Part III Actuarial Memorandum

Version 1

Priority Health

Individual Rate Filing

Effective January 1, 2019

PRHL-131493477
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INTRODUCTION
Priority Health (PH) is proposing revised benefits and rates for 2019.

Significantly, the following items have been updated:
- The base experience has been updated from 2016 to 2017.
- Medical and Rx annual trend factors.
- Adjustments for EHB benefits not in our experience.
- The Benefit Relative Values are being updated for trend leveraging and benefit changes.
- The area factors are being updated using experience from 2017.
- Underlying assumptions for population risk morbidity.
- Underlying assumptions for the risk adjustment program.
- Underlying assumptions for admin, taxes and fees.
- Updated load added to Silver plans offered both on and off exchange.

Actual vs. Expected Results
The rates developed by this filing are expected to produce an aggregate Benefit Ratio as shown on Exhibit 1. Plan management should actively monitor the developing experience for indications that the underlying assumptions of this filing are not developing as anticipated. Deviations from the priced for margin may be caused by fluctuations in medical trend, administrative expenses being higher or lower than target, membership failing to reach targeted levels, changes in the regulatory environment, or other causes.

Note
This rate development and memorandum is based on the applicable requirements under the current federal and state regulations, and that they continue and has been prepared absent any final regulations associated with Short-Term Limited-Duration policies and Association Health plans. If there are any regulatory, legislative or judicial changes to current requirements, there could be a material impact on PH’s business and proposed rates and actuarial assumptions used to develop those rates may no longer be appropriate.

I. GENERAL INFORMATION

A. Company Information
Company Legal Name: Priority Health
HIOS Issuer ID: 29698
NAIC Number: 95561
Market: Individual
Effective Date: January 1, 2019

B. Company Contact Information
Primary Contact Name: Kim Zondervan
Primary Contact Telephone Number: 616-464-0194
Primary Contact Address: 1239 E. Beltline NE, MS 2345, Grand Rapids, MI 49525
Primary Contact Email Address: kimberly.zondervan@priorityhealth.com

Secondary Contact Name: Emily Gross
Secondary Contact Telephone Number: 616-464-8815
Secondary Contact Address: 1239 E. Beltline NE, MS 2345, Grand Rapids, MI 49525
Secondary Contact Email Address: Emily.gross@priorityhealth.com

C. Review Requested: Review and approval of rates for existing and new products.

D. Brief Description of Benefits: Priority Health is proposing one product type, HMO. Two types of benefit plans are being offered, HSA and non-HSA. Both plan types include coverage for all EHBs. The Plan and Benefit template has additional detail on the plan designs.

E. Effective Date and SERFF Tracking Number of Prior Filing:
PH Individual plans PRHL-131065839. This filing had an effective date of 1/1/2018. The 2018 binder number was SERFF Tracking Num: PRHL-MI18-125073628.

F. Scope and Purpose of the Filing:
The purpose of this memorandum is to document and describe the proposed rating for 2019 ACA Individual products. This memorandum is intended to be used only by the Michigan Department of Insurance and Financial Services (DIFS) and plan management in their review of the proposed rating. Other uses may not be appropriate and should take into account the entire memorandum and attached exhibits. The information in this memorandum supports the attached Unified Rate Review Template, the Rate Manual, and the attached rates.

G. Components of this Rate Filing:
- Priority Health Rate Manual
- Michigan Rate Review Checklist
- URRT Template
- Actuarial Memorandum and Certification with Exhibits
- Rate Template
- Autism Attestation
- Supplemental Health Care Exhibit
The rate change proposed by this filing is not greater than 15% for any plans. Therefore, a Part II Justification of the Rate Increase is not required.

II. PROPOSED RATE INCREASE(S)
The proposed rate changes and projected membership and premium amounts are shown by plan on Worksheet 2 of the URRT in the applicable line item.

The reasons for the rate change include:
- Updated experience upon which the rates are based.
- Updated medical and prescription Rx cost and utilization trends.
- Updated benefit relative values, which may cause variation in rate changes by plan.
- Prospective benefit adjustments to existing products; the benefit relative values have been updated, which may cause variation in rate changes by plan.
- Re-evaluation of the anticipated morbidity adjustment to the rating base.
- Anticipated changes in the payments to the Federal Risk adjustment program.
- Updated factors for administrative expenses and margin. With this filing, the margin varies by plan.
- Updated taxes and fees for 2019, due to the 2019 ACA Insurer Tax holiday.

The overall average annual increase which will be experienced by members over January 1, 2018 filed rates is a 2.5% decrease based on the current 2018 projected membership.

| Projected Average Annual 2019 Premium per Member with proposed increase | $5,420 |
| Projected Average Annual 2019 Premium per Member without proposed increase | $5,558 |

III. EXPERIENCE PERIOD PREMIUM AND CLAIMS
The experience shown in the URRT Worksheet 1 is for 2017 Individual, non-grandfathered plans. The experience includes a blend of HSA and non-HSA plans.


B. Date Through Which Claims Were Paid: March 31, 2018

C. Premiums in Experience Period: The premium amounts were taken from Priority Health’s data warehouse. The premiums shown have been adjusted to reconcile with company financial statements. Based on federal requirements, we are not expecting to have MLR rebate.

D. Allowed and Incurred Claims Incurred During the Experience Period: The Allowed Claims and the Incurred Claims shown come from a combination of sources:
1) The medical claim records in the Priority Health data warehouse. Each claim record carries an allowed amount in addition to the Incurred (paid) amount and member cost shares. These amounts were directly used.

2) Capitation claim records in the data warehouse. The Fee-For-Service allowed equivalent was used for both Allowed and Incurred claims.

3) The Rx claim records in the data warehouse. These records carry both an allowed and an Incurred (paid) amount. This amount does include dispensing fees and is before the impact of Rx rebates.

4) Manual adjustments are made for non-system claims payments. These adjustments are made for provider settlements, provider incentive programs, and Rx rebates.

E. Incurred But Not Paid Claims: Claims were completed using the Priority Health claim reserve model. Monthly completion factors are developed for Inpatient, Outpatient, Professional, Injectable, and Rx claims. For each service category, a three year history of claims and membership is used. A 12 month chain ladder method, with high and low months discarded, is used. For the most recent months, the projection method sets the initial values. Other metrics are referenced for subjective adjustments to results, including: Inpatient authorizations, Claim Inventory volumes, and other metrics.

IV. BENEFIT CATEGORIES

Medical claims, including capitated services, have been categorized using the Milliman Health Cost Guidelines Grouper™ Model. The Capitation category requires additional amounts to recognize non-system payments and adjustments. These additional amounts are found by reconciliation with financial statements.

The Other category includes injectable drugs. The measurement unit for these categories is “services”.

V. PROJECTION FACTORS

Section II of the URRT Page 1 shows the development of the expected claims cost from which the Index Rate will be determined. Exhibit 2.1 shows this same calculation in more detail. Each section of the build-up is described below.

Section 0 Base Experience

This section shows actual experience which has been completed for IBNR.

Section 1 Changes in Morbidity of Population Insured

Adjustments were made for the provisions of ACA and changes in our benefit offerings and expected mix of members.

Risk Pool Adjustment: An adjustment was made for an anticipated difference in the risk morbidity for ACA plans based on both average risk factors and the change in the age mix of membership. Exhibit 3 shows the development of this factor. The final factor, 0.9833 or -1.67%, is [1 minus (1 minus Column C * Column D) * Column E] on the exhibit. The adjustment in Column E is to phase in only part the change in risk pool due to the expectation that the large shift to Bronze that Priority Health experienced in 2018 will not be maintained in 2019 as we expect a shift back to silver metal levels with a closer mix in 2019 to the 2017 mix.
The formula for ACA Risk Adjustment and 2018 individual experience were used to develop this factor as follows.

- Member months from the 2017 experience were divided into categories depending on the type of product they have in early 2018.
- A risk score was calculated for each category. These scores are shown in column A and the weighted average is shown in line 11. This was compared to the 2017 segment totals in line 12 for the factor that is shown in Column C.
- An allowable rating factor (ARF) was also developed for each of these categories to show the change in age for the population and is shown in Column B with the weighted average is shown in line 11. The inverse of this compared to the 2017 totals in line 12 is shown in column D.
- These adjustments reflect the migration into the ACA pool from other segments of the population and new members.

**Other:** Adjustments were also made for the migration of members from our POS product to our HMO product in 2018. Although these members are part of our 2017 experience risk pool, we no longer have a separate network factor to account for these members. We have adjusted the claims costs for the morbidity level of these members. An additional adjustment was made to normalize for the 2017 narrow network experience due to the different network contracts.

**Section 2 Other Changes:**
Certain other adjustments were required which did not fit into Section 1, the Risk Morbidity adjustments. These are:

- Additional benefits required for the EHB package

**Additional benefits required for the EHB package**
This experience has been further adjusted to account for benefits that would not be included in the experience period but would be part of the projected essential health benefit package. These include:

- The list of preventive services is being updated. An amount of $0.02 was added to Inpatient Facility, $0.21 was added to Injectables, and $0.21 PMPM was added to Prescription Drugs.

Where these benefits are partially in the experience base, the PMPMs above reflect pro-rated amounts needed to account for the full cost of the benefit. Exhibit 2.4 shows how these PMPMs convert into the percentage factors show in the cost build up.

**Changes in Demographics**
No adjustment was made outside of the Risk Pool Adjustment, described above, for the change in demographics. The demographics in the population have been very steady during the experience period. There was a shift in 2018 towards bronze plans but we expect that shift to revert back to close to the 2017 mix in 2019.

**Sections 3 and 4 Trend:**
The trends used by Priority Health are based on an analysis of Priority Health Commercial Group experience and our best estimate of future trends. Experience for all group sizes has been used to develop these trends. Updated trend data has been provided for our HMO and POS medical business. The updated Rx trend data also includes our PPO business. A summary of the new allowed charges trends are shown in Exhibit 4.

**Medical Trend Analysis**

Allowed charges are used as the starting point for trend development. Historical allowed charge trends are analyzed by reviewing monthly and twelve month rolling average of unit cost and utilization data. This data was then used to produce regression analyses for the historical unit cost and utilization component trends. Estimates of future cost trends are based on discussions with our Provider Contracting area as well as reviewing the historical experience.

The historical experience is reviewed, and from this data, cost and utilization components are chosen for the pricing trends. The pick for each utilization component is based on a consideration of the experience, expected future trends, and a review of the demographics of the group business. The demographics are stable, so there was no adjustment for this.

The pick for each cost component is based on consideration of the historical experience, estimates provided by the provider contracting staff, and estimates of the impact of future medical management activities. The final PMPM trends shown are calculated from the components.

**Rx Trend Analysis**

To develop the Rx trends, twelve month rolling unit cost and utilization data was used to produce a regression analysis for the unit cost and utilization components. This analysis was then supplemented with expected price increases from our pharmacy director, industry data, key cost features from our PBM contract, and a review of the demographics of the group business. After review of all the data, component trends for cost and utilization were chosen.

**Hepatitis C Treatments**

There had been a steady increase in the utilization of the new Hepatitis C drugs through 2015, but recent experience shows a peak in the utilization. These drugs have a unique set of cost and utilization characteristics, low frequency and very high cost. As such, these drugs do not fit well in Generic, Brand, or Specialty categories, so they have been separated.

**2019 Pricing Trend**

The Medical and Pharmacy pricing trends used to develop the index rate for 2019 are shown on Exhibit 4.

VI. **CREDIBILITY MANUAL RATE DEVELOPMENT**

The Individual ACA experience is based on 1,148,688 member months. We deemed that to be fully credible. Therefore, no credibility manual was developed.
VII. CREDIBILITY OF EXPERIENCE

The Individual ACA experience is based on 1,148,688 member months. We deemed that to be fully credible.

VIII. PAID TO ALLOWED RATIO

The Paid to Allowed Average Factor in Projection Period in Section III of Worksheet I is based on the 2017 experience for Individual ACA business and the ratio of paid claims to allowed claims, adjusted through a normalization for the Cost Share Reduction load on silver on-marketplace plans.

IX. RISK ADJUSTMENT AND REINSURANCE

**Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:**

The Risk Transfer Payment formula was used to estimate the extent to which the Priority Health individual experience has a higher or lower than average risk than the overall individual market place. Since this formula is based on a comparison of a Plan’s risk to the state wide Market risk, assumptions were needed for the state wide base. These assumptions were based on competitor URRTs, competitor rate filing data, factors published with the Transfer Payment methodology, the 2016 Transfer Payment amounts, and the 2017 Interim Transfer Payment estimates. These assumptions were then used to produce a range of values for the Risk Transfer payment.

**Projected Risk Adjustments PMPM:**

The estimated 2017 Risk Adjustment accrual model described above was used as a base to project the 2019 Transfer Payment. Adjustments to the model were made for known risk changes in our 2018 block for members that left as well as for members that are new to individual business both from demographic information and prior experience as available from other blocks. In addition, we estimated adjustments to the market average risk as well based on Priority Health expected market share and Priority Health risk pool changes.

Plan management has chosen to use the value from the modeling range of -$44.57 PMPM. This assumption is equivalent to saying that PH members will have a PMPM cost which is -$44.57 lower than the market average, and that PH will therefore have a payable amount due to the transfer formula. This amount is then converted to a percentage factor shown on line 5a of Exhibit 2.1 by comparing it to the completed, trended allowed claims from the experience period, adjusted for the paid to allowed ratio to account for cost sharing. Note that the formula includes the impact of age, area and metal level selection as well as member morbidity.

The PMPM results for this were converted to a percentage of premium and Exhibits 2.1 and 2.2 illustrates how that flows through into our Projected Index Rate and Market Adjusted Index Rate.

The risk adjustment fee is equivalent to $0.15 PMPM or $1.70 annually. The source for this is the 2019 Notice of Benefit and Payment Parameters.

**Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:**
The temporary ACA Reinsurance program ended in 2016 and therefore we have no projected recoveries or impact to premium assumed.

X. NON-BENEFIT EXPENSES AND PROFIT & RISK

**General Administrative expense load**

To develop the general administrative expense load, we used budgeted administrative expense for the period July 1, 2018 through June 30, 2019. This base data represents projections for all functional areas within the Company and aligns with our membership projections for this time period. We trended the administrative budget forward from July 1 through December 31, 2019 taking into consideration expected growth to develop administrative cost estimates for the period January through December 31, 2019.

In the development of product level administrative loads, we review our entire portfolio of products and isolate administrative functions that are specific to a product or group of products. These costs are then allocated only to that specific product or group of products. For the Individual product this includes direct sales (internal and external), marketing and product administration. Those administrative costs that cannot be assigned to a product or group of products are reviewed and allocated to this product based on the best metric available.

Exhibit 5 shows a buildup of the administrative expense and supports an administrative load of $30.00 PMPM.

**Taxes and Fees** – the following are included:

A. Michigan Department of Insurance and Financial Services Regulatory Fee: This represents an annual fee paid based on written premiums to fund the department expenses, including the cost of examinations. We estimate the fee to be approximately 0.04% of premium in 2019 which is based on historical rate increases.

B. Michigan Health Insurance Claims Assessment (HICA): The Michigan HICA assesses carriers a 1.0% tax on claims paid for services performed in Michigan by an individual domiciled in Michigan. HICA was sunset as of October 1, 2018 and replaced with the Insurance Provider Assessment (IPA). See below for a further description of this program.

C. ACA Insurer Tax: Carriers are taxed an assessment that is distributed to the industry based on earned premium. In the 2019 calendar year there is a temporary holiday and therefore the the cost of the 2019 fee is 0.0%.

D. HHS Risk Adjustment User Fee: Carriers are assessed a fee to fund HHS’s operation of the risk adjustment program. This fee is $0.15 PMPM or $1.70 annually as stated in the HHS Notice of Benefit and Payment Parameters for 2019.
E. Patient-Centered Outcomes Research Institute Fee: The fee will fund the Patient-Centered Outcomes Research Institute. This fee is removed with current regulations.

F. Exchange User Fee: The carrier is assessed a fee equal to 3.5% of premium for each member that purchases insurance on the FFM marketplace. These fees are applied as an adjustment to the index rate at the market level to ensure consistency between premium rates both on and off the exchange. This adjustment is based on our estimated mix between on and off exchange membership. Overall, on and off the FFM, we estimate the fee to be approximately 2.8%.

G. Insurance Provider Assessment (IPA): the Michigan IPA assesses $2.40 per member per month on all commercial fully insured members enrolled by the plan. This is reliant on the final regulations for this new assessment.

Profit/Risk Margin: The target profit/risk margin is 1.7% before FIT for all benefit plans in aggregate. The actual profit/risk margin varies by AV Metal Level as shown in the Rate Manual.

Commission: a 4.0% charge is made for average expected commissions. On Exhibit 2.1, commission is included with the administrative expense.

Tax Cuts and Jobs Act of 2017: Priority Health is exempt from federal income taxes as an organization described under Internal Revenue Code Section 501(c )(4) and therefore, will not benefit from the decrease in the statutory Federal income tax rate resulting from the Tax Cuts and Jobs Act of 2017 (TCJA). There are new certain taxes such as excise taxes on high wages earners and unrelated business income related to parking lots and workout facilities that are expected to have a minor increase in cost to the organization. Priority Health did not adjust its rates to account for potential increase in taxes related to the TCJA due to the immaterial nature of the taxes.

XI. PROJECTED LOSS RATIO

The Projected MLR was calculated using the formula required by 45 CFR §158.22. This formula is:

\[
ACA\ MLR = \frac{Incurred\ claims + expenses\ for\ activities\ that\ improve\ health\ care\ quality}{Premiums\ less\ federal\ and\ state\ taxes\ and\ licensing\ and\ regulatory\ fees}
\]

Both the numerator and denominator are adjusted for the transitional reinsurance program. Exhibit 1 details the calculation.

XII. SINGLE RISK POOL

The experience used to complete the URRT Worksheet 1 Experience Period section is for all Priority Health individual plans in effect during 2017. The experience includes a blend of HSA and non-HSA benefit plans. As has been described above, this experience has been adjusted to be appropriate for the Individual market in 2019.

XIII. INDEX RATE
The methodology used to develop the reported Index Rate of the Experience Period in Part I of the Unified Rate Review Template used our base experience for 2017 and added additional benefits that were not part of our experience period that are now part of the Essential Health Benefits package.

The index rate for the projection period was produced using Individual ACA claims experience from calendar year 2017, adjusted as described above in the Projection section. The experience period and index rates include allowed claims for essential health benefits on a PMPM basis.

There are no differences between the total allowed claims and the index rate.

To determine benefit plan premium rates, the projected index rate was adjusted, as allowed in 45 CFR 156.80(d), for network differences, age, area, benefit plan, and member smoking status. Please see the rate manual and Section XXIV below, for additional information.

XIV. MARKET ADJUSTED INDEX RATE
The development of the Market Adjusted Index Rate is shown on Exhibit 2.2. The starting PMPM for this calculation comes from the blended PMPMs from lines 4i of Exhibit 2.1, the projected experience PMPM. Note that no non-EHB have been included in the projection. Finally, adjustments are made for risk adjustment and exchange user fees.

XV. PLAN ADJUSTED INDEX RATES
Plan Adjusted Index Rates are developed on Exhibit 2.3. In this calculation, the Market Adjusted Index rate is further adjusted for:
- Non-EHB benefits
- Plan Benefits (The Benefit Relative Value or BRV)
- Retention
- Smoker Adjustment
- Paid to Allowed Ratio
- Network Factor
- CSR Load only for Silver plans both on and off the exchange

The resulting PMPM is shown both before and after the necessary calibration to use the required Age Factors.

XVI. CALIBRATION
As mentioned above, the Plan Adjusted Index Rates have been calibrated to the age factors. Exhibit 6 shows the calculations and describes the methodology used to calibrate the age factors. The Area Factors, BRVs, Smoker Adjustment Factors and the Network Factors used by the Plan are normalized to 1.000 during development. As a result, the Plan Adjusted Index Rates do not need to be calibrated to fit those factors.

XVII. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT
The Consumer Adjusted Premium Rates are shown in the Rate Template. These premium rates may be calculated using the formula and factors shown in the Rate Manual. The development of the rating factors is described in more detail in Section XXIV. Exhibit 2.3 also shows a comparison of the Consumer Adjusted Premium Rates, before age and area are applied, with the Plan Adjusted Index Rates.
XVIII. AV METAL VALUES

The Metal Level Actuarial Values are shown in Worksheet 2. Most of the benefit plans proposed are not 100% compatible with the AV Calculator, having minor benefit provisions that did not fit into the AV Calculator structure. The differences, however, are small. To insure compliance with the Metal Level requirements, the two step process shown in 45 CFR §156.135 (b)(3) was used to test the variances.

- The AV calculator was used to determine an AV for each proposed benefit plan for the plan provisions that fit within the calculator.
- Adjustments were developed for benefits with non-standard coinsurance, an Urgent Care copay different from other Office Visit copays, pediatric vision and copays per day, in addition to coinsurance.
- After applying all of the adjustments, the resulting adjusted “Test” AVs were then checked to see if they fell into the required AV ranges, which they did.

None of the adjustments change the result of the AV test, other than the 2nd Waiver plan described in more detail in section XXXI below. Exhibit 7 shows the values produced by the AV Calculator, the adjustment factors, and the adjusted AVs which have been used for each plan. These are the values that we have shown in the URRT as well.

The standalone AV calculator was used in the development and pricing of plan designs. In the Plan and Benefits Template, the AV is calculated using the calculator within the template. In some cases, the AVs from the two templates do not match. Further, as described in section XXXI below, the 2nd Waiver plans AV Value from the Plan and Benefits Template is outside of the AV range. We have provided Unique Plan Justifications for these plans.

Please see Section XXVI for the required actuarial certification of the Actuarial Values.

XIX. AV PRICING VALUES

The AV Pricing Values, also called Benefit Relative Values (BRVs), were developed by Priority Health actuarial staff using the Milliman Managed Care Rating Model® (MCRM) to model medical benefits and an internally developed Pharmacy model. These two tools were combined into one model that was then used to determine the BRV for each proposed plan. Where there is an integrated Medical and Rx deductible, the MCRM tool was used to estimate the impact of the integrated deductible.

Prior to setting up the MCRM, product development staff developed templates showing the major benefit features of the proposed plans. These templates were then used to calibrate the benefits in the MCRM. The model was further calibrated to the PMPM allowed level of our proposed plans.

The BRVs are compliant with 45 CFR §147.102. In particular, the MCRM model does not anticipate the health status, claims experience, industry, or length of coverage of the members which may enroll in a particular plan.

The model does consider benefit induced utilization. For example, for plans with office copays, the number of expected office visits is influenced by the amount of the copay. As a second example, the expected number of Rx scripts is adjusted based on the size of the required copay. For
deductible/coinsurance plans, there is an aggregate utilization assumption based on the deductible amount.

Table 3b of the Rate Manual summarizes the results by benefit plan, showing the high level benefit design, the Actuarial Value Metal Level, and the Actuarial Value Pricing Level (BRV). The Priority Health reference plan is based on the projected most popular plan design. The BRVs were then normalized to get back to 1.0.

XX. MEMBERSHIP PROJECTIONS
The membership projections are best estimates developed by the Priority Health Product Development staff. The enrolment for 2017 and early 2018 were used as the starting point in developing these projections as well as expectations for membership shift from 2018 to 2019.

XXI. TERMINATED PRODUCTS
Please see Exhibit 8 for a list of the terminated plans and mappings into current plans.

XXII. PLAN TYPE
The proposed plans are included in the selections shown in Worksheet 2, Section I of the Part I Unified Rate Review Template.

XXIII. WARNING ALERTS
There are no warning alerts.

XXIV. EFFECTIVE RATE REVIEW INFORMATION
Development of Premium Rates
The premium rates developed by Priority Health are intended to be compliant with 45 CFR §147.102 Fair Health Insurance Premiums. The rate manual for the proposed benefit plans is attached. The rate manual shows the formula used to calculate the rates, the various rating factors, and an example of how to calculate the rates. Each of the rating factors is described further below.

Rates are calculated on a member by member basis. Therefore, rates for a family contract are determined as the sum of the individual family member rates. The premiums for no more than the three oldest covered children will be taken into account when determining a family premium.

A. Starting Value
The starting value is the PMPM shown on Line 5e of Exhibit 2.1. This value is not calibrated for average age; the average age adjustment happens later in the Rate Manual formula. Exhibit 9.2 shows the starting value. Quarterly trend factors do not apply to Individual plans.

B. Network Factor
A separate network factor is not needed. This factor is therefore set to 1.000.

C. Age Factors
Priority Health is using the CMS Standard Age Curve. This age curve has a 3:1 ratio for age rating. The published updated factors for children will also be used.

D. Area Factors
Area factors have been developed for each of the 16 rating areas established by the State of Michigan. The area factors were developed in the following manner. Exhibit 9.1 summarizes the development of these factors.

1. In practice, Priority Health uses 15 areas:
   a. Wayne/Monroe = A
   b. = Oakland/Macomb = B
   c. St. Clair = C
   d. Ann Arbor = D
   e. Flint = E
   f. Thumb = F
   g. Jackson/Lansing = G
   h. Saginaw = H
   i. Southwest = I
   j. Kalamazoo = J
   k. Allegan/Barry = K
   l. Grand Rapids = L
   m. Midland = M
   n. Northwest = N
   o. Northeast = O

2. The Milliman Health Cost Guidelines Grouper™ Model was used to aggregate the claims experience for this rate development by area. Member Months and PMPMs were obtained.
   a. Allowed claims and medical member months were used throughout
   b. One year of data: 1/1/17 through 12/31/17

3. A Large Claims Adjustment was then made. This adjustment smoothed the excess amount over all in-state areas. A $500,000 threshold was used.

4. Then the data was normalized for risk based on the ACA Risk Adjustment model.

5. Other adjustments were:
   a. A credibility adjustment was made for smaller regions, with a weighted average of the developed factor and Milliman regional cost factors adjusted for regional discount differences not accounted for in the Milliman factors.
   b. Input was obtained from our provider contracting area regarding contracts expected to be in place for 2019. (The details on these negotiations are considered to be proprietary.)
   c. The new experience does cause the rating factors to change materially in some cases. Final adjustments were included to help smooth the impact of the change and balance the competitiveness of the rates across the areas.

The Final Adjusted PMPMs were then used to create the Final Adjusted Area Factors.

E. Benefit Factor
Please see the section above on AV Pricing Values for a description of these factors.

F. Tobacco-Use Factor
The factor for members who smoke varies by age and are shown in the rate manual. Priority Health does not have any credible data which could be used to develop Smoker rating factor. Therefore, these factors are a best estimate based on information from a research paper based on the Milliman Medical Underwriting Guidelines, a report from e-Health on smoker factor in the market rates, and market place research. As directed by the instructions for the URRT, this factor is calibrated to 1.000. The smoker factors before calibration have not changed from 2018.

Priority Health offers tobacco cessation programs and intervention drugs at no cost to our members.

G. Retention Factors
The factors for administration, taxes and fees, and profit have been described in earlier section and are displayed in the Rate Manual. In the calculation of the rates, the retention factors are applied last so that the profit margin can vary by benefit.

Additional URRT Information
Row 66 Portion of above payable by HHS’s funds on behalf of insured person, in dollars: These amounts are based on actual APTC CSR data.

Row 71 Net Amt of Risk Adj: This amount was estimated using the Risk Transfer Payment formula. The total amount ties to the company’s financial statements.

XXV. RELIANCE
I have relied on Nick Gates, Priority Health Controller, and Cindy Brink, Priority Health Director of Financial Reporting and Analysis, for the development of administrative expenses and projected loss ratios. The results of this work appear to be reasonable.

I have relied on the Priority Health Product Development staff for membership projections. These projections have been examined and appear reasonable.

I have relied on the Milliman Health Cost Guidelines grouper model to categorize claim experience into the categories required by the URRT template. The results of this model were examined and appear reasonable.

I have relied on the Milliman Managed Care Rating Model in the development of benefit relativity factors. The results of this model were examined and appeared reasonable.

XXVI. ACTUARIAL CERTIFICATION

I, Kimberly S. Zondervan, am a member of the American Academy of Actuaries and am qualified to make certifications regarding the development of health insurance premiums. I am employed as an Actuary with Priority Health. I hereby certify that to the best of my knowledge and belief:

1. That the projected index rate is:
   a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), and
   b. Has been developed in compliance with the applicable Actuarial Standards of Practice,
and

c. Is reasonable in relation to the benefits provided and the population anticipated to be covered, and

d. Is neither excessive nor deficient.

2. 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.

3. That the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

4. 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 except those specified in the attached certification. The attached certification, as required by 45 CFR §156.135, identifies plans with Unique designs for which an alternative methodology was used.

5. That the geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Signature

Date June 14, 2018

XXVII. RATE CHANGE SUMMARY
As described in Section II, the URRT worksheet 2 compares the new rates with the old by plan, and shows the weighted average change across all plans.

The following changes to the rating factors.

- Age: None.
- Tobacco: None.
- Geographic: These factors have been re-normalized as described in Section XXIV above.
- Familial Status: None.

XXVIII. SERVICE AREAS

For 2015 through 2019 premium rates have been submitted for all regions except region P. Premium rates are being submitted for all regions where Priority Health intends to sell new business.
XXIX. AUTISM REQUIREMENT
The rate development process does not include an adjustment for autism benefits. Rather, the cost of this benefit is contained in the experience period claims. Since PH is including the cost of Autism claims in its rate development, the Autism fund will not be utilized.

An attestation stating compliance with Order No. 14-017-M is included with this filing.

XXX. SUPPLEMENTAL HEALTH CARE EXHIBIT (SHCE)

The SHCE exhibit filed for 2017 is included in the Supplemental Documentation of this filing. Exhibit 10 shows a reconciliation of this exhibit to the Experience Period Premiums and Incurred Claims shown in worksheet 1 of the URRT. Note that there are timing differences in the 2 reports. The General Ledger is prepared by Accounting and uses the General Ledger and 2017 Calendar Year with no adjustments or run-out. The URRT data comes from the data warehouse and includes any adjustments made January – March 2018.

XXXI. 2nd WAIVER PLANS

As requested and discussed with DIFS, we are filing 2 Silver plans with a 94% cost share variation that will be available off exchange for the Healthy Michigan 2nd Waiver population only. These 94% variation plan designs will be offered off-exchange only with a cost sharing arrangement to be worked out with DHHS. Therefore they are priced as Silver plans, with the pricing the same as the Silver $3,200 plan, filed with separate QHP ID for use off exchange only. There is a different formulary associated with the 2 plans for this population.

XXXIII. CSR SUBSIDY

This filing assumes that the Cost Share Reduction subsidy will not be funded in 2019. Therefore, the Silver plans that are offered both on and off exchange have an additional rating factor, as shown in our rate manual, to adjust the premium rates for the loss of the subsidies.

To develop the factor we made assumptions on the population migration due to high silver premiums both on and off exchange to determine the base membership left in silver plans that would receive the load for the additional cost. We then took the expected subsidy amount that would be lost in 2019 and spread it over the expected premium for the base membership left in silver plans.

Note that the 2nd waiver plans described above in section XXXI are off-exchange only and therefore do not have a factor applied to them.