Part III Actuarial Memorandum

Highmark Benefits Group

Individual Rate Filing

Effective January 1, 2026

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I. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Highmark Benefits Group's ("HBG", "Company") individual block of business rate filing, for products with an effective date of January 1, 2026. 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 ("Department"), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of HBG's rate filing. However, we recognize that this certification may become a public document. HBG 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 HBG.

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 Benefits Group
- State: The Commonwealth of Pennsylvania has regulatory authority over these policies.
- HIOS Issuer ID: 79962
- Market: Individual
- Effective Date: January 1, 2026

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.

The primary drivers of the rate increase are cost and utilization trend and morbidity impacts of the expiration of the enhanced advanced premium tax credits.

In accordance with the Department's April 9, 2025 rate filing guidance, this filing assumes the enhanced federal premium subsidies are not extended for Plan Year 2026. Additionally, this filing assumes the federal government continues to not fund the cost sharing reduction subsidies. Finally, in accordance with the Department's May 12, 2025 all-carrier meeting updated guidance, the impact of the state 1332 Reinsurance program is captured using the prescribed parameters of $60,000 attachment point, 43% coinsurance rate, and $100,000 reinsurance cap. If the finalized parameters differ from those described in this filing, a revised submission would be required.

Modifications to the rate development may likely be necessary if significant unforeseen events occur. Significant unknown outcomes that are under discussion at the federal level include expiration of enhanced advance premium tax credits, funding of Cost Share Reductions that may require removal of Silver loading, and finalization of the Marketplace Integrity and Affordability Rule. Some additional examples include, but are not limited to, other changes in legislation/regulations (including rules, regulatory guidance, etc.), material provider contracting changes, or changes in the participation of QHP issuers that would materially impact risk adjustment transfer amounts. As a result, the Company 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 2024, paid through February 2025. This includes 2024 experience in Affordable Care Act compliant plans. HBG did not offer any transitional plans in 2024.

III.2 Current Date:

The current date shown represents a snapshot of February 1, 2025.

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

- Historical Experience: We chose HBG's current experience for the individual block of business for the period January 1, 2024 through December 31, 2024, with claims paid through February 2025 as the basis for the 2026 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 HBG'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 2024 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 2024 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: The Company is using a completion factor of 0.983 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 drug utilization was converted to a "per 30-day" script count.

V. Projection Factors

V.1 Trend Factors

This development of the CY2026 rates reflects an annual trend rate of 11.7% (5.4% cost, 6.0% utilization) for medical and 8.8% (5.0% cost, 3.7% utilization) for pharmacy. These trends reflect HBG'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 medical trend represents a blended average for all medical types of services and is applied to the aggregate medical experience for pricing. Component data was not used in the development of the trend except pharmacy-specific projections were used to adjust the Pharmacy trend. The Pharmacy trend takes into account factors such as projected specialty drug use, pipeline drugs coming to market, and provider contracting. 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 Morbidity Adjustment of 0.979 is comprised of the following: the morbidity impact from claims experience, an adjustment to account for out-of-network tiering on the PPO plans, and an adjustment to account for the anticipated morbidity impact resulting from the expiration of the enhanced premium subsidies. Each of the components is described in more detail below.

In accordance with the Department's guidance, the morbidity change related to the Reinsurance program is set to 1.000.

Morbidity Impact from Claims Experience

This adjustment of 0.965 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.

Out-of-network PPO Tiering Impact

This adjustment of 0.976 reflects the expected reduction in claims expense resulting from proposed out-of-network tiering on the PPO plan designs. The Company has experienced an extremely high level of out-of-area out-of-network claims in its current PPO plans. As a result, the existing PPO plan designs are being modified to create two out-of-network cost sharing tiers. Tier 1 (Out-of-Network In-State) for providers located within Pennsylvania, and Tier 2 (Out-of-Network Out-of-State) for providers located outside of Pennsylvania. Costs will vary depending on the tier of the provider chosen. The adjustment factor was derived by assuming that 90% of the CY2024 out-of-state out-of-network allowed spend would be eliminated due to this change.

Morbidity Impact from Expiration of Enhanced Premium Subsidies

This adjustment of 1.040 reflects the anticipated morbidity impact resulting from the expiration of the enhanced federal premium subsidies that were implemented by the American Rescue Plan Act (ARPA) and extended by the Inflation Reduction Act (IRA). The Company derived

the adjustment factor from a member level lapse model that compared average allowed PMPM costs before and after assumed lapses caused by the loss of the enhanced subsidies. Lapse assumptions were developed in consultation with the Company's Sales team and varied based on factors such as a member's income relative to Federal Poverty limits, expected net premium increase, and exchange status (i.e. on vs off exchange). Additionally, results were calibrated and compared to publicly available studies performed by Oliver Wyman (OW) and the Congressional Budget Office (CBO). The resulting factor lands comfortably within the Department's recommended range of 1.00 to 1.07.

V.3 Changes in Demographics

We project no material change in the average rating factor (age, tobacco load and area combined).

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 1.019 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

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

VII. Credibility of Experience

The experience is from HBG's individual book of business in 2024. 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 HBG. 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 reinsurance, risk adjustment, and the exchange user fee.

IX.1 Projected Reinsurance PMPM

In accordance with the Department's May 12, 2025 all-carrier meeting updated guidance, the impact of the state 1332 Reinsurance Program is captured using the following parameters for 2026: an attachment point of $60,000, a coinsurance rate of 43%, and a cap of $100,000. HBG estimated the impact of the reinsurance program under these tentative parameters by trending Highmark PA individual ACA CY2024 incurred claims by member to the CY2026 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 4.0%. 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 and benefits in addition to EHB. This amount is reflected in worksheet 1 of the URRT.

IX.2 Projected Risk Adjustment PMPM

The estimated average risk score for HBG's projected 2026 population was developed by using HBG's 2024 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 HBG based upon its projected 2026 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 2026.

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

The analysis resulted in HBG receiving from the risk adjustment pool. The $38.97 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, HBG has assumed no adjustment to the projected risk adjustment transfer for the Risk Adjustment Data Validation (RADV) program.

IX.3 Exchange User Fee %

The 2.84% 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 1.27 and represents the non-payment of Cost Sharing Reduction subsidies. Consistent with the Department's guidance, this adjustment falls within the prescribed range of 1.22 to 1.30.

Exhibit I shows the quantitative support for the CSR load. The tables on Exhibit I demonstrate three different methods for determining the load. The Company evaluated the three methods and elected to assume a 1.27 CSR load. Additionally, these values aligned with the results of the Department's ACA CSR Survey from March 2025. The Company intends to continue to monitor the CSR load development and adjust as necessary in future years.

In accordance with the May 2, 2025 CMS bulletin notice and the May 27, 2025 CMS FAQ, the Company estimated the CSRs paid for enrollees in PY2024 to be $8.6 million. A modified version of the example method released in the CMS FAQ related to comparing EHB paid-to-allowed ratios was used since the actual CSRs paid cannot be quantified in the limited timeframe provided. The Company compared EHB paid-to-allowed ratios between each CSR plan variant to the standard plan and applied the differential to the actual EHB allowed claims in that variant. The Company relied on credible experience paid-to-allowed ratios for the CSR 87 and CSR 94 plan variants, and historical Pricing AVs for the standard plan and the CSR 73 plan variant because they were not credible.

Impact of Resumed Federal Funding of Cost Sharing Reduction Subsidies

As requested by the Department, this section describes the Company's preliminary evaluation of the impact associated with potential resumed federal funding of Cost-Share Reduction (CSR) plans. An increase in morbidity of 1 to 3% is anticipated as more healthy members are expected to leave the risk pool. Enrollment is expected to decline materially and shifting of

metal mix will occur as Gold members move to Silver or Bronze plans. Risk adjustment is assumed to be a (1%) to 1% premium rate impact due to uncertainty regarding the changes to the statewide risk pool. Administrative expenses and pricing AVs may increase due to a different mix of membership, with premium rate impacts expected to be 1% or less. In general, premium rate impacts will vary as Silver rates are expected to decline due to the removal of the current CSR load, but Gold and Bronze rates would be expected to increase. Final evaluation of the impacts mentioned here could change as the Company continues to evaluate this recent development.

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 are offered in several plans. Fourteen plans have an adult dental and vision benefit, four plans have an adult vision exam benefit, and twelve plans have a hearing 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:

- $0.20 PMPM for Risk Adjustment User Fee
- $0.34 PMPM for Patient Centered Outcomes Research Institute (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:

The profit/contingency factor is set to 0%. HBG has voluntarily refrained from including a risk and contingency factor in this filing. By this voluntary restraint, HBG is not waiving any right to include a risk and contingency factor which HBG believes is consistent with historical and legal interpretations of HBG 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 1.7898. This factor is calculated by dividing the all members age factor of 1.7879 by the ratio of billable members to total members 0.9989. The age curve calibration factor is 1/1.7898 = 0.5587.

XI.2 Geographic Calibration Factor:

The projected weighted average geographic factor is 1.0000. Each Plan Adjusted Index Rate represents the rate for an average member with a geographic factor of 1.0000. The geographic calibration factor is 1/1.0000 = 1.0000.

XI.3 Tobacco Calibration Factor:

The projected weighted average tobacco factor is 1.0058. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of 1.0058. The tobacco calibration factor is 1/1.0058 = 0.9942.

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 2026 using the federally-prescribed MLR methodology is 93.8%.

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. Screenshots and certifications for these plans were submitted as part of HBG's QHP application. When applicable and 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 HBG's expectations for 2026. These projections reflect expected changes in market share due to market competition, relative price levels, changes in plan offerings (where applicable), and the impact of the expiration of the enhanced advanced premium tax credits.

HBG expects membership in 2026 to follow a similar metal level distribution as the 2025 Individual ACA enrollment distribution.

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%	49.1%	5.0%
150%-200%	87%	34.3%	3.5%
200%-250%	73%	3.0%	0.3%
>250%	70%	13.7%	1.4%
Total		100.0%	10.1%

XV. Terminated Plans and Products

All plans in the 2024 experience period are still available in 2026.

XVI. Plan Type

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe HBG'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 HBG to accompany its rate filing 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 reflects 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 HBG 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: Actuarial Manager, Individual Markets

Date: September 9, 2025

XVIII. Exhibit I