BCBSM 2019 Individual Rate Filing

Actuarial Memorandum

June 14, 2018

Table of Contents

Executive Summary

In support of the Part I Unified Rate Review Template (URRT) for the 2019 Blue Cross Blue Shield of Michigan (BCBSM) individual market rate submission, we submit this Part III Actuarial Memorandum, which includes a corresponding actuarial certification, as required by the Affordable Care Act (ACA). The memorandum provides documentation for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate changes. As requested within the Part III instructions, the actuarial memorandum also provides actuarial certifications related to:

- The methodology used to calculate the Actuarial Value (AV) Metal Value for each plan offered;
- The appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based;
- The index rate is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates; and,
- The geographic rating factors reflect only differences in the costs of delivery and marketplace factors and do not include differences for population morbidity by geographic area.

The information contained within the memorandum provides the documentation and analysis required as outlined in the Part III Actuarial Memorandum instructions provided in Bulletin 2018-07-INS (Bulletin), issued by the Department of Insurance and Financial Services (DIFS) on March 22, 2018.

This memorandum is intended solely for the purpose stated above. It is not intended for and should not be used or relied on for any other purpose.

Section 1: General Information

Company Information

- Company Legal Name: Blue Cross Blue Shield of Michigan Mutual Insurance Company
- State: Michigan
- HIOS Issuer ID: 15560
- NAIC Number: 54291

Company Contact Information

- Primary Contact Name: Jeremy Henderson
- Primary Contact Title: Actuary Manager, Individual Pricing
- Primary Contact Telephone Number: (313) 225-5646
- Primary Contact Email Address: JHenderson@bcbsm.com

General Filing Information

- Market: This filing covers products that will be offered in the individual market.
- Review Requested: Rate Change
- Brief Description of Benefits: The products included in this filing provide comprehensive medical expense benefits subject to cost-sharing provisions relating to deductible, coinsurance, and co-payments. All Essential Health Benefits (EHBs) are covered as described in the state benchmark plan and no EHB substitutions were made as they are not allowed per guidance from the State of Michigan. Appendix Exhibit D.1 provides an outline of the benefits under all products in this filing and the corresponding HIOS identifiers. Please refer to the benefit template and schedule pages for additional details.
- Effective Date: For policies issued from January 1, 2019 through December 31, 2019
- Prior Filing Information:
    - Effective Date: For policies issued from January 1, 2018 through December 31, 2018
    - SERFF Tracking Number: BBMI-131060304
    - Binder Number: BBMI-MI18-125072755

DIFS Checklist

- As required by the State of Michigan, attached in Appendix Exhibit A is the checklist of items required for the Actuarial Memorandum in support of the URRT.

Section 2: Proposed Rate Change(s)

All the plans offered in 2018 will remain open in 2019. Exhibit 2.1 provides the proposed rate increases for all existing products. Significant drivers of the rate changes outlined in Exhibit 2.1 are:

- Medical inflation and increased utilization as described in section 5 of this memorandum.
- Anticipated changes in the average morbidity of the marketplace covered population as described in section 5 of this memorandum.
- Anticipated changes in taxes and fees imposed on all issuers in 2019 as summarized in section 10 of this memorandum.
- Updated administrative expenses as a percentage of total premiums in 2019 as summarized in section 10 of this memorandum.
- Updated projections for risk adjustment transfer as summarized in Section 9 of this memorandum.

The requested rate increases are based on the same single risk pool of experience for the individual market. However, the increases will vary slightly across some products and plans due to the following:

- Changes in cost sharing provisions to get plans back into Actuarial Value ranges.
- An updated benefit pricing model with more recent underlying claims data.

As required by the DIFS checklist, Exhibit 2.2 outlines the annual expected premium rate increases, along with membership and contract counts affected by the proposed rate change.

Exhibit 2.1: Rate Changes by Product

Product ID	Rate Change
15560MI035	3.7%
15560MI112	5.4%
15560MI113	5.9%
Overall	**4.2%**

Exhibit 2.2: Premium, Members, Contracts

Projected Average Annual 2019 Premium per Member with proposed increase	$	7,942
Projected Average Annual 2019 Premium per Member without proposed increase	$	7,624
Number of Policy Holders		31,926
Covered Lives		52,332

Cost Share Reduction (CSR) Subsidy Funding

The rate changes shown in Exhibit 2.1 reflect discontinuation of funding for CSR subsidies. Rates for silver plans offered both on and off marketplace are 8.5% higher due to the loss of funding. Historical CSR payments were compared to total premium to determine the increase needed for Silver 70/73 members as well as Silver 87/94 members. The two buckets were then weighted on expected member distribution for an overall increase of 8.5%.

Exhibit 2.3: CSR Load Development

	2017 Member Distribution	Proj. 2019 Mem Distribution	Rate Increase Needed
Silver 73/70	74%	60%	0.3%
Silver 94/87	26%	40%	20.9%
Total			8.5%

Anticipated Change in Corporate Liability from Tax Cuts and Jobs Act of 2017

On December 22, 2017, H.R. 1, formally known as the Tax Cuts and Jobs Act (the "Act"), was enacted into law. The Act makes broad and complex changes to the U.S. tax code, including, but not limited to, changing the U.S. federal corporate tax rate to 21 percent, as compared to Blue Cross Blue Shield of Michigan (BCBSM)'s historical use of a tax rate of 20 percent applied since becoming federally taxable in 1986.

The Act also repealed the 20 percent corporate alternative minimum tax (AMT) for tax years beginning after December 31, 2017, and provides any existing AMT credit carryovers are creditable or refundable for tax years 2018 through 2021. BCBSM has approximately $533 million of AMT credit carryovers that are expected to be fully utilized or refunded on tax returns filed through 2021. These AMT credits are reported as a deferred tax asset on the BCBSM Annual Statement and portions of the amount are admissible over the next three years but no cash is expected to be received before 2020, after the filling of the Corporation's 2018 tax return in October of 2019.

Statutory Accounting Principles require that tax assets and liabilities reflect the applicable tax rate in effect when the assets and liabilities are utilized, as such, BCBSM's deferred tax assets ("DTA") and deferred tax liabilities ("DTL") have been remeasured (from 20%) to reflect the new corporate tax rate of 21%. BCBSM's premeasurement of its deferred tax assets and liabilities is subject to further refinement as additional information becomes available and further analysis is completed.

The net financial impact of the Act's changes resulted in a net increase in BCBSM's DTA's that are counted as admissible assets under Statutory Accounting Principles, which had the effect of increasing Risk Based Capital (RBC) by approximately 50 points in 2017. Blue Cross Blue Shield of Michigan's year end RBC of 651 percent was an increase from the 547 percent level reported in 2016 and comes after a two-year decline of 130 percent. The RBC reported in 2017 is lower than the RBC reported in 2012, 2013 and 2014 (the three years immediately before the decline).

The increase in 2017 RBC was a significant factor in BCBSM's return to a "stable" credit rating, and a level BCBSM believes remains in the range of safe, reliable, and entitled to public confidence, after being put on a negative credit rating downgrade watch by A.M. Best in 2016.

Impact on Rate Development of Tax Cuts and Jobs Act of 2017

As a result of the tax reform, BCBSM's corporate tax rate increased from 20% to 21%. BCBSM is not increasing rates to offset this additional tax and will instead absorb the expense.

Section 3: Experience Period Premium and Claims

The underlying data used to establish the 2019 rates reflects the experience of all policies that currently meet the State of Michigan definition of an individual policy.

- Dates of Service for the Experience Period Used to Develop Rates: January 1, 2017 through December 31, 2017
- Paid through date: March 31, 2018

Premiums (net of MLR Rebate) in Experience Period

Experience period premium, including premium subsidies, is $506,344,397 as seen in worksheet 1 of the Unified Rate Review Template. There are no MLR rebates expected in 2017.

Allowed and Paid Claims Incurred During the Experience Period

Allowed claims for the experience period were derived by taking paid claims and adding member cost sharing amounts (deductibles, coinsurance and co-pays), cost sharing subsidies for the member, as well as any coordination of benefits. These amounts were taken from our claims payments systems with the exception of the settlement amounts which come from our internal financial statements.

The amounts were adjusted for any reported hospital settlements as well as rebates for prescription drugs as reported by our third-party pharmacy benefit manager. These two items are reflected as adjustments to claim costs.

As of 2017, BCBSM is not participating in the Autism Coverage Reimbursement Program established by PA 101 of 2012 for our individual business. Therefore, autism claims are included in the experience period data. These are estimated to be $5.65 PMPM.

To reflect claims incurred in the experience period but paid after the paid-through date, we adjusted the uncompleted incurred claim cost by the completion factors shown in Exhibit 3.1 below. Claims were completed using our internal reserving models, utilizing the following methodology:

- For each type of service, a lag triangle was created (e.g. IP Hospital, Outpatient facility, Professional, Drug) based on a four-year monthly history of claims and membership.
- A completion factor methodology was used to develop incurred claims estimates for all incurred months.

- Claims inventory levels are monitored and adjustments to payment rates were made as needed.
- Seasonal factors accounting for working days and benefit changes were used to adjust trends and expected PMPMs.

Exhibit 3.1: Experience Allowed Claims Cost Development

2019 Blue Cross Blue Shield of Michigan Individual Rate Development

	Benefit Category				
	Inpatient Hospital	**Outpatient Hospital**	**Professional**	**Prescription Drug**	**Total**
Experience Period Data					
Experience Period Membership					82,951
Utilization per 1,000	89.79	2,520.47	21,833.96	13,033.27	
IBNR	1.012	1.012	1.015	1.000	
Completed Utilization per 1,000	90.83	2,549.66	22,162.90	13,033.29	
Cost per Service	$16,969.78	$791.92	$121.46	$118.81	
Experience Period Allowed Claims PMPM	**$128.44**	**$168.26**	**$224.33**	**$129.04**	**$650.08**
Experience Period Index Rate					*$650.08*

A reconciliation between the experience period incurred claims and premium shown on Worksheet II of the URRT and provided in the Supplemental Health Care Exhibit is shown in Exhibit 3.2.

Exhibit 3.2: Reconciliation of Experience Period Data and Supplemental Health Care Exhibit

Premium Reconciliation		
SHCE Health Premiums Earned (Part 1, Line 1.1)	**$**	**620,954,661**
MLR Individual Definition Adjustments (D&V)	$	21,788,856
Miscellaneous Rate Credit	$	60,057
Risk Adjustment Transfer	$	(108,023,633)
Remove Group Conversion Revenue	$	281,370
Ancillary Premium	$	(28,716,912)
Experience Period Premium from SHCE	**$**	**506,344,397**
URRT Experience Period Premium	**$**	**506,344,397**
Percentage Difference		**0.0%**
Incurred Claims Reconciliation		
SHCE Total Incurred Claims (Part 1, Line 5.0)	**$**	**502,523,274**
MLR Individual Definition Adjustments (D&V) - Paid Claims	$	17,987,969
MLR Individual Definition Adjustments (D&V) - IBNR	$	(219,995)
Admin Reclass	$	(801,532)
Other Accounting Adjustments	$	(700,637)
Hospital Settlements and Provider Refunds	$	23,598,933
Remove Group Conversion Incurred Claims	$	(201,681)
Additional Runout and Prior Year Restates	$	337,470
Ancillary Claims	$	(22,690,844)
Rx Rebates and Hospital Settlements	$	(23,335,263)
Net Difference in Treatment of Rx Rebates and Hospital Settlements	$	263,670
Experience Period Incurred Claims from SHCE	**$**	**496,497,694**
URRT Experience Period Incurred Claims	**$**	**496,504,049**
Percentage Difference		**0.0%**

Section 4: Benefit Categories

The following describes what was included within the different benefit categories required by the URRT:

- Facility – Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient or outpatient facility setting and billed by the facility.
- Professional - Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees. It also includes non-capitated ambulance, home-healthcare, DME, prosthetics, supplies, pediatric vision and other services.
- Prescription Drug (Rx) – Includes drugs dispensed by a pharmacy and processed by pharmacy benefit manager.

The claims were classified into the different benefit categories based on a multitude of attributes, but included the following common fields: Claims Source (Source), Place of Service (POS), Procedure codes (CPT/HCPCS), Diagnosis codes (ICD9/ICD10), Revenue Codes, and Type of Claims (medical, dental, vision, Rx). As new procedure codes are added and as we migrate to ICD10 diagnosis code framework, the methodology and/or business logic to define the benefit categories will change accordingly.

Section 5: Projection Factors

Projected Changes in Benefits

The claims experience for the BCBSM individual product portfolio is based on plans that cover all EHBs required by the Affordable Care Act.

Pediatric vision is not included in the medical and drug claims experience data. Therefore, $0.49 PMPM was added to the allowed claims PMPM to account for this required coverage in 2019 to meet EHB requirements. Exhibit 5.1 demonstrates the development of the projected 2019 allowed PMPM cost for the pediatric vision benefit.

Exhibit 5.1: Development of Pediatric Vision Cost

Pediatric Vision Plan Design	
Frequency	12/12/12 (exams/lenses/frames)
VSP Network	Choice
Copay	$0/$0 (exam/material)
2017 Plan PMPM Cost for Pediatric Vision	$2.57
2017 to 2019 Annualized Vision Trend	5.0%
Projected 2019 Plan PMPM Cost	$2.83
Projected % Members Less than Age 19	17.3%
PMPM (for all members)	$0.49

Pediatric dental is not a covered service for the current BCBSM individual plans that will be offered on and off the Exchange in the State of Michigan; however, the EHB requirement will be met through our offering of a standalone dental product. Thus, no added cost for pediatric dental was included for these plans.

Projected Changes in the Morbidity of the Insured Population

BCBSM modeled the expected market level risk in 2019 based on information on emerging 2018 age neutral market level risk information for the following subset of current individual market members:

- Members enrolled in 2018 ACA compliant plans: The risk levels of these members were approximated by utilizing emerging age neutral risk levels of BCBSM's and Blue Care Network's (BCN's) ACA compliant populations.
- Previously uninsured members that will be entering the Individual market in 2019 and members that were enrolled with a competitor in 2018, or "New to Blue": The assumed risk level of these members is based on the actual risk and claims levels observed from those that were new to BCBSM in historical BCBSM experience.

Exhibit 5.2 outlines BCBSM's expected 2019 age and area-neutral risk utilizing the CCIIO risk scoring on the two populations outlined above, normalized to the CCIIO risk score of the 2017 population in the base experience. The expected population percentage for each population was derived by utilizing emerging BCBSM and BCN enrollment information as well as other publicly available market information with regards to ACA enrollment for the State of Michigan. The risk scoring for each of these groups was based on an age neutral CCIIO risk scoring methodology developed by BCBSM. Actual claims history of the member was utilized if they had been enrolled with BCBSM or BCN during the 2017 calendar year.

Exhibit 5.2: Projected BCBSM Risk Score Based on Prior Coverage and Regulatory Impacts

	Average Risk Score	**% Total Membership**
ACA Plans	1.086	90.0%
New to Blue	1.069	10.0%
2019 Health Status Risk Score	**1.081**	**100.0%**
Regulatory Impact on Morbidity	1.050	
2019 Change in Morbidity	**1.135**	

Regulatory Impact on Morbidity

We have included a factor of 5.0% to account for regulatory risk that encompasses known changes to enforcement of the Affordable Care Act's individual mandate as well as member behavior given the uncertainty of the market.

When comparing the expected 2019 individual market age neutral risk projection to the measured age neutral risk level of the population underlying the 2017 experience period, the

expected health status change is 8.1%. With the additional 5.0% regulatory impact on morbidity, total morbidity is expected to increase 13.5%.

Projected Changes in Demographics

BCBSM utilized 2018 enrollment data in the Individual ACA plans to project its age distribution for 2019. Based on this modeling, the average prescribed CMS age factor is expected to be 3.3% higher than our 2017 experience period.

Other Adjustments

BCBSM offered a mix of broad and narrow network products within its product portfolio in 2017. An adjustment was made to the index rate to account for the expected change in the mix of members enrolled in broad and narrow network products between 2017 and 2019. With the closure of narrow network products in 2018, the percentage of members enrolled in narrower network products decreased slightly over that experienced in 2017. To account for this change, we adjusted our index rate up by 0.1%.

Trend from 2017 to 2019

The following key considerations were taken into account in the trend projection factor development:

- The entire BCBSM non-Medicare eligible book of business experience was used to measure historical and project future trend. This included all commercial lines of business, including individual, small group, and large group. For group, this included both self-insured and fully-insured customers.
- Adjustments were made in the base trend development for changes in age, benefit mix and large claims during the experience period to derive individual underlying experience trends.
- Experience period trends by type-of-service (Facility, Professional and Pharmacy) were projected forward accounting for expected changes in utilization and price.
- Anticipated changes in provider contracts were included as cost trend adjustments.
- New medical management and other initiatives designed to lower health care costs were considered to adjust utilization and cost trends.
- Utilization trends for all types-of-service are projected forward based on analysis of historical patterns and expected changes in the future.
- Historical observed individual market trend in excess of the BCBSM book of business trends, changes in age, benefit mix, and large claims was examined to project additional expected trend during the projection period.

Facility trends were determined separately for inpatient and outpatient categories. The price trend was calculated using the historical and projected contractual price increases in each facility

and blending the facilities using historical claims. Price trends were adjusted for changes in severity of services, payments for uncompensated care, and incentives for performance and quality initiatives.

Professional claims were split out by provider class for e.g. Physicians, CRNAs, Laboratory, DME, Ambulance, Independent Physical Therapy and Certified Nurse Practitioners. Physicians (MDs, DOs, chiropractors, psychologists, and podiatrist) were further split into procedure-based categories such as radiology, pathology, anesthesiology, surgery, evaluation and management, preventive services, cardiovascular, and maternity. This was done to capture the impact of fee schedule changes, severity of services, relative value unit impacts and changes in coding including bundling of codes and new codes from CMS. Adjustments were made to historical and projected claims to account for one time impacts including health care reform and historical high cost claimants.

BCBSM's pharmacy projection model breaks up the pharmacy business into four categories:

- Base model: All drugs except those included in the next two bullet points.
- Specialty drugs: High cost drugs for certain rarer and more severe conditions.
- Outlier model: Significant drugs that lost patent protection in the experience period or will lose patent protection in the projected period.
- Impact of new drugs expected to be released in the market between the experience and the projection period.

Historical data and knowledge of future impacts in the industry and initiatives/programs within BCBSM are used to project price trends and mix of drugs in each of these models. The base model also assumes an increase in our generic dispensing rate.

Exhibit 5.3: Trend Projection Factors

2017 to 2018 Trend	IP Hospital	OP Hospital	Other Hospital	Professional	Rx	Composite
Base Trend	10.8%	12.7%	6.5%	10.2%	14.5%	11.8%
One Time Impact Adjustments*	-1.7%	-1.7%	-0.4%	-1.7%	-1.4%	-1.6%
Total 2017 to 2018 Trend	**8.9%**	**10.8%**	**6.1%**	**8.3%**	**12.9%**	**10.0%**

2018 to 2019 Trend	IP Hospital	OP Hospital	Other Hospital	Professional	Rx	Composite
Base Trend	9.9%	12.1%	5.9%	10.4%	15.7%	11.8%
One Time Impact Adjustments*	-0.6%	-0.6%	-0.4%	-0.6%	-1.9%	-0.9%
Total 2018 to 2019 Trend	**9.3%**	**11.5%**	**5.6%**	**9.8%**	**13.5%**	**10.8%**

Annualized 2017 to 2019 Trend	IP Hospital	OP Hospital	Other Hospital	Professional	Rx	Composite
Base Trend	10.4%	12.4%	6.2%	10.3%	15.1%	11.8%
One Time Impact Adjustments*	-1.2%	-1.2%	-0.4%	-1.2%	-1.7%	-1.3%
Total Annualized Trend	**9.0%**	**11.1%**	**5.8%**	**9.0%**	**13.2%**	**10.4%**

Other Adjustments

We are projecting to receive 0.2% less in hospital settlements in the projection period than in the experience period. We are also projecting an additional 4.2% reduction in pharmacy claims due to higher rebates relative to the experience period. Similar to trend projections, our pricing assumptions for hospital settlements and pharmacy rebates are updated each year based on the most up to date information available including hospital contracting changes, provider reimbursement system changes, pharmacy vendor contracts, and projected pharmacy spend.

Section 6: Credibility Manual Rate Development

No manual rates were used given the size of our current block.

Section 7: Credibility of Experience

100% credibility was assigned to the experience data due to the volume of membership and claims in the experience period.

Section 8: Paid to Allowed Ratio

The current paid to allowed ratio of our Individual book of business is 76.7%. BCBSM has projected the paid to allowed ratio for the entire pool in 2019 will be 74.0% given the expected 2019 membership projections by product and the expected impact of trend leveraging.

The plan level relativities were developed based on a proprietary benefit modeling tool which incorporates actual cost and utilization data for BCBSM's Michigan group PPO population. The tool was created with the assistance of The Terry Group and is also utilized for adjusting AVs in the Center for Consumer Information and Insurance Oversight (CCIIO) AV calculator. Please see Exhibit C in the Appendix for the plan level relativities.

Section 9: Risk Adjustment and Reinsurance

Risk Adjustment

BCBSM utilized its own modeling to project 2019 membership and risk scores for the Individual market and BCBSM as described in Section 5. Age rating and other applicable adjustments were factored into the risk adjustment transfer calculation.

Based on our modeling, as outlined in Section 5, we anticipate having a higher risk profile than our competitors for 2019. This is due in part to the fact that we were considered the insurer of last resort through 2013, and many of these high risk members continued their coverage with BCBSM. We expect to receive $158.59 PMPM in the risk adjustment transfer process. The $158.44 PMPM projected risk adjustment transfer shown in Worksheet 1 of the URRT includes an adjustment for the $0.15 PMPM prescribed risk adjustment user fee. The $158.59 was grossed up by the expected paid to allowed ratio and then applied to the Market Adjusted Index Rate and is therefore applied uniformly to all Plan Adjusted Index Rates.

Reinsurance

The transitional reinsurance program expires after 2016 so we are not including any adjustments for this program.

Section 10: Non-Benefit Expenses and Profit & Risk

BCBSM utilizes a cost allocation methodology consistent with industry standards which allocates all cost by direct, variable and overhead categories. The administrative expenses were projected by line of business using that methodology and current membership projections. Projected administrative expense assumptions are established using input from the functional business areas within BCBSM. The functional areas provide expertise in their business support area's costs, which is appropriate in projecting administrative expense. The projected administrative PMPM was converted to an expense ratio and applied uniformly by plan. A uniform expected commission percentage was also applied to each plan.

The individual pricing exercise targets a 2% contribution to surplus. In future filings, BCBSM may need to modify its contribution to surplus factor for its individual block of business depending on internal and external capital requirements. All retention factors were converted into percentages of post-tax premium in the average premium development.

Exhibit 10.1: Retention Factors

Retention Factors	% of Post-Tax Premium
Administrative Costs	13.67%
Commissions	1.25%
Contribution to Surplus	2.00%
Total Retention	**16.9%**

Please see the following exhibit for taxes and fees used in 2019 individual rate filing:

Exhibit 10.2: Taxes and Fees Factors

Tax	% of Post-Tax Premium
Comparative Effectiveness Fee	0.02%
Federal Insurer Premium Tax	0.0%
Insurance Provider Assesment	0.4%
Exchange Fee	1.9%
State Premium Tax	1.0%
Federal Income Tax	0.5%

The PMPM amount for the prescribed comparative effectiveness fee was converted into a percentage based on the total average premium and then applied uniformly by plan. The Comparative Effectiveness Fee is set at 75% of the projected full year amount, as the tax is being phased out in 2019. For issuers using a calendar year counting method, covered lives for 2019 are multiplied by 3/4.

Congress has enacted a moratorium on the Federal Insurer Premium Tax for 2019.

On May 29, 2018, the Michigan Senate and House of Representatives passed companion bills that repealed the Health Insurance Claims Assessment (Senate Bill 992) and created the Insurance Provider Assessment (Senate Bill 994). BCBSM anticipates that these bills will be signed by the Governor and approved by CMS, and is proactively replacing the Health Insurance Claims Assessment with the $2.40 PMPM Insurance Provider Assessment in the Index Rate development.

BCBSM anticipates that Senate Bill 1016 will also become law before January 1, 2019, and is proactively reducing the MI State Premium Tax used in rate development from the prior value of 1.25% to 0.95%, as included in SB 1016.

BCBSM believes both of these bills are likely to become law in their current form and the rates in this filing pass the expected tax savings to consumers. Should either of these bills fail to become law in their current form, BCBSM would like the flexibility to resubmit rates that reflect the final accurate tax assessments.

The Exchange user fees are 3.5% of Exchange premium. BCBSM is projecting 55% of individual members will enroll through the Exchange in 2019. Therefore, BCBSM is applying a 1.9% Exchange user fee in the Plan Adjusted Index Rate Development.

Federal income tax is expected to be 21% of the projected margin.

The total taxes and fees, not including risk adjustment fees, equate to 3.8% of post-tax premium.

Section 11: Projected Loss Ratio

In 2019, risk adjustment payments and receipts will be accounted for as claims (or negative claims) in the loss ratio calculation. Federal and State taxes and fees, including federal income tax and taxes and fees related to the ACA, will be removed from premium in the denominator of the MLR calculation. State taxes and regulatory assessments are also removed from the denominator.

We expect the BCBSM Individual segment to be above the MLR thresholds, between 83.2% and 83.9%.

Additionally, in 2019 the MLR calculation will be a three-year average of 2017, 2018, and 2019, which will smooth any unexpected fluctuations experienced in 2019.

The loss ratio rules for individual or family expense coverage R 500.801-806 are not applicable.

Section 12: Single Risk Pool

The BCBSM Individual rate filing was developed in compliance with the single risk pool requirement of the ACA. As permitted by the ACA regulations, the premium rate for the catastrophic medical plans can reflect differences in anticipated demographics and morbidity due to the plan eligibility. Since the catastrophic plan's age distribution is expected to be much younger and healthier, we applied an adjustment of 0.79 to the overall index rate to get to a catastrophic plan rate level based on the market risk level.

Section 13: Index Rate

The index rate was developed by taking the 2019 allowed claims PMPM for the entire individual pool. BCBSM plan designs for the projection period do not include benefits in excess of the essential health benefit requirements. As a result, the index rate developed is equal to allowed claims. The development of the index rates for the experience period and projection period are shown below.

Exhibit 13.1: Index Rate Development

	Experience Period	Projection Period
Index Rate Development		
Allowed Claims PMPM	$650.08	$923.23
Index Rate PMPM	**$650.08**	**$923.23**

More information on the 1/1/2019 Projection Period allowed claims PMPM development can be found in Exhibit B in the Appendix.

Section 14: Market Adjusted Index Rate

To set the 2019 plan level rates, the 2019 index rate was first adjusted for the anticipated allowed risk adjustment transfer and the Exchange user fee as shown below.

Exhibit 14.1: Market Adjusted Index Rate Development

Market Adjusted Index Rate Development	
Projected 2019 Index Rate	$923.23
- Projected Risk Adjustments (net of Risk Adjustment user fee) PMPM	$214.11
- Projected Reinsurance Recoveries (net of reins. Premium) PMPM	$0.00
+ Projected Exchange User Fee	$17.23
2019 Market Adjusted Index Rate	$726.36
Projected Issuer's Portion of Total Allowed Claims (TAC)	**$923.23**
Allowed Risk Adjustment + Reinsurance + Exchange Fees	**($196.87)**

More information regarding the projected risk adjustment transfer can be found in Section 9. More information on the projected exchange user fee can be found in Section 10.

Section 15: Plan Adjusted Index Rates

A brief description of the methodology used to derive plan adjusted index rates follows. Please refer to Exhibit C of the Appendix for the detailed calculations.

The projected 2019 market adjusted index rate from Exhibit 14.1 was the starting allowed claims PMPM (after risk adjustment and Exchange Fees) for all plans BCBSM intends to offer in 2019. To develop the Plan Adjusted Index Rates, the Market Adjusted Index Rate was adjusted by the following:

- Actuarial Value and Cost Sharing Design of the Plan including utilization differences due to differences in cost sharing
- Impact of specific eligibility categories for the Catastrophic Risk Pool
- Administrative Costs including administrative expense factors, contribution to surplus factors, and taxes and fees (less exchange user fee and risk adjustment fees)

Section 16: Calibration

Age Curve Calibration

BCBSM's individual age curve calibration is a member weighted average using the age factors prescribed by the ACA. The membership is based on the projected population described in Section 5. The average age factor for this population is 1.708. To account for the three-child cap, non-billable members will receive an age factor of 0.000. Re-calculating the average age factor setting non-billable members to 0.000 results in a 1.699 projected average age factor for the total single risk pool in 2019.

The nearest age to the average age factor is 49. The factor for age 49 is 1.706.

Geographic Factor Calibration

The geographic factor calibration uses a member weighted average across the 16 Michigan rating regions, calculated to have an average area factor of 1.000. To calibrate the plan to a 1.000 geographic factor, the plan adjusted index rate is divided by 1.000.

For example, to calibrate each plan to age 49 (at a 1.0 geographic factor), the plan adjusted index rate is divided by 0.996, (which is calculated as 1.699*1.000/1.706).

Tobacco Factor Calibration

The tobacco factor calibration uses a member weighted average of the tobacco surcharge included in tobacco premium. The expected average tobacco surcharge is 1.008. To calibrate the plan to a 1.000 for a non-smoker, the plan adjusted index rate is divided by 1.008.

Section 17: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is calculated by first taking the Plan Adjusted Index Rate and dividing by the calibration factors stated in Section 16 to create the Calibrated Plan Adjusted Index Rate as shown in Exhibit C. As shown in Exhibit 17.1, each member's rate is determined by applying the appropriate area factor, age factor and tobacco factor to the starting plan base rate.

Exhibit 17.1: Consumer Adjusted Premium Rate Development

			(A)	(B)	(C)	(D)	(E) = (A x B) x C	(F) = (E) x (D)
Plan ID	Rating Area ID	Age	Calibrated Plan Adjusted Index Rate	Area Factor	Age Factor	Tobacco	Final Rate (non-Tobacco)	Final Rate (Tobacco)
15560MI0350003	Rating Area 1	0 - 14	$460.82	0.957	0.765	1.000	$337.40	$337.40
15560MI0350003	Rating Area 1	15	$460.82	0.957	0.833	1.000	$367.39	$367.39
15560MI0350003	Rating Area 1	16	$460.82	0.957	0.859	1.000	$378.86	$378.86
15560MI0350003	Rating Area 1	17	$460.82	0.957	0.885	1.000	$390.33	$390.33
15560MI0350003	Rating Area 1	18	$460.82	0.957	0.913	1.000	$402.68	$402.68
15560MI0350003	Rating Area 1	19	$460.82	0.957	0.941	1.000	$415.03	$415.03
15560MI0350003	Rating Area 1	20	$460.82	0.957	0.970	1.000	$427.82	$427.82
15560MI0350003	Rating Area 1	21	$460.82	0.957	1.000	1.050	$441.05	$463.10
15560MI0350003	Rating Area 1	22	$460.82	0.957	1.000	1.050	$441.05	$463.10
15560MI0350003	Rating Area 1	23	$460.82	0.957	1.000	1.050	$441.05	$463.10
15560MI0350003	Rating Area 1	24	$460.82	0.957	1.000	1.050	$441.05	$463.10
15560MI0350003	Rating Area 1	25	$460.82	0.957	1.004	1.050	$442.81	$464.95
15560MI0350003	Rating Area 1	26	$460.82	0.957	1.024	1.050	$451.64	$474.22
15560MI0350003	Rating Area 1	27	$460.82	0.957	1.048	1.050	$462.22	$485.33
15560MI0350003	Rating Area 1	28	$460.82	0.957	1.087	1.050	$479.42	$503.39

The final rate for non-tobacco user is calculated by multiplying the Starting Plan Base Rate (A) by the Area Factor (B) and rounding to two decimals to create the area rate. This is then multiplied by the Age Factor (C) and rounding to two decimals to get the Final Member Rate for non-smoker. The final rate for tobacco-user is calculated by multiplying the final rate for non-tobacco user by the smoker load and rounding to two decimals.

Section 18: Actuarial Value Metal Values

Exhibit D in the Appendix summarizes the process and analysis performed by BCBSM to derive the Actuarial Values (AVs) of the proposed 2019 BCBSM Individual products in order to comply with rules governing the definition of Qualified Health Plans (QHPs). All analyses and calculations comply with prescribed regulations. The conclusions in this report are based on the regulations as we understand them as of the date of the Final Rule, including all subsequent interpretation and guidance provided by CCIIO.

The ACA requires that health care coverage provided by issuers of non-grandfathered plans in the individual market must cover EHBs and have AVs that fall within the following metal classifications, within the revised de minimis ranges of the anchor percentage for each category.

- Platinum at 90% (86% to 92%)
- Gold at 80% (76% to 82%)
- Silver at 70% (66% to 72%)
- Bronze at 60% (56% to 65%)

Also, the Affordable Care Act calls for cost sharing reductions (CSRs) for qualified low income members in the individual market with variations as follows, with a +/- 1% de minimis, off the anchor percentage for each income category.

- 100-150% of FPL at 94% (93% to 95%)
- 150-200% of FPL at 87% (86% to 88%)
- 200-250% of FPL at 73% (72% to 74%)

The results of our analysis rely on the Actuarial Value Calculator tool provided by CCIIO. Any adjustments made to the results of the AV tool are disclosed below and comply to the best of our knowledge with the guidelines for allowed adjustments provided within the final rules. We have also disclosed below areas or issues with the tool that may have an impact on our analysis or assertions. We are hereby confirming that methods used to model cost sharing features which did not fit directly into a benefit or cost sharing category provided within the AV tool comply with allowed adjustments and methodologies outlined in regulations.

Section 19: Actuarial Value Pricing Values

Please refer to Exhibit C in the Appendix for the Actuarial Value Pricing Values for each plan. Benefit designs and emerging experience, on a risk-adjusted basis, were factored into the actuarial pricing values, which were based on the pool level experience. No morbidity adjustments were utilized when developing benefit differentials between plans within the pool.

Exhibit C in the Appendix also provides the components of the Actuarial Value Pricing Values due to cost sharing design, provider network, utilization management, administrative costs, and taxes/fees (excluding exchange user fees or risk adjustment fees).

Section 20: Membership Projections

BCBSM's individual book of business is projected to decrease by 37%, from experience period enrollment of approximately 83,000 members to approximately 52,000 members in 2019. The more competitive market place in 2019 is the primary reason for declining membership in the BCBSM individual book of business. BCBSM projects the following distribution of membership by metal level in 2019, based largely on 2018 enrollment:

Exhibit 20.1 BCBSM Individual Membership by Metal Level

BCBSM Individual Membership Projection by Metal Level in 2019	
	% of Total Members
Platinum	0.0%
Gold	7.0%
Silver	32.0%
Bronze	57.9%
Catastrophic	3.0%
Total	100.0%

Section 21: Terminated Plans and Products

Please see Exhibit E for the list of all BCBSM Individual HIOS Plan IDs for single risk pool plans that were effective during or after the experience period but terminated before 2019. The names of the plans are included as well as the crosswalk between the terminated plan IDs to the 2019 plan IDs.

Section 22: Plan Type

All products BCBSM intends to offer in the Individual market are PPO products.

Section 23: Warning Alerts

No Warning Alerts are triggered on Worksheet 2:

Section 24: Effective Rate Review Information (optional)

There is no additional information provided by BCBSM.

Section 25: Reliance on Third Parties

The following information, processes, or analysis were provided by third parties outside of BCBSM. All other information or analysis provided within the memorandum have been performed or provided by internal associates of BCBSM. The actuary, by providing the attestation below, is confirming the accuracy and completeness of all information and analysis provided within the memorandum.

As stated within Section 18, Actuarial Value Metal Values, and Section 19, Actuarial Value Pricing Values, we relied upon a benefit modeling tool created in conjunction with The Terry Group.

BCBSM is attesting to the completeness of all plan product and pricing actuarial analysis. Milliman, Inc. provided high level peer review for all medical plan pricing, product determination, and documentation.

Section 26: Actuarial Certifications

I, John Dunn, Vice President & Chief Actuary, am an employee of Blue Cross Blue Shield of Michigan and a member of the American Academy of Actuaries.

I certify that the projected index rate provided within the memorandum is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR §156.80 and §147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- 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 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.

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 except those specified in the documentation above. The values for all excepted plans were developed in accordance with generally accepted actuarial principles and methodologies.

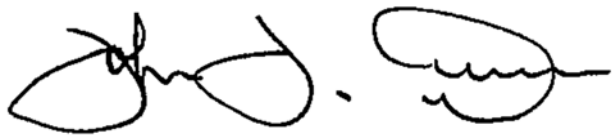
I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and marketplace factors, and do not include differences for population morbidity by geographic area.

I am disclosing the Part I Unified Rate Review Template does not demonstrate the process used by BCBSM to develop the rates, but rather 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.

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice:

- Actuarial Standard of Practice No. 5, ‘Incurred Health and Disability Claims’,
- Actuarial Standard of Practice No. 8, ‘Regulatory Filings for Rates and Financial Projections for Health Plans’,
- Actuarial Standard of Practice No. 12, ‘Risk Classification’,

- Actuarial Standard of Practice No. 23, 'Data Quality',
- Actuarial Standard of Practice No. 25, 'Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages',
- Actuarial Standard of Practice No. 26, 'Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Group Employer Health Benefit Plans',
- Actuarial Standard of Practice No. 41, 'Actuarial Communications', and
- Actuarial Standard of Practice No. 50, 'Determining Minimum Value and Actuarial Value under the Affordable Care Act'.



John Dunn, FSA, MAAA
Vice President & Chief Actuary
600 E. Lafayette Blvd.
Detroit, MI 48226-2998
(313) 225-7700
June 14, 2018

I, Erika Monroe, Vice President, Actuarial Pricing, am an employee of Blue Cross Blue Shield of Michigan and a member of the American Academy of Actuaries.

I certify that the projected index rate provided within the memorandum is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR §156.80 and §147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- 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.

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- Actuarial Standard of Practice No. 12, ‘Risk Classification’,
- Actuarial Standard of Practice No. 23, ‘Data Quality’,

- Actuarial Standard of Practice No. 25, 'Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages',
- Actuarial Standard of Practice No. 26, 'Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Group Employer Health Benefit Plans',
- Actuarial Standard of Practice No. 41, 'Actuarial Communications', and
- Actuarial Standard of Practice No. 50, 'Determining Minimum Value and Actuarial Value under the Affordable Care Act'.

Erika Monroe, FSA, MAAA
Vice President, Actuarial Pricing
600 E. Lafayette Blvd.
Detroit, MI 48226-2998
(313) 448-4055
June 14, 2018

I, Jeremy Henderson, Actuary Manager, Individual Pricing, am an employee of Blue Cross Blue Shield of Michigan and a member of the American Academy of Actuaries.

I certify that the projected index rate provided within the memorandum is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR §156.80 and §147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- 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 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.

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 except those specified in the documentation above. The values for all excepted plans were developed in accordance with generally accepted actuarial principles and methodologies.

I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and marketplace factors, and do not include differences for population morbidity by geographic area.

I am disclosing the Part I Unified Rate Review Template does not demonstrate the process used by BCBSM to develop the rates, but rather 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.

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice:

- Actuarial Standard of Practice No. 5, ‘Incurred Health and Disability Claims’,
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- Actuarial Standard of Practice No. 26, 'Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Group Employer Health Benefit Plans',
- Actuarial Standard of Practice No. 41, 'Actuarial Communications', and
- Actuarial Standard of Practice No. 50, 'Determining Minimum Value and Actuarial Value under the Affordable Care Act'.

Jeremy Henderson, ASA, MAAA
Actuary Manager, Individual Pricing
600 E. Lafayette Blvd.
Detroit, MI 48226-5932
(313) 225-5646
June 14, 2018

Section 27: Rate Change Summary

In support of the DIFS rate checklist, a description of the allowable rating factors for 2019 is included below:

Age Factors

- BCBSM uses age factors prescribed in the final HHS Notice of Benefit and Payment Parameters for 2019.
- Age rate adjustment is applied based on the following age bands:
    - A single age factor for children 0 to 14 years of age, where the age rate adjustment is the same for all members in this age range.
    - One-year age bands starting at age 15 through age 63.
    - A single age band for individuals 64 years of age and older, where the age rate adjustment is the same for all members in this age range.
- The premium variation between the youngest and the oldest adult individuals between the ages of 21 – 64+ should not exceed a ratio of 3:1 as prescribed by the ACA and adopted by the State of Michigan.

Geographic Factors

- All rates will utilize the area rating factor associated with the geographic location of the policy holder within the state.
- There are 16 geographic rating areas as established by the State of Michigan.
- BCBSM's area factors for 2019 are shown in Exhibit 27.1.

Exhibit 27.1: Area Rating Factors

Area		**Area Factor**
A	Wayne/ Monroe	0.957
B	Oakland/ Macomb	0.957
C	St. Clair	1.015
D	Ann Arbor	1.047
E	Flint	0.932
F	Thumb	0.985
G	Lansing	1.027
H	Saginaw	0.976
I	Southwest	1.120
J	Kalamazoo/ Battle Creek	1.026
K	Allegan/ Barry	1.010
L	Grand Rapids	1.128
M	Midland	0.954
N	N.W. Lower	0.929
O	N.E. Lower	0.943
P	UP	1.160
Composite		1.000

Tobacco Factors

- BCBSM will be utilizing the tobacco rating factors as shown in Exhibit 27.2.

Exhibit 27.2: Tobacco Rating Factors

BCBSM Tobacco Load					
Age	**Load**	**Age**	**Load**	**Age**	**Load**
0-14	1.00	32	1.05	50	1.09
15	1.00	33	1.05	51	1.09
16	1.00	34	1.05	52	1.10
17	1.00	35	1.05	53	1.11
18	1.00	36	1.05	54	1.12
19	1.00	37	1.05	55	1.12
20	1.00	38	1.05	56	1.13
21	1.05	39	1.05	57	1.14
22	1.05	40	1.06	58	1.15
23	1.05	41	1.06	59	1.15
24	1.05	42	1.06	60	1.15
25	1.05	43	1.06	61	1.15
26	1.05	44	1.06	62	1.15
27	1.05	45	1.07	63	1.15
28	1.05	46	1.07	64	1.20
29	1.05	47	1.08	65 and over	1.20
30	1.05	48	1.08		
31	1.05	49	1.08		

Family Composition

- Family rates equal the sum of:
    - Rates for all enrollees age 21 and over,
    - plus rates for all subscribers or spouses under age 21, as applicable,
    - plus the rates of the three oldest children under age 21, as applicable.

BCBSM attests that it has not imposed any annual dollar limits and has not converted annual dollar limits to non-quantitative limits on any statutorily mandated treatment for autism spectrum disorders, as provided for in DIFS' Order No. 14-017-M.

APPENDIX

Exhibit A: DIFS Rate Checklist

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Checklist for Individual and Small Group **MEDICAL** Plans

RATES

Effective for Plan Years beginning on or after January 1, 2019

(See FIS 2304 (3/18) for Rates Checklist for Stand-Alone Dental Plans)

Issuer Name: Blue Cross Blue Shield of Michigan	**HIOS ID:** 15560	**Market:** Individual ☒ Small Group ☐
Rate Contacts *(provide two)*: Jeremy Henderson, Erika Monroe		**Phone Numbers:** (313) 225-5646, (313) 448-4055
Emails: JHenderson@bcbsm.com, EMonroe@bcbsm.com		
Third Party Filer Name and Contact (if applicable): Click here to enter text.		

Medical Plans Rate Checklist Instructions:

NOTE: A separate fully completed checklist is required for Individual and Small Group rates offered by the Issuer. This checklist is to be used for medical plans only.

A. The required format for saving this document and all supporting documentation is: CompanyName_MIMedicalRateChecklist_Version#. (See Medical Bulletin – File Naming Section).
B. Forms and rates must be filed together under the same SERFF filing.
C. The Rates Table Template must contain the rates for only one market. **DO NOT** combine the individual and small group rates onto one template.
D. All components of the Rate Filing shall be filed under the appropriate tabs in SERFF. The filing should be comprised of:
    i. Rate manual showing only **Michigan-specific** rates. NOTE: If the Issuer is filing in multiple states, **DO NOT** include rates or methodology pages for other states;
    ii. Sample rate calculation;
    iii. Michigan Rate Review Checklist for medical plans;
    iv. Unified Rate Review Template (Part I);
    v. Written Description Justifying the Rate Increase, if applicable (Part II);
    vi. Actuarial Memorandum (Part III), including, but not limited to:
        a. Description and exhibits showing the development of rates from the experience;
        b. Methodology and assumptions used to calculate each plan's actuarial value.

Checklist for Individual and Small Group **MEDICAL** Plans - Rates

Requirement	Requirement Met:	Provide Either:		URR Instructions Section Reference
		Actuarial Memorandum Section Number	Exhibit or Chart Number or page # if applicable	
General Information				4.2
Review Requested *(select only one):* • Rate change • New in ACA MI market • Continued use of existing rates	☒ ☐ ☐	**Section 1**	Page 5	
Description of Benefits *(a narrative description of the benefits that will be provided by the policy forms included in the filing.)*	☒	**Section 1**	Page 5	
Effective Date of Requested Rate Adjustments	☒	**Section 1**	Page 5	
SERFF Tracking Number, Binder Number, and Effective Date of Prior Filing	☒	**Section 1**	Page 5	
Proposed Rate Change(s)				4.3
Proposed Percentage Rate Change	☒	**Section 2**	Page 6	
Reason for Rate Change	☒	**Section 2**	Page 6	
Average Annual Premium *(The average premium for the entire single risk pool, before and after the requested rate change)*	☒	**Section 2**	Page 7	
Number of Policyholders and Covered Lives *(The number of Michigan policyholders and covered lives affected by the proposed rate change)* *Number of Policyholders is the number of policies in the individual market and the number of enrollees in the small group market. Dependents should not be counted. Number of Covered Lives is the total number of lives insured, including dependents.*	☒	**Section 2**	Page 7	
Address how the Tax Cuts and Jobs Act of 2017 (TCJA) impacts the proposed level of rate change. This should include information relative to the anticipated change in corporate tax liability and how this impacts rate development.	☒	**Section 2**	Page 7-8	
Experience Period Premium and Claims				4.4.1
Paid Through Date	☒	**Section 3**	Page 9	
Premiums (net of MLR Rebate) in Experience Period	☒	**Section 3**	Page 9	
Allowed and Incurred Claims Incurred During the Experience Period	☒	**Section 3**	Page 9-10	
Benefit Categories	☒	**Section 4**	Page 12	4.4.2

Checklist for Individual and Small Group **MEDICAL** Plans - Rates

Requirement	Requirement Met:	Provide Either:		URR Instructions Section Reference
		Actuarial Memorandum Section Number	Exhibit or Chart Number or page # if applicable	
Projections Factors				4.4.3
Changes in Morbidity of the Population Insured	☒	**Section 5**	Page 14-15	
Changes in Benefits	☒	**Section 5**	Page 13	
Changes in Demographics	☒	**Section 5**	Page 15	
Other Adjustments	☒	**Section 5**	Page 15	
Trend Factors (cost/utilization)	☒	**Section 5**	Page 15-17	
Credibility Manual Rate Development				4.4.4
Source and Appropriateness of Experience Data	☒	**Section 6**	Page 18	
Adjustments Made to the Data	☒	**Section 6**	N/A	
Inclusion of Capitation Payments	☒	**Section 6**	N/A	
Credibility of Experience				4.4.5
Description of the Credibility/Methodology Used	☒	**Section 7**	Page 19	
Credibility Levels	☒	**Section 7**	N/A	
Paid to Allowed Ratio	☒	**Section 8**	Page 20	4.4.6
Risk Adjustment and Reinsurance				4.4.7
Projected Risk Adjustments PMPM	☒	**Section 9**	Page 21	
Projected ACA Reinsurance Recoveries Net of Reinsurance Premium	☒	**Section 9**	Page 21	
Non-Benefit Expenses and Profit & Risk				4.4.8
Administrative Expense Load *(see below for further required information)*	☒	**Section 10**	Page 22	
• Describe how expenses vary by product • Describe the source data and how its use is appropriate • Show support of the allocation of the following non-benefit expenses: ◦ Commissions and Brokers Fees ◦ General Expenses ◦ Reinsurance ◦ Other Admin Costs	☒ ☒ ☒ ☒ ☒ ☒ ☒	**Section 10**	Page 22	
Profit (or Contribution to Surplus) and Risk Margin	☒	**Section 10**	Page 22	
Taxes and Fees	☒	**Section 10**	Page 22-23	

Checklist for Individual and Small Group **MEDICAL** Plans - Rates

Requirement	Requirement Met:	Provide Either:		URR Instructions Section Reference
		Actuarial Memorandum Section Number	Exhibit or Chart Number or page # if applicable	
Projected Loss Ratio				4.5
For the **individual** market, only, compliance with the loss ratio rules for individual or family expense coverage R 500.801-806	☒	**Section 11**	Page 24	
Projected loss ratio using federally prescribed MLR methodology	☒	**Section 11**	Page 24	
Single Risk Pool	☒	**Section 12**	Page 25	4.6.1
Index Rate	☒	**Section 13**	Page 26	4.6.2
Provide the Index rate	**$923.23**	**Section 13**	Page 26	
Market Adjusted Index Rate	☒	**Section 14**	Page 27	4.6.3
Plan Adjusted Index Rates	☒	**Section 15**	Page 28	4.6.4
Calibration				4.6.5
Age Curve	☒	**Section 16**	Page 29	
Geographic Factor	☒	**Section 16**	Page 29	
Consumer Adjusted Premium Rate Development				4.6.6
Provide an exhibit reconciling plan adjusted index rate to consumer adjusted premium rate	☒	**Section 17**	Page 30	
Small group only				
Provide trend factors (if applicable) that apply to the weighted average plan adjusted index rates.	☐	**N/A**	N/A	
Is tobacco rating used? Yes No	 ☐ ☐	**N/A**	N/A	
If Yes, a tobacco wellness plan is required. Please identify which policy form number includes the tobacco wellness plan.	**N/A**	**N/A**	N/A	

AV Metal Values Please provide screenshots of the AV calculator for unique plan designs. If option 45 CFR 156.135(b)(2) and/or (3) is used, provide the adjustments and the development of the adjustments that were made to reach the correct AV percentage. Each screenshot must be labeled with the	☒	**Section 18**	Page 31	4.7.1

Requirement	Requirement Met:	Provide Either:		URR Instructions Section Reference
		Actuarial Memorandum Section Number	Exhibit or Chart Number or page # if applicable	
corresponding Plan ID. If effective coinsurance is used, provide the development.				
AV Pricing Values	☒	**Section 19**	Page 32	4.7.2
Membership Projections	☒	**Section 20**	Page 33	4.7.3
Terminated Products	☒	**Section 21**	Page 34	4.7.4
Plan Type	☒	**Section 22**	Page 35	4.7.5
Warning Alerts	☒	**Section 23**	Page 36	4.7.6
Effective Rate Review Information	☒	**Section 24**	Page 37	4.8.1
Reliance	☒	**Section 25**	Page 38	4.8.2
Actuarial Certification	☒	**Section 26**	Page 39-44	4.8.3
Sample Rate Calculation	☒	**Section 17**	Page 30	
Additional Michigan Requirements				
Rate Change Summary	☒	**Section 27**	Page 45	[redacted]
Rate tables and factors including: Quarterly rate tables in the small group market	☒	**Section 27**	Page 45	
Factors including: Age, tobacco, geographic, and family status	☒	**Section 27**	Page 45-46	
Supplemental Health Care Exhibit (SHCE) Provide a reconciliation between SHCE and URRT Experience Period Premiums and Incurred Claims, and include a copy of SHCE in binder and Rate/Form filing.	☒	**Section 3**	Page 11, Exhibit 3.2	
Autism Benefits	[redacted]			[redacted]
Do rates include a provision for autism benefits? Check box if yes.	☒	**Section 3**	Page 9	
Provide PMPM included in rates	**$5.65**	**N/A**	N/A	
If rates do not include a provision for autism benefits, will the Autism fund be utilized for reimbursement?	☒	**N/A**	N/A	
Please provide an attestation stating compliance with Order No. 14-017M	☒	**Section 27**	Page 46	

Requirement	Requirement Met:	Provide Either:		URR Instructions Section Reference
		Actuarial Memorandum Section Number	Exhibit or Chart Number or page # if applicable	
SERFF Rate Data Fields				
All fields in the Rate/Rule tab have been completed, including the Company Rate Information and Rate Review Detail sections. Each proposed HIOS Product must be listed in the Products section of the Rate Review Detail section and all percentage changes, number of policyholders and lives, and premium changes should be shown.	☒			
Rates and Service Areas				
Rates have been submitted for all rating areas covering the proposed service areas. Submit **only** Michigan-specific rates.	☒			
All Templates and the URRT have been submitted in the filing and binder in XLSM format.	☒			
Any new submission of a template and/or document placed in the Binder will be placed in the filing and vice versa (see page 1 for required format).	☒			
Full product names are shown on worksheet 2 of the URRT.	☒			
All on-Marketplace and off-Marketplace plans offered in a market are included in a single URRT.	☒			
The requested rate change percentage must be the same on the URRT, Actuarial Memorandum, SERFF R2D2, and Supplemental Documentation.	☒			

Exhibit B: Market Average Premium Development

2019 Blue Cross Blue Shield of Michigan Individual Rate Development

	Benefit Category				
	Inpatient Hospital	**Outpatient Hospital**	**Professional**	**Prescription Drug**	**Total**
Experience Period Data					
Experience Period Membership					82,951
Utilization per 1,000	89.79	2,520.47	21,833.96	13,033.27	
IBNR	1.012	1.012	1.015	1.000	
Completed Utilization per 1,000	90.83	2,549.66	22,162.90	13,033.29	
Cost per Service	$16,969.78	$791.92	$121.46	$118.81	
Experience Period Allowed Claims PMPM	**$128.44**	**$168.26**	**$224.33**	**$129.04**	**$650.08**
Experience Period Index Rate					*$650.08*
Adjustments from Experience Period to Projection Period					
Changes in the Morbidity of the Population Insured	1.135	1.135	1.135	1.135	1.135
Other					
Changes in Benefits	1.000	1.000	1.002	1.000	1.001
Changes in Demographics	1.033	1.033	1.033	1.033	1.033
Other Adjustments	1.003	1.003	1.001	0.959	0.994
Annualized Trend Factor	1.090	1.111	1.090	1.132	1.104
Price Trend	1.047	1.056	1.029	1.056	1.045
Use Trend	1.041	1.052	1.059	1.072	1.056
Projected 2019 Allowed Claims PMPM	**$179.59**	**$244.41**	**$313.23**	**$186.00**	**$923.23**
Projection Period Index Rate	*$179.59*	*$244.41*	*$313.23*	*$186.00*	*$923.23*
Credibility Adjustment					
Credibility Manual Allowed Claims PMPM	$0.00	$0.00	$0.00	$0.00	$0.00
Credibility Weight					0%
Projected 2017 Allowed Claims PMPM	**$179.59**	**$244.41**	**$313.23**	**$186.00**	**$923.23**
Paid Claims Development					
Projected Average Paid to Allowed Ratio					74.00%
Projected 2019 Paid Claims PMPM (before risk programs)					**$683.19**
Projected Risk Mitigation Program Transfers					
Projected Risk Adjustments (net of risk adjustment user fees) PMPM					$158.44
Projected Reinsurance Recoveries (net of reinsurance contributions) PMPM					$0.00
Projected Exchange User Fee					($12.75)
Projected 2019 Incurred Claims					**$537.50**
Average Premium Development					
Administrative Expense Load					14.92%
Profit & Risk Load					2.00%
Taxes & Fees (excluding Risk Adjustment, Reinsurance and Exchange User Fees)					1.87%
Projected 2019 Average Gross Premium Rate					**$661.81**

Exhibit C: Plan Adjusted Index Rate Development

		Total BCBSM Individual Pool	Blue Cross® Premier PPO Silver Extra	Blue Cross® Premier PPO Gold	Blue Cross® Premier PPO Silver	Blue Cross® Premier PPO Bronze HSA	Blue Cross® Premier PPO Value
	Projected Membership	**52,332**	3,593	3,671	4,399	10,096	1,594
A	**Market Adjusted Index Rate**	**$726.36**	**$726.36**	**$726.36**	**$726.36**	**$726.36**	**$726.36**
B	EHB - Allowed PMPM	**$923.23**	**$923.23**	**$923.23**	**$923.23**	**$923.23**	**$923.23**
C	Risk Adjustment + Reinsurance + Exchange Fees - Allowed PMPM	**($196.87)**	**($196.87)**	**($196.87)**	**($196.87)**	**($196.87)**	**($196.87)**
D	Paid to Allowed Ratio (as shown on wksht 1)	**0.740**	**91.64%**	**97.36%**	**85.80%**	**64.34%**	**63.18%**
E	Plan Paid to Allowed Ratio Relativity To Average		1.238	1.316	1.159	0.869	0.854
F	Benefit Richness Utilization Adjustments (relative to average)		1.056	1.090	1.028	0.975	0.974
G	Provider Network/Utilization Management (relative to average)		**1.000**	**1.000**	**1.000**	**1.000**	**1.000**
H	Catastrophic Risk Pool Adj.	**0.993**	**1.000**	**1.000**	**1.000**	**1.000**	**0.786**
I = B * DAVG * E * F * G * H	EHB - Paid PMPM	**$678.86**	**$893.22**	**$980.15**	**$814.64**	**$579.26**	**$446.55**
J = C * DAVG * E * F * G * H	Risk Adjustment + Reinsurance + Exchange Fees - Paid PMPM	**($144.76)**	**($190.47)**	**($209.01)**	**($173.72)**	**($123.52)**	**($95.22)**
K = I + J	**Plan Cost PMPM**	**$534.09**	**$702.74**	**$771.14**	**$640.93**	**$455.74**	**$351.32**
	Distribution and Administrative Costs						
L	Administrative Costs	14.92%	14.92%	14.92%	14.92%	14.92%	14.92%
M	Contribution to Surplus	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
N	Taxes and Fees (excluding Risk Adjustment, Reinsurance and Exchange User Fees)	1.87%	1.87%	1.87%	1.87%	1.87%	1.87%
O = L + M + N	**Total Distribution and Administrative Costs**	**18.79%**	**18.79%**	**18.79%**	**18.79%**	**18.79%**	**18.79%**
P = K / (1-O)	**Plan Adjusted Index Rate**	**$657.67**	**$865.34**	**$949.56**	**$789.22**	**$561.18**	**$432.61**
Q	Age Calibration Factor	1.699	1.699	1.699	1.699	1.699	1.699
R	Area Calibration Factor	1.000	1.000	1.000	1.000	1.000	1.000
S	Tobacco Calibration Factor	1.008	1.008	1.008	1.008	1.008	1.008
T = P / Q / R / S	**Calibrated Plan Adjusted Index Rates**	**$384.00**	**$505.26**	**$554.43**	**$460.82**	**$327.67**	**$252.59**
U = P / A	**Pricing AV**		**1.19**	**1.31**	**1.09**	**0.77**	**0.60**
	Portion of the AV Pricing Value attributed to the Index Rate Modifiers						
V = P / A / W / X / Y / Z	Actuarial Value and Cost Sharing Design of the Plan		0.97	1.06	0.88	0.63	0.62
W = (H * (B + C)) / A	Catastrophic Risk Pool Adj.		1.00	1.00	1.00	1.00	0.79
X = (G * (B + C)) / A	Provider Network/Utilization Management		1.00	1.00	1.00	1.00	1.00
Y	Benefits in Addition to Essential Health Benefits		1.00	1.00	1.00	1.00	1.00
Z = P / K	Administrative Costs (excluding Risk Adjustment, Reinsurance and Exchange User Fees)		1.23	1.23	1.23	1.23	1.23
AA = V * W * X * Y * Z	**Total Pricing AV**		**1.19**	**1.31**	**1.09**	**0.77**	**0.60**

		Total BCBSM Individual Pool	Blue Cross® Premier PPO Silver Saver HSA	Blue Cross® Premier PPO Bronze Extra	Blue Cross® Premier PPO Bronze Saver	Blue Cross® Premier PPO Silver Off Marketplace
	Projected Membership	**52,332**	6,886	10,528	9,680	1,884
A	**Market Adjusted Index Rate**	**$726.36**	**$726.36**	**$726.36**	**$726.36**	**$726.36**
B	EHB - Allowed PMPM	**$923.23**	**$923.23**	**$923.23**	**$923.23**	**$923.23**
C	Risk Adjustment + Reinsurance + Exchange Fees - Allowed PMPM	**($196.87)**	**($196.87)**	**($196.87)**	**($196.87)**	**($196.87)**
D	Paid to Allowed Ratio (as shown on wksht 1)	**0.740**	**83.43%**	**66.89%**	**62.53%**	**79.07%**
E	Plan Paid to Allowed Ratio Relativity To Average		1.127	0.904	0.845	1.069
F	Benefit Richness Utilization Adjustments (relative to average)		1.019	0.978	0.973	1.004
G	Provider Network/Utilization Management (relative to average)		**1.000**	**1.000**	**1.000**	**1.000**
H	Catastrophic Risk Pool Adj.	**0.993**	**1.000**	**1.000**	**1.000**	**1.000**
I = B * D_{AVG} * E * F * G * H	EHB - Paid PMPM	**$678.86**	**$784.50**	**$603.71**	**$561.53**	**$732.71**
J = C * D_{AVG} * E * F * G * H	Risk Adjustment + Reinsurance + Exchange Fees - Paid PMPM	**($144.76)**	**($167.29)**	**($128.74)**	**($119.74)**	**($156.25)**
K = I + J	**Plan Cost PMPM**	**$534.09**	**$617.21**	**$474.97**	**$441.78**	**$576.46**
	Distribution and Administrative Costs					
L	Administrative Costs	14.92%	14.92%	14.92%	14.92%	14.92%
M	Contribution to Surplus	2.00%	2.00%	2.00%	2.00%	2.00%
N	Taxes and Fees (excluding Risk Adjustment, Reinsurance and Exchange User Fees)	1.87%	1.87%	1.87%	1.87%	1.87%
O = L + M + N	**Total Distribution and Administrative Costs**	**18.79%**	**18.79%**	**18.79%**	**18.79%**	**18.79%**
P = K / (1-O)	**Plan Adjusted Index Rate**	**$657.67**	**$760.02**	**$584.87**	**$544.00**	**$709.84**
Q	Age Calibration Factor	1.699	1.699	1.699	1.699	1.699
R	Area Calibration Factor	1.000	1.000	1.000	1.000	1.000
S	Tobacco Calibration Factor	1.008	1.008	1.008	1.008	1.008
T = P / Q / R / S	**Calibrated Plan Adjusted Index Rates**	**$384.00**	**$443.77**	**$341.50**	**$317.63**	**$414.47**
U = P / A	**Pricing AV**		**1.05**	**0.81**	**0.75**	**0.98**
	Portion of the AV Pricing Value attributed to the Index Rate Modifiers					
V = P / A / W / X / Y / Z	Actuarial Value and Cost Sharing Design of the Plan		0.85	0.65	0.61	0.79
W = (H * (B + C)) / A	Catastrophic Risk Pool Adj.		1.00	1.00	1.00	1.00
X = (G * (B + C)) / A	Provider Network/Utilization Management		1.00	1.00	1.00	1.00
Y	Benefits in Addition to Essential Health Benefits		1.00	1.00	1.00	1.00
Z = P / K	Administrative Costs (excluding Risk Adjustment, Reinsurance and Exchange User Fees)		1.23	1.23	1.23	1.23
AA = V * W * X * Y * Z	**Total Pricing AV**		**1.05**	**0.81**	**0.75**	**0.98**

Exhibit D: Actuarial Value Memorandum (Medical and Rx)

Table of Contents

Section D.1: 2019 BCBSM Individual Medical Product Portfolio

This section provides a high-level summary of the product portfolio for BCBSM's individual healthcare reform compliant plans. The associated product Actuarial Values (AVs) are included for each plan as well. For more detailed descriptions of each plan, please refer to the benefit template and schedule pages. See Section 4 for plan specific AV calculator inputs.

BLUE CROSS BLUE SHIELD OF MICHIGAN
Individual 2019 Metal Plan Designs

Deductible/OOP Max	AVC Input	Gold	Silver				Bronze			Catastrophic
Plan Name		Blue Cross® Premier PPO Gold	Blue Cross® Premier PPO Silver Extra	Blue Cross® Premier PPO Silver	Blue Cross® Premier PPO Silver Saver HSA	Blue Cross® Premier PPO Silver Off Marketplace	Blue Cross® Premier PPO Bronze Extra	Blue Cross® Premier PPO Bronze HSA	Blue Cross® Premier PPO Bronze Saver	Blue Cross® Premier PPO Value
Medical/Rx Ded	Yes	$500	$4,000	$2,000	$3,300	$2,000	$6,650	$6,700	$7,900	$7,900
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OOPM	Yes	$7,000	$7,900	$7,900	$6,700	$7,500	$7,900	$6,700	$7,900	$7,900
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	No	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual
Medical Deductible waived for:	Yes	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent
Service Category[1]										
Inpatient	Yes	20%	20%	20%	20%	20%	40%	0% After Deductible	0% After Deductible	0% After Deductible
Outpatient	Yes	20%	20%	20%	20%	20%	40%	0% After Deductible	0% After Deductible	0% After Deductible
ER	Yes	$250 + 20%	20%	$250 + 20%	$250 + 20%	$250 + 20%	40%	0% After Deductible	0% After Deductible	0% After Deductible
Radiology (MRI, CT, PET)	Yes	20%	20%	20%	20%	20%	40%	0% After Deductible	0% After Deductible	0% After Deductible
Preventative	Yes	0%	0%	0%	0%	0%	0%	0%	0%	0%
PCP Office Visit	Yes	$30 After Deductible	$30 Before Deductible	$30 After Deductible	$30 After Deductible	$30 After Deductible	$35 Before Deductible	0% After Deductible	0% After Deductible	Deductible Waived for 3 OV apply $30 copay
Specialist Office Visit	Yes	$50 After Deductible	$65 Before Deductible	$50 After Deductible	$50 After Deductible	$50 After Deductible	$75 Before Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Urgent Care	No	$75 + 20% After Deductible	$75 Before Deductible	$75 + 20% After Deductible	$75 + 20% After Deductible	$75 + 20% After Deductible	$75 Before Deductible	0% After Deductible	0% After Deductible	0% After Deductible
MH/SA	Yes	$30 After Deductible	$30 Before Deductible	$30 After Deductible	$30 After Deductible	$30 After Deductible	$35 Before Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Rx Generic	Yes	$15 After Deductible	$15 Before Deductible	$15 After Deductible	$15 After Deductible	$15 After Deductible	$35 Before Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Rx Preferred Brand	Yes	25% ($40 min, $100 max) After Deductible	$50 Before Deductible	25% ($40 min, $100 max) After Deductible	25% ($40 min, $100 max) After Deductible	25% ($40 min, $100 max) After Deductible	35% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Rx Non-Preferred Brand	Yes	50% ($80 min, $100 max) After Deductible	$100 Before Deductible	50% ($80 min, $100 max) After Deductible	50% ($80 min, $100 max) After Deductible	50% ($80 min, $100 max) After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Rx Preferred Special	No	40% After Deductible	40% After Rx Deductible	40% After Deductible	40% After Deductible	40% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Rx Non-Preferred Special	No	45% After Deductible	45% After Rx Deductible	45% After Deductible	45% After Deductible	45% After Deductible	45% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Actuarial Value - Medical and Rx										
AV from AVC		79.3%	71.8%	70.2%	66.9%	70.5%	63.1%	61.3%	58.5%	60.6%
Dental										
Deductible		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Network Coinsurance (Class 1/2/3)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OOPM (Child/Children only)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Annual Dollar Maximum (Adult Only)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vision										
Coverage	Yes	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only
Frequency	Yes	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)
Copay (Exam/Materials)	Yes	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annual Dollar Allowance		$0	$0	$0	$0	$0	$0	$0	$0	$0
VSP Network	Yes	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network
HIOS Plan IDs										
HIOS Product ID		15560MI035	15560MI113	15560MI035	15560MI035	15560MI035	15560MI112	15560MI035	15560MI035	15560MI035
HIOS Plan IDs		15560MI0350004-00 15560MI0350004-01 15560MI0350004-02[2] 15560MI0350004-03[2]	15560MI1130001-00 15560MI1130001-01 15560MI1130001-02[2] 15560MI1130001-03[2]	15560MI0350003-00 15560MI0350003-01 15560MI0350003-02[2] 15560MI0350003-03[2]	15560MI0350006-00 15560MI0350006-01 15560MI0350006-02[2] 15560MI0350006-03[2]	15560MI0350007-00	15560MI1120001-00 15560MI1120001-01 15560MI1120001-02[2] 15560MI1120001-03[2]	15560MI0350002-00 15560MI0350002-01 15560MI0350002-02[2] 15560MI0350002-03[2]	15560MI0350005-00 15560MI0350005-01 15560MI0350005-02[2] 15560MI0350005-03[2]	15560MI0350001-00 15560MI0350001-01
Actuarial Value - Pediatric Dental EHB										
AV		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1] ER = Emergency Room, PCP = Primary Care Physician, SP = Specialist, MH = Mental Health, SA = Substance Abuse, Img = Imaging, ST = Speech, OT/PT = Occupational/Physical, Prev = Preventative, Lab = Laboratory

[2] These are HIOS Plan IDs for the zero and limited cost sharing AV variations for Native American medical plans. The plans have no or limited cost sharing for a Native American who is determined to be eligible by the Exchange for cost sharing reductions.

BLUE CROSS BLUE SHIELD OF MICHIGAN
Individual 2019 CSR Plan Designs

Deductible/OOP Max	AVC Input	Silver								
Plan Name		Blue Cross® Premier PPO Silver Extra 73	Blue Cross® Premier PPO Silver Extra 87	Blue Cross® Premier PPO Silver Extra 94	Blue Cross® Premier PPO Silver 73	Blue Cross® Premier PPO Silver 87	Blue Cross® Premier PPO Silver 94	Blue Cross® Premier PPO Silver Saver HSA 73	Blue Cross® Premier PPO Silver Saver 87	Blue Cross® Premier PPO Silver Saver 94
Medical/Rx Ded	Yes	$3,500	$1,000	$500	$1,650	$500	$200	$2,700	$600	$300
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OOPM	Yes	$6,300	$2,500	$1,250	$6,000	$2,000	$800	$4,000	$1,600	$650
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	No	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual	Embedded, 2x Individual
Medical Deductible waived for:	Yes	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent	Prevent
Service Category[1]										
Inpatient	Yes	20%	20%	5%	20%	10%	10%	20%	10%	10%
Outpatient	Yes	20%	20%	5%	20%	10%	10%	20%	10%	10%
ER	Yes	20%	20%	5%	$250 + 20%	$250 + 10%	$100 + 10%	$250 + 20%	$250 + 10%	$100 + 10%
Radiology (MRI, CT, PET)	Yes	20%	20%	5%	20%	10%	10%	20%	10%	10%
Preventative	Yes	0%	0%	0%	0%	0%	0%	0%	0%	0%
PCP Office Visit	Yes	$30 Before Deductible	$10 Before Deductible	$5 Before Deductible	$30 After Deductible	$30 After Deductible	$10 After Deductible	$30 After Deductible	$30 After Deductible	$10 After Deductible
Specialist Office Visit	Yes	$65 Before Deductible	$25 Before Deductible	$10 Before Deductible	$50 After Deductible	$50 After Deductible	$30 After Deductible	$50 After Deductible	$50 After Deductible	$30 After Deductible
Urgent Care	No	$75 Before Deductible	$40 Before Deductible	$25 Before Deductible	$75 + 20% After Deductible	$75 + 10% After Deductible	$30 + 10% After Deductible	$75 + 20% After Deductible	$75 + 10% After Deductible	$30 + 10% After Deductible
MH/SA	Yes	$30 Before Deductible	$10 Before Deductible	$5 Before Deductible	$30 After Deductible	$30 After Deductible	$10 After Deductible	$30 After Deductible	$30 After Deductible	$10 After Deductible
Rx Generic	Yes	$15 Before Deductible	$5 Before Deductible	$3 Before Deductible	$15 After Deductible	$15 After Deductible	$15 After Deductible	$15 After Deductible	$15 After Deductible	$15 After Deductible
					25% ($40 min, $100 max)	25% ($40 min, $100 max)	25% ($40 min, $100 max)	25% ($40 min, $100 max)	25% ($40 min, $100 max)	25% ($40 min, $100 max)
Rx Preferred Brand	Yes	$50 Before Deductible	$25 Before Deductible	$5 Before Deductible	After Deductible	After Deductible	After Deductible	After Deductible	After Deductible	After Deductible
					50% ($80 min, $100 max)	50% ($80 min, $100 max)	50% ($80 min, $100 max)	50% ($80 min, $100 max)	50% ($80 min, $100 max)	50% ($80 min, $100 max)
Rx Non-Preferred Brand	Yes	$100 Before Deductible	$50 Before Deductible	$10 Before Deductible	After Deductible	After Deductible	After Deductible	After Deductible	After Deductible	After Deductible
Rx Preferred Special	No	40% After Rx Deductible	40% After Rx Deductible	40% After Rx Deductible	40% After Deductible	40% After Deductible	40% After Deductible	40% After Deductible	40% After Deductible	40% After Deductible
Rx Non-Preferred Special	No	45% After Rx Deductible	45% After Rx Deductible	45% After Rx Deductible	45% After Deductible	45% After Deductible	45% After Deductible	45% After Deductible	45% After Deductible	45% After Deductible
Actuarial Value - Medical and Rx										
AV from AVC		73.9%	86.9%	93.2%	73.2%	86.7%	93.2%	72.7%	87.2%	93.4%
Dental										
Deductible		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Network Coinsurance (Class 1/2/3)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OOPM (Child/Children Only)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Annual Dollar Maximum (Adult Only)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vision										
Coverage	Yes	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only	Pediatric only
Frequency	Yes	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)	12/12/12 (exam/lenses/frames)
Copay (Exam/Materials)	Yes	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annual Dollar Allowance		$0	$0	$0	$0	$0	$0	$0	$0	$0
VSP Network	Yes	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network	VSP Choice Network
HIOS IDs										
HIOS Product ID		15560MI113	15560MI113	15560MI113	15560MI035	15560MI035	15560MI035	15560MI035	15560MI035	15560MI035
HIOS Plan IDs		15560MI1130001-04	15560MI1130001-05	15560MI1130001-06	15560MI0350003-04	15560MI0350003-05	15560MI0350003-06	15560MI0350006-04	15560MI0350006-05	15560MI0350006-06
Actuarial Value - Pediatric Dental EHB										
AV		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1] ER = Emergency Room, PCP = Primary Care Physician, SP = Specialist, MH = Mental Health, SA = Substance Abuse, Img = Imaging, ST = Speech, OT/PT = Occupational/Physical, Prev = Preventative, Lab = Laboratory

Section D.2: Calculating Medical Actuarial Value (AV)

The AV of each medical and prescription drug plan was calculated using the prescribed AV Calculator as updated and modified for the 2019 calendar year. For benefit designs that fit adequately into the framework of the tool, we populated the proper cost sharing features for those benefit provisions outlined within the tool. There were benefit provisions offered by BCBSM whose cost sharing features did not fit directly into a benefit or cost sharing category provided within the tool. Regulations prescribe that, in these instances, an issuer must estimate the impact of these benefit provisions by utilizing one of the methodologies identified below:

1) Calculate the plan's AV by:
   a) Estimating a fit of its plan design into the parameters of the AV Calculator; and
   b) Having an actuary, who is a member of the American Academy of Actuaries; certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies.
2) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters. Then, have an actuary, who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

When confronted with benefits provisions or cost sharing requirements that did not fit cleanly within the construct of the prescribed AV tool, BCBSM preferred to utilize approach 1, described above. We did this by utilizing an internal proprietary benefit relativity tool to estimate the effective cost sharing value for a specific cost category of our product offerings that could then be input into the AV Calculator. The benefit modeling tool is a Microsoft Excel spreadsheet tool developed by incorporating actual cost and utilization data for BCBSM's group PPO population. The tool was created with the assistance of The Terry Group.

The Terry Group has extensive experience in developing sophisticated health care benefit modeling tools for a diverse customer base, building models that are based on a plan's specific claims and exposure data. The information is used to develop utilization rates and unit cost amounts for up to 100 medical service categories. This array of rates and costs are used to measure the cost impact of various benefit plan co-pays, limits and exclusions that are specific to each medical category. All models employ plan provided claim probability distributions that are used to measure the effects of co-pays, deductibles and out-of-pocket limits when these provisions apply simultaneously to multiple medical service categories. The results of these calculations are adjusted for user-selected assumptions for demographic mix, geographic mix, trend, and provider reimbursement arrangements.

The population utilized within the tool included all BCBSM large and small group PPO customers, for both fully-insured and self-insured arrangements. Since the experience of these pools encompassed plans that also covered the required essential health benefits for the

Michigan marketplace in 2019, and is large and credible, we felt the tool would be a good proxy of expected cost and utilization patterns for the future individual and small group markets, as modified by the ACA market rules.

Data within our proprietary tool is summarized by detailed cost categories and covers all essential health benefit categories, including but not limited to inpatient hospital, outpatient hospital, physician services, laboratory, mental health, and prescription drugs. The tool allowed the Actuarial Department to determine the expected cost and the paid to allowed ratios for varying degrees of member cost sharing for benefit categories which could not be cleanly input in the AV Calculator.

Specific benefit provisions modeled within the proprietary tool for input in the AV Calculator are outlined below. The following assumptions and/or methods were utilized to derive the final AVs for each product.

1) We summarize methods and provisions that required outside analysis for input into the tool. However, if a benefit category was not accounted for within the tool, it was determined that that any changes to cost sharing for these specific benefit categories was not considered to be material from a regulatory perspective.
2) If a method or assumption had an impact of .2% or less on the AV value, it was considered immaterial.
3) When a plan provision was covered with both a coinsurance and co-pay, thus requiring an adjustment to the tool, we opted to replicate an effective coinsurance for these services rather than an effective co-pay. We had a higher level of comfort with how coinsurance provisions were handled within the tool as compared to co-pay values.
4) Results shown for the AV derivation of each product were based on pressing the calculation button once.
5) We took results produced by the tool 'as is'.
6) The State of Michigan also regards state mandated benefits such as autism as essential health benefits. These benefits have a relatively small value and are subject to the same cost sharing as all other benefits, which suggest that they should not materially impact AV. Therefore we did not make any adjustments for state mandates in the AV calculation.

Benefits Requiring an Effective Benefit Value Calculation

All benefits that required an effective value calculation for input into the AV Calculator have been identified below.

Issue 1: Minimum and Maximum Coinsurance on Preferred (Tier 2) and Non-Preferred (Tier 3) Brand Pharmacy Benefits

Issue Description: The CCIIO AV Calculator does not allow a user to enter a minimum and maximum co-pay amount for preferred and non-preferred pharmacy tiers.

Solution Approach: We calculated and input an effective co-pay for the brand non-formulary drug tier that includes the effect of the minimum and maximum co-pays based on the analysis outlined below. The analysis demonstrates that the effective co-pay accurately reflects the average co-pay within the minimum and maximum co-pay.

We used the proprietary benefit modeling tool to determine the necessary co-pay for each tier of brand drugs that would give the same (or very close) paid per member per month costs as a coinsurance design with a minimum and a maximum co-pay. Below are examples of the calculation for the Blue Cross® Premier Silver plan.

	Allowed PMPM with 25% $40 Min and $100 Max	Paid PMPM with 25% $40 Min and $100 Max	Allowed PMPM with $58 copay	Paid PMPM with $58 copay
Brand Formulary	$17.35	$10.77	$17.35	$10.77

	Allowed PMPM with 50% $80 Min and $100 Max	Paid PMPM with 50% $80 Min and $100 Max	Allowed PMPM with $88 Co-pay	Paid PMPM with $88 Co-pay
Brand Non-Formulary	$16.88	$10.48	$16.88	$10.48

$15/25% [$40 min, $100 max]/50% [$80 min, $100 max]/40%/45% with Blue Cross® Premier Silver plan.

Issue 2: Two Tier Specialty Rx Coinsurance

Issue Description: The CCIIO AV tool only has one specialty tier and does not accommodate many of our prescription drug plans which have a two tier specialty prescription drug program.

Solution Approach: We determined an effective specialty coinsurance based on a weight from reviewing the weighting of claims between the two specialty tiers. The example below reflects the effective coinsurance for the Blue Cross® Premier PPO Silver plan. We were able to obtain allowed claims utilization information for a two tier specialty plan from the BCBSM proprietary benefit modeling tool. The claims spend was utilized to weight the coinsurance amount.

	Percent of Allowed Claims	Coinsurance
Tier 4	75.1%	60%
Tier 5	24.9%	55%
Effective Amount		58.8%

Issue 3: Benefits are subject to both co-pay and coinsurance.

Issue Description: Some of the benefits in the BCBSM Individual plans are subject to both a flat dollar co-pay and coinsurance. The CCIIO AV tool only allows for either a flat dollar co-pay or coinsurance percentage, but not both.

Some benefit categories were not provided as an input area within the AV Calculator.

Solution Approach: Using BCBSM's benefit modeling tool, we obtained the paid PMPM for all medical services combined, as the plan is designed. After this amount was established, the benefit model was then used to solve for the effective plan coinsurance percentage until the same (or very similar) medical paid PMPM has been reached, by making all medical benefits (except for plans where a portion of the primary care and specialist office visits are covered with flat dollar co-pays before the deductible) subject to deductible and coinsurance with no co-pays.

Example (Blue Cross® Premier Silver Plan):

	Plan As Designed without OOPM			Plan with Effective Coinsurance without OOPM			Difference
Plan	Medical Co-pay	Member Coinsurance Percent	Medical Paid PMPM	Medical Co-pay	Member Coinsurance Percent	Paid PMPM	
Blue Cross® Premier Silver	Varies by Service	20%	$252.80	$0 for all Services	24.96%	$252.80	$0.00

In the example above, we run these plans through without applying to the total out-of-pocket to get a true effective coinsurance. The resulting benefit PMPMs are about the same comparing the benefits as designed versus the converted effective coinsurance percentage without copays. The impact of this change on the AV from the CCIIO AV Calculator is significant only when using either copays or coinsurance. On the same Blue Cross® Premier Silver plan, the AV Calculator produces an AV of 70.21% when the effective coinsurance on medical services is used (24.96%), while the AV would be 71.23% if the calculator was run using only the 20% member coinsurance without taking into account the co-pay amounts. All Individual details outside of the model adjustments are included in the appendix.

Issue 4: Modeled but not Material

As stated above, we made an assumption that if an essential health benefit category was not provided as an input area within the AV Calculator, it was assumed that the benefit category would not have a material impact on the product AV if the provisions for these benefits were changed. Below are some specific benefit categories not provided for in the AV Calculator:

- Limiting Chiropractic and Physical Therapy Services
- Differing Coinsurance for Bariatric Surgery
- Inclusion of additional benefits where it is not clear where those benefits would be classified within the AV Calculator (Infertility, TMJ, DME, Prosthetics and Orthotics)

Section D.3: Non-Essential Health Benefit Provisions

Benefits above and beyond those required by EHB coverage guidelines are not to be included in calculating AV for qualified health plans for 2019 individual customers. BCBSM does not plan to offer benefits that are outside of the EHB guidelines provided by the state of Michigan within its individual medical plans.

Section D.4: Appendix

Section D.4.A: Screen Shots of the AV Calculation for the Portfolios

Metal Level: Bronze

Blue Cross® Premier PPO Bronze Saver, HIOS ID: 15560MI0350005-00 (OFF), 15560MI0350005-01 (ON)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$7,900.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$7,900.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Blue Cross® Premier PPO Bronze Saver

Plan HIOS ID:

Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.53%
Metal Tier:	Bronze
Additional Notes:	
Calculation Time:	0.1836 seconds

Final 2019 AV Calculator

Metal Level: Silver

Blue Cross® Premier PPO Silver Saver HSA, HIOS ID: 15560MI0350006-00 (OFF), 15560MI0350006-01 (ON)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,300.00			
Coinsurance (%, Insurer's Cost Share)			74.92%			
MOOP ($)			$6,700.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$15.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$58.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☐		$88.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑	58.76%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Blue Cross® Premier PPO Silver Saver HSA

Plan HIOS ID:

Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	66.93%
Metal Tier:	Silver
Additional Notes:	
Calculation Time:	0.2461 seconds

Final 2019 AV Calculator

Metal Level: Silver (73% AV Level)

Blue Cross® Premier PPO Silver Saver HSA, HIOS ID: 15560MI0350006-04 (ON)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,700.00			
Coinsurance (%, Insurer's Cost Share)			75.17%			
MOOP ($)			$4,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$15.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$58.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☐		$88.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑	58.76%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Blue Cross® Premier PPO Silver Saver HSA 73

Plan HIOS ID:

Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.74%
Metal Tier:	Silver
Additional Notes:	
Calculation Time:	0.2969 seconds

Final 2019 AV Calculator

Metal Level: Silver (87% AV Level)

Blue Cross® Premier PPO Silver Saver, HIOS ID: 15560MI0350006-05 (ON)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$600.00
Coinsurance (%, Insurer's Cost Share)			84.75%
MOOP ($)			$1,600.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$15.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$58.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☐		$88.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑	58.76%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Blue Cross® Premier PPO Silver Saver 87

Plan HIOS ID:

Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.21%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.2461 seconds

Final 2019 AV Calculator

Metal Level: Silver (94% AV Level)

Blue Cross® Premier PPO Silver Saver, HIOS ID: 15560MI0350006-06 (ON)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$300.00
Coinsurance (%, Insurer's Cost Share)			88.22%
MOOP ($)			$650.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$15.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$58.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☐		$88.00	☑	☑			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑	58.76%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Blue Cross® Premier PPO Silver Saver 94

Plan HIOS ID:

Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.45%
Metal Tier:	Platinum
Additional Notes:	
Calculation Time:	0.2031 seconds

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