
Actuarial Memorandum

Paramount Care of Michigan Issuer #23592

**2027 Small Group ACA Off-Exchange Health Premium Rate Filing for POS for the
State of Michigan**

June 3rd, 2026

Developed By:

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EXECUTIVE SUMMARY

This memorandum documents the development of small group rates for Paramount Care of Michigan's (PCM) off-exchange POS plans. Paramount is offering small group health insurance products in the Platinum, Gold, Silver, and Bronze metal tiers, effective [January 1, 2027](#). This filing will apply to any policies that are issued from [January 1 to December 31, 2027](#).

Paramount is an insurer of commercial and managed Medicare in southeast Michigan. Paramount is part of the Medical Mutual family of companies.

1. GENERAL INFORMATION

Company Legal Name: Paramount Care of Michigan

Address of the Submitting Company: 214 Elm Ave., Ste. 107, Monroe, MI 48162-26787

State: Michigan

HIOS Issuer ID: 23592

Market: Small Employer Group Market

Effective Date: [January 1, 2027](#)

This is a new filing for the above effective date.

Company Contact Information

Primary Contact Name: Samuel Thomas

Primary Contact Email Address: Samuel.Thomas@MedMutual.com

Toll-free number: 1-888-891-0707

SERFF Rate Review Detail

Projected Earned Premium: \$ [REDACTED]

Projected Incurred Claims: \$ [REDACTED]

Projected Risk Transfer \$ [REDACTED]

Projected Incurred Claims after Risk Transfer \$ [REDACTED]

Annual PMPM: Min: \$ [REDACTED] Max: \$ [REDACTED] Weighted Avg.: \$ [REDACTED]

Description of Benefit

The benefits include Inpatient hospital, Outpatient hospital, Professional services, and Pharmacy. The descriptions are located in Appendix F.

Prior Filing Information

Effective date is [January 1, 2026](#)

SERFF Tracking Number: [PARM-134536553](#)

Other General Information

Months of Rate Guarantee: These rates will be guaranteed until the end of the policy year, which is a year from the effective date.

Unique Identifying Form Number of Submitted Form:

- 1) Summary of Benefits: [ACA POS MI PLATINUM 1.27](#), [ACA POS MI HIGH GOLD 1.27](#), [ACA POS MI MID GOLD 1.27](#), [ACA POS MI COPAY FOCUS GOLD 1.27](#), [ACA POS MI LOW GOLD 1.27](#), [ACA POS MI HIGH SILVER 1.27](#), [ACA POS MI HIGH BRONZE 1.27](#), [ACA POS MI MID SILVER 1.27](#), [ACA POS MI LOW SILVER 1.27](#), [ACA POS MI LOW BRONZE 1.27](#)
- 2) Handbook: [PCM SG MI POS 1.27](#)
- 3) ID Card: [LS-76 PCM 1.20](#)
- 4) Enrollment Application: [LS-31 Rev. 9/13](#)
- 5) Group Policy: [PCM: Group Policy R27](#)
- 6) Group App: [MI MasterGroupApp 1.20](#)

SERFF Tracking Number: [PARM-134932659](#)

Binder SERFF Number is [PARM-MI27-125122361](#)

Cross Walk of Plans

This table below shows all of the POS ACA plans that Paramount will offer effective [January 1, 2027](#).

Marketing Name 2026	Marketing Name 2027	HIOS ID
ACA POS MI PLATINUM	ACA POS MI PLATINUM	23592MI0130001
ACA POS MI HIGH GOLD	ACA POS MI HIGH GOLD	23592MI0130002
ACA POS MI MID GOLD	ACA POS MI MID GOLD	23592MI0130003
ACA POS MI COPAY FOCUS GOLD	ACA POS MI COPAY FOCUS GOLD	23592MI0130011
ACA POS MI LOW GOLD	ACA POS MI LOW GOLD	23592MI0130004
ACA POS MI HIGH SILVER	ACA POS MI HIGH SILVER	23592MI0130005
ACA POS MI HIGH BRONZE	ACA POS MI HIGH BRONZE	23592MI0130007
ACA POS MI LOW SILVER	ACA POS MI LOW SILVER	23592MI0130009
ACA POS MI LOW BRONZE	ACA POS MI LOW BRONZE	23592MI0130010

2. PROPOSED RATE INCREASE

Paramount will sell small employer group policies outside of the exchange with effective dates beginning [January 1, 2027](#). The effective rate increase is [REDACTED] for all proposed small employer group POS policies out of the exchange.

Change in Assumptions

Below is a list of the assumptions that have an impact in the change of the premiums from [2026 to 2027](#).

The increase is due to the changes in the following:

- Impact of blended experience is [REDACTED]
- Use of a higher trend assumption from the experience period to the rating period is [REDACTED]
- Combined impact of demographic changes, Induced Utilization due to AV difference from manual, geographic and Morbidity is [REDACTED]
- Risk Adjustment transfer impact of [REDACTED]
- Impact of Pricing AV and Induced Demand Increase of pricing AV [REDACTED]
- Impact of Age Calibration, Geographic Calibration and Tobacco Calibration is [REDACTED]
- Change of Profit is [REDACTED]
- Other Changes including admin expenses is [REDACTED]

Based on the projected enrollment for [2027](#), the average monthly premium is currently \$ [REDACTED] PMPM and the proposed average monthly premium is \$ [REDACTED] PMPM

This is expected to affect [REDACTED] lives and [REDACTED] policyholders.

Rate Increases Varying Among Plans

The pricing AVs were developed by Paramount, using Wakely Pricing Model, for the various plans changed from [2026](#) to [2027](#). Some of the plan's pricing AV had a sharper increase than other plan's pricing AV. There are benefit changes in the plans to meet the metal level AV requirements, which vary by plan. There is also leveraging of member cost sharing due to trend, and the impact of this leveraging varies by plan. Furthermore, the fixed admin costs are the same PMPM for all plans which would have an impact of premium percentage changes as well.

3. MARKET EXPERIENCE

Paramount has established a single risk pool for the entire small group POS business off exchange that is non-grandfathered, non-transitional, and ACA compliant.

The experience used, as a single risk pool, for this market is for Michigan Small Group POS ACA. There are no transitional groups in this experience.

4. EXPERIENCE PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

There is experience the membership is [REDACTED] MM. The credibility is [REDACTED] credible. This is based on $([REDACTED]24,000)^{0.5}$. The rates are based on this experience subject to adjustment for EHB which is not in the experience. The experience nets out the private reinsurance recoveries, subrogation, and pharmacy rebates.

- a. Allowed PMPM medical and pharmacy costs were developed using historical information for Paramount's small group POS experience in Michigan. The experience is from CY 2025 paid through March 2026.
- b. The overall completion factor for the claims (excluding pharmacy) is [REDACTED]. This reflects an expected portion of paid claims to incurred claims with only two months of run-out.
- c. Allowed PMPMs for Michigan were adjusted for trend and ACA changes including EHB. The claims were adjusted for demographics, benefits (EHBs), provider reimbursement, and prevalence of smoking and morbidity.
- d. Administration costs and regulatory fees and taxes, along with contribution to surplus, were added.

The data of the enrollment is as of March 31, 2026. This is used for lines 2.11-2.13 on worksheet 2 of the URRT.

IBNR

The IBNR is developed by using Paramount fully-funded commercial experience respectively and using a triangle method to project completion factors. The experience is combined small and large groups. Each cell in the triangle method is broken out by incurred month and paid month. Ratios are developed between what is paid in x number of months over what is paid in x+1 months for the most recent available 12 months. These ratios are taken to 36 months. The completion factor over 36 months of run out is 1.0000. The above ratios are multiplied starting with month 36 and working its way back up to month 1. Please note that month 1 is the month that claims are incurred and paid during the same month. For example, a completion factor for claims that is paid in 15 months is as follows: Product of (Paid in Month x/Paid in Month x+1) with x being from 15 to 36. The months, for each term, is a twelve-month period for each set of x with the most recent month at x months from when the triangles were constructed. In this case, the claims triangle was developed in March 2026.

The completion factors are developed based on the method described above. The completion factor below represents claims that are incurred in CY 2025 and paid from January 2025 through March 2026. This is an average of the respective 12-month completion for the respective payment period. Completion factors were developed separately for inpatient, outpatient, and professional. The composite completion factor is [REDACTED] for medical claims. Pharmacy data was assumed to be fully complete since pharmacy data typically completes within a few weeks. There is no indication of the incurred claims being unusually high or low compared to what is paid for the paid and incurred period.

Claims in the Experience Period	Allowed Claims	Paid Claims

5. BENEFIT CATEGORIES

The claims were split out by inpatient, outpatient, PCP, specialist, physical therapy, generic drugs and brand name drugs, and specialty drugs. We mapped the claims to URRT category as follows:

- Inpatient claims to the URRT category of Inpatient Hospital
- Outpatient claims to the URRT category of Outpatient Hospital
- PCP, physician, and physical therapy claims to the URRT category of Physician
- A small amount of claims went to the URRT category of Other which comprise of the following:

Ambulance
Ambulance-Air Ambulance
Ambulance-General Classification
Ambulance-Neonatal Ambulance Services
Dentistry
Durable Medical Equipment
Durable Medical Equipment (Other than renal)-General
Durable Medical Equipment (Other than renal)-Purchase of New DME
Hearing Aid Filter
Hearing Services
Home Health
Home Health (HH) Aide-General
Home Health (HH) Aide-Visit Charge
Home Health (HH)-Medical Social Services-General
Home Health (HH)-Medical Social Services-Other Medical Social Services
Home Health (HH)-Medical Social Services-Visit Charge
Home Health (HH)-Oxygen-Stat Equip/Supply/Contents
Home health prospective payment system (HIPPS)

Medical/Surgical Supplies and Devices-Prosthetic/Orthotic Devices
Orthotics & Prosthetics

- Paramount does not have any capitated claims
- Generic drug, brand name drug and specialty drug claims were mapped to the URRT category of Prescription Drug

6. PROJECTION FACTORS

Trend Factors (cost / utilization)

We made the following trend assumptions based on ongoing increases in utilization and unit costs. These assumptions are based on in-house Medical Mutual ACA data and actuarial judgement.

Service Category	Year 1 Cost Trend	Year 1 Use Trend	Year 2 Cost Trend	Year 2 Use Trend
██████████	████	████	████	████
██████████	████	████	████	████
██████████	████	████	████	████
██████	████	████	████	████
██	████	████	████	████
██████	████	████	████	████
██████████	████	████	████	████

The average annualized trend over the two-year period is █████

Geographic and Provider Contracting Adjustment

The purpose of this adjustment is to reflect the impact of changes in expected geographic mix and provider contracts between the base experience and the projection period expected population. We applied an adjustment to the 2025 experience to account for changes specifically in provider contracts from 2025 to 2027. The impact of this adjustment can be found in the 'Calculation of Average Premium' tab of volume 2 of the 2027 POS Exhibits files. The development of this adjustment can be found in the supporting document 'Provider Contracting Changes for 2027 MI ACA'.

Demographics Adjustment

The purpose of this adjustment is to reflect the impact of changes in expected demographics between the base experience and the projection period expected population. As there are no expected demographic differences between the experience population and the expected rating population, no adjustment was made.

Morbidity Adjustment

The purpose of this adjustment is to reflect the impact of changes in expected morbidity between the base experience and the projection period expected population. As there are no expected morbidity

differences between the experience population and the expected rating population, no adjustment was made.

Benefit Richness and Induced Utilization Adjustment

Since there were no major changes in benefit richness from 2025 to 2027, we did not make an adjustment for benefit richness or induced utilization.

Essential Health Benefits (EHB)

Paramount intends to cover the Michigan EHB benchmark plan as is. No substitutions or additional benefits are being offered with one exception. The exception is pediatric dental which will not be embedded in the HMO product. Paramount will be requiring all groups to purchase pediatric dental coverage through a stand-alone exchange-certified dental plan offered by Delta Dental and/or Paramount Dental.

There are two main benefits that are non-EHB. These benefits are adult vision and accidental dental. The costs of these two were estimated based on the base and manual rate experience. These Non-EHB Benefits make up an estimated [REDACTED] of claim costs.

Other Adjustments

There are no additional adjustments made.

7. MANUAL RATE ADJUSTMENTS

The manual rate is based on 2025 Michigan Large Group POS and Ohio Small Group HMO experience. The adjustment factors used are as follows:

Demographics Adjustment

The purpose of this adjustment is to reflect the impact of changes in demographics (age/gender) between the manual population and the base population. The demographic adjustment applied to the manual rate is [REDACTED]

The development of this adjustment is shown in the supporting document 'Manual Rate Calibration Factors – MI POS ACA 2027'. The impact of this adjustment can be seen in Appendix A.

Benefits Adjustment

We applied an adjustment to the manual rate to reflect the differences in benefits covered between the manual population and the base population. The manual rate includes non-ACA experience which needs to be adjusted for EHBs. The adjustment made to the manual population to calibrate it to the base population to account for differences in benefits covered is [REDACTED]. The development of this adjustment is shown in the supporting document 'Manual Rate Calibration Factors – MI POS ACA 2027'. The impact of this adjustment can be seen in Appendix A.

Morbidity

A morbidity factor of [REDACTED] was used to adjust the manual to the experience population. The development of this adjustment is shown in the supporting document '[Manual Rate Calibration Factors – MI POS ACA 2027](#)'. The impact of this adjustment can be seen in Appendix A.

Provider Contracting Adjustment

Paramount projected the contracting targets for inpatient facility, outpatient facility and professional categories of service for large group business. There are contracting changes at ProMedica facilities. There are contracts with some of the ProMedica facilities located in Michigan. This has an impact of [REDACTED] cost reduction on the medical claims, which will comprise of [REDACTED] of the total cost.

Furthermore, since the HMO networks are the same between the Michigan business and the Ohio business no adjustments are needed for provider contracting and hospital discounts with the exception of the local ProMedica facilities located in Michigan.

There is a provider contracting adjustment for the medical claims only of [REDACTED]. This is located in appendix A.

Inclusion of Capitation Payments

Paramount does not currently have any capitated arrangements.

8. CREDIBILITY OF EXPERIENCE

Paramount has been in the small group market since inception. The Michigan Small Group POS ACA experience for 2025 has been used and the credibility is [REDACTED] which = ([REDACTED]24,000)^0.5.

Credibility Standard Methodology

Based on an application of classical credibility theory, the determination of full credibility depends on the assumed variation in the claim experience. Our goal is to determine the number of individuals that are needed to have a probability, P, of being within a percentage, k, relative to the expected claim amount. We chose values of P = 95% and k = 10%, which is consistent with the values used by CMS for Medicare. After using the *Central Limit Theorem* and some simplification, the following formula is produced:

$$N_f = \frac{(z^2_{1-p} * \sigma^2)}{k^2 * \mu^2}$$

Z_{score} (Z²_{1-p})

Margin of error (k)

Variance of population (σ²)

Mean of population (μ²)

MM for full credibility (N_f)

This approach is commonly known as the “limited fluctuation” approach. After plugging in our assumptions, we get the following formula:

$$N_f = \frac{(1.96^2 * \sigma^2)}{0.1^2 * \mu^2}$$

In order to perform this calculation, the unknown values of σ and μ must be estimated. The usual approach is to substitute an estimate (σ_{hat} and μ_{hat}).

N_f is defined on a per capita basis (per enrollee regardless of the number of months enrolled during the year). We convert the final result to member months by multiplying N_f by the average monthly exposure of the data set. The data set **All Durations** includes membership enrolled for any period of time in contrast to **Full Year** which only includes membership enrolled for the entire year.

9. INDEX RATE DEVELOPMENT

Index Rate for Projection Period

The index rate for the period with effective date of January 1, 2027 is \$ [REDACTED]

The index rate in the URRT worksheet 1 in cell F42 is \$ [REDACTED]

Risk Adjustment

The assumed RAF in the development of the index rate is intended to adjust for differences between the issuer’s single risk pool population and the average morbidity in the currently-insured market. As a starting point we used the state average PLRS, ARF, and GCF, however we used the IDF and AVs that would correspond the plans to be issued and the expected membership distribution.

$$\text{HHS Transfer formula: } T_i = \left[\frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)} \right] \bar{P}_s$$

The reports from the **CY 2025** CMS Edge Server were used to calculate Paramount’s factors in the numerator of the formula above. A combination of the **2025** Interim CMS report and the Wakely National Risk Adjustment Risk Adjustment Report were used to calculate the factors for the state in the denominator.

The following adjustments are made to project the risk transfers:

The **2025** state market average premium (\$ [REDACTED]) was trended at [REDACTED] to derive the **2026** market average premium. To trend the premium from **2026** to **2027**, the claim cost trend of [REDACTED] is used as an

assumption. This puts the 2027 projected state market average premium at [REDACTED].

The state average premium estimate used to calculate risk transfers was reduced by 14% per the 2018 Final Notice of Benefit and Payment Parameters to exclude administrative fees from risk transfer.

The projected risk transfer calculated for 2027 is [REDACTED] PMPM. The development of this projected is located in the [Risk Transfer](#) tab of the [2027 POS Exhibits Vol 2](#) supporting document.

This projection was converted to a factor of [REDACTED] using the following formula located in cell F38 of the [Calculation of Average Premium](#) tab of the [2027 POS Exhibits Vol 2](#) supporting document, which includes an adjustment from a paid basis to an allowed basis.

The risk adjustment in this filing includes the risk transfer [REDACTED]. We converted this PMPM estimate into a market level adjustment factor of 1.0099 as shown in Appendix A. This factor [REDACTED] the market adjusted index rate by \$[REDACTED] PMPM (as shown in cell F44 on Worksheet 1 of the URRT.)

The impact of this adjustment can be seen in Appendix A.

10. NON-BENEFIT EXPENSES AND PROFIT & RISK

[Administrative Expense Load](#)

Paramount developed expected administration costs based on current administrative costs for small group lines of business among Medical Mutual's book of business as well as historical administrative expenses for Paramount-specific small group ACA products. These admin expenses do not vary among different products for Paramount's Small Group ACA business. The expected administrative costs for Paramount's Small Group ACA business is \$[REDACTED] PMPM.

[Contribution to Surplus & Risk Margin](#)

[REDACTED] of premiums have been allocated to contribution to surplus and risk margin. 21% of this amount will go towards federal income taxes.

[Agent Fees](#)

\$[REDACTED] PMPM agent fees is being assumed for all plans.

[Taxes and Fees](#)

Taxes and regulatory fees include the following:

1. PCORI Fee = \$[REDACTED] PMPM
2. Risk Transfer Fee = \$[REDACTED] PMPM
3. Issuer Fee = estimated at [REDACTED] for 2027

4. The Insurance Provider Assessment Tax = \$ [REDACTED] PMPM
5. 21% of the Contribution to Surplus & Risk Margin is corporate income tax.

Private Reinsurance Cost, Reinsurance Recovery and Subrogation

The private POS reinsurance rate is expected to be at \$ [REDACTED] PMPM for 2027. This provides coverage for losses exceeding \$1,000,000 per member per year for services. The reinsurance recoveries and subrogation in 2025 experience period were \$ [REDACTED] and \$ [REDACTED] PMPM respectively from other products in Michigan. These amounts are on an allowed basis for the sake of this filing.

Private Reinsurance & Subrogation	CY 2025	Rating Period
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

11. PLAN ADJUSTED INDEX RATE

Paid to Allowed Ratios

The paid to allowed ratios (pricing AVs) were developed by Paramount by using the Wakely Pricing Model. The Wakely Pricing Model uses detailed claims data from a nationally-representative sample of over 8 million ACA lives to develop paid-to-allowed pricing estimates for final rate development (as opposed to metal tier categorization). The model uses actuarially-sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out-of-pocket cost sharing parameters on paid claims. Paramount calibrated the utilization and unit cost assumptions in the model to the allowed cost estimates underlying the manual rate and/or experience rate, including adjustments for EHB, trend, provider reimbursement changes and other adjustments discussed elsewhere in this report.

Paramount applied the formula of [REDACTED] to calculate the induced demand adjustment factors which account for the changes in utilization solely due to difference in cost sharing (behavioral factors and not morbidity factors).

The table of actuarial values and induced demand factors are shown in Appendix A, items 11 and 12.

The plan adjusted index rate is the market index rate multiplied by the paid to allowed ratios plus the non-benefit expenses. See appendix A for calculation.

12. CALIBRATION FACTORS

The age, area, and tobacco calibration factors were calculated by taking the inverse of the average respective factor of the base population. The development of these factors can be found in the supporting document '[MI POS ACA 2027 Calibration Factors](#)'.

The impact of this adjustment can be seen in Appendix A, item 24.

The calibration factors are below:

- Age: [REDACTED]
- Area: [REDACTED]
- Tobacco: [REDACTED]

Note: the URRT is multiplying these factors.

13. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The consumer adjusted premium rate development is based on the plan adjusted index rate multiplied by the calibration factors multiplied by the appropriate factors, such as age, smoker, geography, and trend.

14. PROJECTED LOSS RATIO

Paramount estimates indicate projected loss ratio for the small group line of business of [REDACTED] for [2027](#).

Please see the below exhibit for details:

MLR Calculation Component	PMPM
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

The Loss ratio in the URRT will be different since regulatory taxes and quality improvement expenses are not considered in the URRT.

Furthermore with the number of lives below 1,000, any premium refund won't happen due to allow adjustment for credibility being unlimited.

Breakout of QI Expenses

The categories are as follows along with the allocation that comprise of \$ PMPM.

- Improve Health Outcome \$ PMPM
- Activities to Prevent Hospital Readmission \$ PMPM
- Improve Patient Safety and Reduce Medical Errors \$ PMPM
- Wellness and Health Promotion Activities \$ PMPM
- HIT Expenses for Health Care Quality Improvement \$ PMPM.

The above methodology has satisfied an audit.

15. PLAN PRODUCT INFORMATION

AV Metal Levels

The Federal AVC was used without modification to generate the AV metal tier (URRT, Worksheet 2). The Federal AVCs for the plans are as follows:

Federal AVC Values by Metal Level		
Plan Name	Metal Level	Federal AVC

Induced Demand Factors

Benefit richness utilization adjustments were applied to stratify the market adjusted index rate to levels suitable for each of the metal tiers.

The following equation was used for the induced demand:

A regression line was developed to derive the above equation from federal IDF curve. We did not use nationwide membership projections.

The same underlying cost distribution and cost level was used in the development of cost sharing factors, adjusted for only induced demand. Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.

Plan Name	HIOS ID	Projected 2027 MM	Fed AV	Raw ID	Normalized ID

The pricing AVs are different from the Federal AVs primarily because the different estimated allowed PMPMs are different from those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. The other variance is a slight difference in the methodology of the pricing models.

The underlying claims data and membership used to calculate pricing AV is the same for each plan, the only difference is that we reflected the federal induced demand factors which by definition are not morbidity.

16. MEMBERSHIP PROJECTIONS

The membership projections for 2027 were developed by Medical Mutual and Paramount on the population eligible and expected to enroll in the small group POS off-exchange. Actual enrollment is highly dependent on consumer decisions and the competitiveness of rates in the market.

The following table shows estimates of Paramount small group POS off-exchange enrollment by metal tier:

Enrollment Projections		
Plan Name	Metal Level	% Enrollment

17. PLAN TYPE

The plan types for all the small group off-exchange plans are POS. The drop downs in worksheet 2 section 1 of the URRT describe the issuer's plan exactly.

18. TERMINATED PRODUCTS

Paramount will sell and renew ACA compliant policies with effective dates beginning [January 1, 2027](#). There are no new terminated plans or products that were active in [2026](#).

19. EFFECTIVE RATE REVIEW INFORMATION

Not filled out, optional.

20. RELIANCE

Samuel Thomas who works for Medical Mutual of Ohio at 300 Madison Ave., Suite 270, Toledo, OH 43604 relied on information provided by others at Paramount and Medical Mutual. Paramount is part of the Medical Mutual family of companies. This information includes, but is not limited to the following:

- Base data and enrollment, including financial reconciliation
- Membership projections
- Provider contracting levels, including descriptions of the relationship between the Delivery systems and Paramount

- Administrative cost projections
- Profit Margin
- Product design information
- Provider network information including discount data
- CCIIO and the State of Michigan regulatory and compliance interpretations and rulings
- Paramount calculated the AVs from BOA which is developed by Medical Mutual which is item (11) in appendix A, I.D. which is item (12) in appendix A. The Age and Tobacco factors which are in appendix B have not changed from the prior filing. The formula found in appendix A has not changed from the prior filing.
- The Induced Demand formula came from INS Consultants.
- Wakely Consulting provided information for credibility, risk adjustment estimates, and the Wakely Pricing Model which helped calculate the plan-specific pricing AVs

21. ACTUARIAL CERTIFICATION

I, Samuel Thomas, am an Associate in the Society of Actuaries (ASA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries for preparing premium rate filings for insurers.

This actuarial certification applies to the Paramount Care of Michigan small group POS product to be offered outside of the federal health exchange.

1. The premium rates filed are in compliance with applicable laws, rules and guidelines of the State of Michigan
2. The premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory
3. The premium rates are calculated on the basis of sound actuarial principles
4. The premium rates are reasonable when related to the applicable coverage and characteristics of the applicable class of enrollees.
5. The index rates are developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates.
6. The premium rates filed are prepared in conformity with the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board that are listed below:

ASOP No. 5, Incurred Health and Disability Claims

ASOP No. 8, Regulatory Filings for Health Plan Entities

ASOP No. 12, Risk Classification

ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures

ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans

ASOP No. 41, Actuarial Communication

ASOP No. 42 - Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

ASOP No. 50 - Determining Minimum Value and Actuarial Value under the Affordable Care Act

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are neither excessive nor deficient although actual experience will vary from the estimates given the inherent uncertainty in developing premium rates under the ACA.

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.

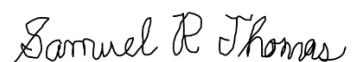
The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs. All benefits are EHB plus two small non-EHB benefits.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The geographic are rating factors do only reflect the differences in the costs of delivery.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

A handwritten signature in cursive script that reads "Samuel R Thomas".

Samuel Thomas, ASA, MAAA
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Appendix A

This below template is for the calculation of the consumer index rate effective [January 1, 2027](#).

Rating Work Flow - Template				
This rating model uses small group experience to develop exchange premiums for small group market				
Small Group Claims Experience	Medical	Rx		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Manual Rate				
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]		[REDACTED]	
[REDACTED]	[REDACTED]		[REDACTED]	
Develop Projected Claim Cost from Experience	Med + Rx			
[REDACTED]	[REDACTED]		[REDACTED]	
[REDACTED]	[REDACTED]			
[REDACTED]	[REDACTED]			
[REDACTED]	[REDACTED]			
[REDACTED]	[REDACTED]		[REDACTED]	

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Appendix B

Rating Factors

Plan Name	Induced Demand	Pricing AVs	Cost Sharing Factors

Rating Area	Previous Factor	Proposed Factor	Counties in Rating Area

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Quarterly Trending Factors

These factors were derived by using the methodology in Appendix A and having the trend factor which item is (1) uses a three-year instead of a two- year trend. All the other assumptions such as AV, ID and non-benefit expenses remain the same.

Using Plan Adjustment Rate for 2027 \$ [REDACTED]
Using Plan Adjustment Rate for 2028 \$ [REDACTED]

2028 to 2027 Ratio [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]

Family Structure – Family rates can be determined by adding up the rates for an individual. However, when calculating the total family rate, the charge is limited to the first three children under the age of 21. There is no limitation on children over 21.

Example Rate Buildup:

Rate Build up

Example

Plan : ACA POS MI MID GOLD \$ [REDACTED]

Age 41 X [REDACTED]
Rating Area 4 X [REDACTED]
Smoker Yes X [REDACTED]
Effective Date July 1, 2027 X [REDACTED]

Rate to Charge \$ [REDACTED]

Appendix C – Michigan Checklist

In another file that has been submitted

Appendix D -Non-Applicable ASOPs

None

Appendix E - Final Rates

In another file that has been submitted

Appendix F

In another document that has been submitted