# Part III Actuarial Memorandum

**Version 1**

**Secondary Filing**

**Priority Health**

**Individual Rate Filing**

**Effective January 1, 2026**

**PRHL-134555284**

SECONDARY

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# Part III Actuarial Memorandum
# Priority Health
# Individual Rate Filing
# Effective January 1, 2026

INTRODUCTION

Priority Health (PH) is proposing revised benefits and rates for 2026.

Significantly, the following items have been updated:

- The base experience has been updated from 2023 to 2024.
- Medical and Rx annual trend factors.
- Adjustments for benefit changes.
- The Benefit Relative Values are being updated for trend leveraging and benefit changes.
- Area factors.
- Network factors.
- Silver CSR Load removed.
- Underlying assumptions for the risk adjustment program.
- Underlying assumptions for admin, taxes and fees.
- Underlying assumptions for population morbidity due to the expiration of EPTC subsidies and CSR funding
- Underlying assumptions for population morbidity due to CSR funding

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, other than as specified in this filing, and that they continue. 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.**

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## I. GENERAL INFORMATION

A. Company Information
Company Legal Name: Priority Health
HIOS Issuer ID: 29698
NAIC Number: 95561
Market: Individual
Effective Date: January 1, 2026

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

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-134114323. This filing had an effective date of 1/1/2025. The 2025 binder number was SERFF Tracking Num: PRHL-MI25-125118720 .

F. Scope and Purpose of the Filing:
The purpose of this memorandum is to document and describe the proposed rating for 2026 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
- Part II Justification
- Actuarial Memorandum and Certification with Exhibits
- Rate Template
- Supplemental Health Care Exhibit

- Chronic Condition Plan Justification Actuarial Memorandum

The rate change proposed by this filing is greater than 15% for some plans. Therefore, a Part II Justification of the Rate Increase is required and included.

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.
- Anticipated morbidity impact from the expiration of EPTC subsidies and CSR funding
- 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.
- Removal of Silver CSR Load.
- There is no separate adjustment for COVID-19 in our build up. We expect ongoing costs to be consistent with our base period and included in the overall trend.

The overall average annual increase which will be experienced by members over January 1, 2025 filed rates is a 10.02% increase.

| | |
|---|---|
| Projected Average Annual 2026 Premium per Member with proposed increase | $8,001 |
| Projected Average Annual 2026 Premium per Member without proposed increase | $7,272 |

If the Enhanced Advanced Premium Tax Credit subsidies (EPTCs) are extended to 2026 with the same structure as 2025, the following would change in our filing.

- The EPTC load noted in Exhibit 2.1 would be removed.
- If the extension is before 7/31/25, the Exchange User Fee would be 1.5% instead of 2.5%, per the NBPP.
- The assumption for proportion of membership that is on exchange would increase to 89%.
- The Admin and Fees conversion from PMPM to % of premium would need to be revised. The PMPMs would not be updated but the % of premium would be updated with the base changes.
- The combination of these changes leads to approximately a -3.7% impact if EPTC subsidies are extended before 7/31/25 and -2.8% impact if EPTC subsidies are extended after 7/31/25. These

are based on the change to Exhibit 2.1 line 10b, Adjusted Premium with the updates noted above. The final URRT increase could vary slightly.

## III. MARKET EXPERIENCE

The experience used to complete the URRT Worksheet 1 Experience Period section is for all Priority Health individual plans in effect during 2024. 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 2026.

## IV. EXPERIENCE PERIOD PREMIUM AND CLAIMS

The experience shown in the URRT Worksheet 1 is for 2024 Individual, non-grandfathered plans. The experience includes a blend of HSA and non-HSA plans.

A. Dates of Service for the Experience Period: January 1, 2024 through December 31, 2024.

B. Date Through Which Claims Were Paid: April 30, 2025

C. Current Enrollment and Premium listed on Worksheet 2 is based on members as of April 30, 2025.

D. 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.

E. 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.

F. Incurred But Not Paid Claims: Claims were completed using a claims reserve model ("Claims Projection System") licensed from Axene Health Partners. Monthly completion factors are developed for Inpatient, Outpatient, Professional, Injectable, and Rx claims. For each service category, a five 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, where the completion factor is less than 75%, the projection method is used to develop the IBNR estimate. In addition, adjustments are considered for metrics such as authorized admissions, expected monthly seasonality, amount of pended claims, number of claim payment cycles in a month, accounts receivable of a major provider, high dollar claims accrual, and other information available during the month.

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V. 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.

VI. 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. The cost of gender affirming care was removed from the index rate. 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.

EPTCs expiration adjustment: An adjustment was made for the expected change in the market risk morbidity with the expiration of EPTC subsidies. The development can be found in Exhibit 9.4. Expected market changes are shown by metal level. The membership distribution reflects the expected Michigan market membership in 2026. We relied on our Product team for the membership impact input. Priority Health had a larger rate increase than the rest of the market in 2025 and we have assumed the morbidity impact from the Priority Health turnover as a proxy for the expected morbidity impact from the subsidy expiration. This is illustrated in the Morbidity Impact column. The Claims PMPM column is based on 2024 Priority Health paid claims (consistent with the Morbidity Impact calculation data source) and was used to weight the impact appropriately. We have assumed that our morbidity impact will be similar to the market morbidity impact. Therefore, we have assumed no impact to Risk Adjustment for the EPTC expiration because while the market average morbidity will increase our relative risk to the market will not change.

CSR Funding adjustment: An adjustment was made for the expected change in the market risk morbidity with the funding of CSR subsidies. The development can be found in Exhibit 9.5. Expected market changes are shown by metal level. Similar to the EPTC expiration adjustment, a similar approach was made for the incremental membership distribution changes expected in the Michigan market membership in 2026 if CSR subsidy payments were to resume. Priority Health had a larger rate increase than the rest of the market in 2025 and we have assumed the morbidity impact from the Priority Health turnover as a proxy for the expected morbidity impact from the subsidy expiration. This is illustrated in the Morbidity Impact column. The Claims PMPM column is based on 2024 Priority Health paid claims (consistent with the Morbidity Impact calculation data source) and was used to weight the impact appropriately. We have assumed that our morbidity impact will be similar to the market morbidity

impact. Therefore, we have assumed no impact to Risk Adjustment if CSRs are funded because while the market average morbidity will increase our relative risk to the market will not change.

Other: An additional adjustment was made to normalize for the narrow network experience due to the different network contracts and geographic distribution compared to expected in the experience period.

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

- Changes to benefits required for the EHB package

Changes to benefits required for the EHB package / Plan Design Changes
This experience has been further adjusted to account for benefits that would not be included in the experience period but the projected essential health benefit package would have different coverage. These include:

- An increase of $0.11 PMPM was made for a change to the coverage of augmentative communication devices.
- An increase of $0.19 PMPM was made for a change to the coverage of orally administered anticancer medication.
- An increase of $0.01 PMPM for a change to the coverage of sleep apnea surgery and varicose vein surgery.
- An increase of $0.06 PMPM for a change to the coverage requirements for eligibility of incapacitated dependents.

Exhibit 2.4 shows how this PMPM convert into the percentage factor shown in the cost build up.

Changes in Demographics
No additional adjustment was made for the change in demographics beyond the assumption for EPTC subsidy expiration.

**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 with adjustments made for emerging Individual experience. 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 is shown in Exhibit 4.

*Medical Trend Analysis*
This section describes Priority's normal trend development.

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. In addition, extensive discussions are held with the Medical and Pharmacy team to validate and revise the picks based on clinical expertise. 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. 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 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.

*2026 Pricing Trend*

The Medical and Pharmacy pricing trends used to develop the 2026 index rate are shown on Exhibit 4.

## VII. CREDIBILITY MANUAL RATE DEVELOPMENT

The Individual ACA experience is based on 1,830,115 member months. We deemed that to be fully credible. Therefore, no credibility manual was developed.

## VIII. CREDIBILITY OF EXPERIENCE

The Individual ACA experience is based on 1,830,115 member months. We deemed that to be fully credible.

## IX. PAID TO ALLOWED RATIO

The Paid to Allowed Average Factor in Projection Period in Section III of Worksheet I is based on the ratio of paid claims to allowed claims in the Individual ACA experience, adjusted through a normalization for the Cost Share Reduction load on silver on-marketplace plans and 2026 benefits.

## X. 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 marketplace. Since this formula is based on a comparison of a plan's risk to the statewide market risk, assumptions were needed for the statewide base. These assumptions were based on competitor URRTs, competitor

rate filing data, factors published with the Transfer Payment methodology, the 2023 Transfer Payment amounts, and the 2024 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 2024 Risk Adjustment accrual model described above was used as a base to project the 2026 Transfer Payment. We have adjusted for the expected metal mix of the 2026 members as well as the impact of premium increases.

Plan management has chosen to use the value from the modeling range of -$71.50 PMPM. This assumption is equivalent to saying that PH members will have a PMPM cost which is $71.50 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 and the adjustments as shown in Exhibit 2.1, lines 10a and 10b for Narrow Network and Silver CSR load impact. 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.

**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.

## XI. 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 January 1, 2025 through December 31, 2025. This base data represents projections for all functional areas within the company and aligns with our membership projections for this time period. We rolled the administrative budget forward taking into consideration expected growth to develop administrative cost estimates for the period January through December 31, 2026.

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 $34.37 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 0.03% of premium in 2026 which is based on historical rate increases.

B. HHS Risk Adjustment User Fee: Carriers are assessed a fee to fund HHS's operation of the risk adjustment program. This fee is $0.20 PMPM or $2.40 annually as stated in the HHS Notice of Benefit and Payment Parameters for 2026.

C. Patient-Centered Outcomes Research Institute Fee: The fee will fund the Patient-Centered Outcomes Research Institute. This fee is $3.81 PMPY for 2026.

D. Exchange User Fee: The carrier is assessed a fee equal to 2.5% 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 2.0% with 80% of members on exchange.

If EPTC subsidies are extended before 7/31/25, the Exchange User Fee would be 1.5% and the assumed proportion of members on exchange would be 89%, resulting in a 1.3% fee on and off the FFM.

If the EPTC subsidies are extended after 7/31/25, the Exchange User Fee would still be 2.5% and the assumed proportion of members on exchange would be 89%, resulting in a 2.2% fee on and off the FFM.

E. Insurance Provider Assessment (IPA): the Michigan IPA assesses $2.40 PMPM on all commercial fully insured members enrolled by the plan.

Profit/Risk Margin: The target profit margin is 2.3% before FIT for all benefit plans in aggregate. There is an additional risk margin of 1.1%. The actual profit margin varies by AV Metal Level as shown in the Rate Manual.

Commission: A 4.2% charge is made for average expected commissions. On Exhibit 2.1, commission is included with the administrative expense.

## XII. 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 2024 and added additional benefits that were not part of our experience period that are now part of the Essential Health Benefits.

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The index rate for the projection period was produced using Individual ACA claims experience from calendar year 2024, adjusted as described above in the Projection section. The experience period and projection period 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 XXII below, for additional information.

## XIII. 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 4g 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.

## XIV. 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 as shown in the Rate Manual
- Plan Benefits (The Benefit Relative Value or BRV) and Cost Sharing as shown in the Rate Manual
- Retention as shown in the Rate Manual
- Paid to Allowed Ratio as shown in the Rate Manual
- Network and Adjustment Factors as shown in the Rate Manual

The resulting PMPM is shown both before and after the necessary calibration to use the required Age Factors, Smoker and Area factors. Please note that a Catastrophic Adjustment is Not Applicable.

## XV. CALIBRATION

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 BRVs 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. There are also calibration factors for Tobacco and Area. All calibration factors are shown in the Rate Manual as well as Exhibit 2.1, section 9.

## XVI. 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 XXII. 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.

## XVII. PROJECTED LOSS RATIO

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

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

Exhibit 1 details the calculation.

## 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 ensure compliance with the Metal Level requirements, for benefits with multiple copays for one AV calculator input, 45 CFR §156.135 (b)(2) was used to adjust the inputs. A weighting was used to blend the copays to adjust for only one input in the AV calculator.

For other benefit provisions, 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.

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.

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

## XIX. MEMBERSHIP PROJECTIONS

The membership projections are best estimates developed by the Priority Health Product Development staff. The enrollment for 2024 and early 2025 were used as the starting point in developing these projections as well as expectations for membership in new plans.

## XX. TERMINATED PRODUCTS

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

## XXI. PLAN TYPE

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

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## XXII. 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 5d 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. 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.

C. Network Factor

A separate network factor is not needed. This factor is therefore set to 1.000. Narrow network factors are shown in the Rate Manual.

D. Age Factors

Priority Health is using the CMS Standard Age Curve. This age curve has a 3:1 ratio for age rating.

E. Area Factors

Area factors have been developed for all 15 of the 16 of the rating areas established by the State of Michigan. Exhibit 9.1 summarizes these factors. The factors are also shown in Worksheet 3 of the URRT. The area factors were developed in the following manner:

1. Plan Experience MLR for 2024 was used. This was adjusted for:
    a. Risk Adjustment to remove morbidity from the experience.
    b. Input obtained from our provider contracting area regarding contracts expected to be in place for 2026. (The details on these negotiations are considered to be proprietary.)
    c. Large claims adjustment. This adjustment smoothed the excess amount over all in-state areas. A $500,000 threshold was used.
    d. Credibility for small regions, with a weighted average of the developed factor and the 2023 GCF factor published with the Risk Adjustment Final Report.
2. The new experience and methodology 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.

F. Benefit Factor

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

G. 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 marketplace 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 2025.

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

H. 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.

## XXIII. RELIANCE

I have relied on Nick Gates, Priority Health Interim President, and Sara McGlynn, Priority Health Manager, Financial Reporting, 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 and the Actuarial Team members 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 and the Actuarial Team members in the development of benefit relativity factors. The results of this model were examined and appeared reasonable.

## XXIV. 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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
5. Note that the URRT does not demonstrate the process used to develop the rates but represents information required by federal regulation to provide support for the review of rate increases, 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.

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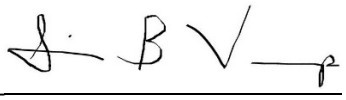
Signature 

Date June 16, 2025

I, Simon B. Veldkamp, 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:

6. 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.

Signature 

Date June 16, 2025

XXV. 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 updated as described in Section XXII above.
- Familial Status: None.

XXVI. SERVICE AREAS

For 2015 through 2026 premium rates were submitted for all regions except region P. Premium rates are being submitted for all regions where Priority Health intends to sell new business. In 2026, some plans will only be offered in some of the regions where Priority Health sells business.

XXVII. AUTISM REQUIREMENT

SECONDARY

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.

XXVIII. SUPPLEMENTAL HEALTH CARE EXHIBIT (SHCE)

The SHCE exhibit filed for 2024 is included with this filing. Exhibit 3 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 2024 Calendar Year with no adjustments or run-out. The URRT data comes from the data warehouse and includes any adjustments made January – April 2025.

XXIX. CSR SUBSIDY

This filing assumes that the Cost Share Reduction subsidy will be funded in 2026. Therefore, an additional rating factor for Silver plans to adjust the premium rates for the loss of the subsidies is not necessary.

XXX. ESTIMATED 2024 CSR AMOUNT

Priority Health has adjusted premiums for silver plans offered both on and off exchange with a “silver load” based on the expected shortfall in CSR plan premium due to no federal reimbursement. We have based our "silver load" on the expected membership by CSR level and the expected spread of premium needed for the difference in the premium paid versus the richness of the plan for on-exchange plans only. We have created an estimate range for 2024 CSR reimbursements had they been funded. This can be seen in Exhibit 10.

- Method 1: use estimated premium load by CSR level against 2024 total premium
- Method 2: use paid to allowed ratios by CSR level against 2024 allowed claims