard Gold + Vision + Adult Dental**
64004DE0100011	**Clear Gold + Vision + Adult Dental**
64004DE0100009	**Complete Gold + Vision + Adult Dental**

64004DE0100010	**Everyday Gold + Vision + Adult Dental**
64004DE0100008	**Standard Silver + Vision + Adult Dental**
64004DE0100006	**Clear Silver + Vision + Adult Dental**
64004DE0100005	**Everyday Silver + Vision + Adult Dental**
64004DE0100007	**Focused Silver + Vision + Adult Dental**
64004DE0100003	**Elite Bronze + Vision + Adult Dental**
64004DE0100002	**Everyday Bronze + Vision + Adult Dental**
64004DE0100001	**Premier Bronze HSA + Vision + Adult Dental**
64004DE0100004	**Standard Expanded Bronze + Vision + Adult Dental**

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

  Not applicable. This is an initial rate filing; there is no proposed rate change.

Medical Loss Ratio (MLR)

Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR falls below 80%, the insurance company will issue rebates to members in accordance with the law.

- What is the projected MLR for the proposed rate(s)?

  The projected medical loss ratio (MLR) is 84.9%. The projected MLR is based on the prescribed calculation from 45 CFR 158, but solely reflects the projection year single risk pool experience, rather than the three-year combined period that is used for determining MLR rebates.

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

  Not applicable. This is an initial rate filing; there is no proposed rate change.

- What types of activities does the Company conduct to improve the health care quality for members that are included as part of the 80% (or greater) share?

  We will be implementing several programs to help improve the health care quality for members. My Health Pays is a program that rewards members for completing health activities. We will also have incentives set in place for providers to achieve pre-determined quality metrics and provide more efficient care.

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

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