15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

Erik C. Huth, FSA, MAAA
Consulting Actuary

erik.huth@milliman.com

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Wisconsin Actuarial Memorandum
Physicians Plus Insurance Corporation
Individual Rate Filing – Wisconsin
Effective January 1, 2017

1. GENERAL INFORMATION

Company Identifying Information

Company Legal Name:	Physicians Plus Insurance Corporation
State:	Wisconsin
HIOS Issuer ID:	58564
Market:	Individual
Effective Date:	January 1, 2017
SERFF IDs:	PHPI-130655110

Company Contact Information

Primary Contact Name:	Corey Huber
Primary Contact Telephone Number:	(608) 417-4547
Primary Contact Email-Address:	corey.huber@pplusic.com

Description of Benefits

The Network Choice product (58564WI026) provides coverage for inpatient, outpatient, physician, prescription drugs, and miscellaneous services subject to deductible, coinsurance, and copays. All member cost-sharing applies to the maximum out-of-pocket amount. Pharmacy cost sharing for some plans reflects a five-tier (generic tier 1, generic tier 2, formulary brand, non-formulary brand, and specialty) copayment or coinsurance structure. For other plans, the deductible and coinsurance apply to pharmacy costs instead of the five-tier copay structure.

Network Choice plans are available at Gold, Silver, Bronze, and Catastrophic benefit levels, with individual deductibles ranging from $2,000 to $7,150 per year. Member coinsurance percentages range from 0% to 50%. Individual out of pocket maximums range from $2,500 to $7,150 per year. Pharmacy cost sharing is included in the out of pocket maximum for all plans.

The Network Choice product includes one HMO network with two service areas, includes adult vision benefits that exceed the Essential Health Benefits (EHBs), and does not include wellness benefits.

2. SCOPE AND PURPOSE, PROPOSED RATE CHANGE(S)

Scope and Purpose

This Wisconsin Actuarial Memorandum applies to Physicians Plus Insurance Corporation's (PPIC's) off-exchange individual plans with effective dates of January 1, 2017 through December 31, 2017. Note that Physicians Plus will no longer offer plans on the individual exchange. This filing is both an initial rate filing for new plans and a requested rate change filing for PPIC's individual Affordable Care Act (ACA) compliant plan rates filed for effective dates January 1, 2016 through December 31, 2016. Many plans that were available on the exchange in 2016 are being "cross walked" to 2017 off-exchange plans, as displayed in Exhibit 1. The experience basis, benefit plans, rating factors, and other projection assumptions were updated for this filing.

The overall requested renewing / cross-walked plan rate change is [redacted]. Requested rate changes vary by plan due to changes in determining plan pricing relativities, cross walking methodology, and changes in geographic rating factors. The minimum and maximum rate changes by plan are [redacted] and [redacted], respectively.

The overall plan base rate change is [redacted]. The plan base rate change is the change in the 21-year-old non-tobacco user base rate from 2016 to 2017 for each plan.

2017 geographic rating factors changed (although the relativities between Dane and non-Dane areas did not change) based on PPIC's projected geographic distribution to make the geographic rating factors composite to 1.000. 2017 tobacco factors have not changed from 2016, except for minor revisions to age 30, 31, 34, 35, 39, 58 and 59 tobacco factors. There is no overall rate impact due to this minor revision.

Exhibit 1 provides a comparison of 2016 and 2017 plan base rates. Exhibit 1 rate changes are the same for all ages since the age rating factors do not change.

Two ACA plans available in 2016 will be terminated effective December 31, 2016. Ten plans available in 2016 will be "cross walked" to new 2017 plans, and five plans available in 2016 will continue without change. Four new plans will be available in 2017.

This submission does not include proposed rate changes on transitional policies which will be addressed in a separate submission.

This filing applies to the Network Choice products in PPIC's Single Risk Pool (SRP):

This Wisconsin Actuarial Memorandum is submitted in conjunction with the following components of a comprehensive rate filing package:

- Wisconsin Product List
- Part I Unified Rate Review Template (URRT)
- Part II Rate Increase Justification
- Wisconsin Rate Pages and Service Area Template
- Federal Rate Data Template
- Rate Filing Actuarial Certification
- Wisconsin Product Data Template (one spreadsheet for each product identified in Wisconsin Product List)

All of the above filing components (and their attachments) must be reviewed in aggregate because they rely on others for a full explanation of the rate development process, assumptions, caveats, and limitations. This Actuarial Memorandum is subject to the terms and conditions of the Consulting Services Agreement between Physicians Plus Insurance Corporation and Milliman signed November 17, 2004. This information is intended for use by the State of Wisconsin Office of the Commissioner of Insurance (OCI), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of PPIC's individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this Actuarial Memorandum prepared for PPIC by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Reason for Rate Increase(s)

Along with presenting rates for newly offered plans in 2017, this rate filing is intended to request a rate change for the currently filed individual rates effective January 1, 2016 through December 31, 2016.

Premium rates are developed based on historical experience for individual medical business sold through PPIC, in conjunction with internal research proprietary to Milliman and other industry studies and surveys. The primary drivers of the rate change are:

- Base Experience –PPIC's 2017 premium rates are based on blended 2014 and 2015 individual non-grandfathered experience, while PPIC's 2016 premium rates are based on blended 2013 and 2014 individual non-grandfathered experience.

- Trend – The [redacted] annual trend used to project 2017 experience from the 2014 and 2015 base experience is lower than the trend used to project the 2013 and 2014 experience forward to 2016 in last year's rate development.

- Provider Reimbursement – PPIC's negotiated provider discounts are different in 2017 relative to both the experience period and 2016. The projected claims is adjusted to reflect this change in provider reimbursement.

- Risk Adjustment Transfer Payments – I estimate a risk adjustment transfer payment for the 2017 rate development compared to the estimate of no risk adjustment transfer estimated in the 2016 rate development.

- Federal Transitional Reinsurance Program – The federal reinsurance program is no longer applicable starting in 2017. Therefore, PPIC has not projected any federal reinsurance recoveries or contributions for calendar year 2017.

- Morbidity – I include [redacted] morbidity load to the 2014 and 2015 non-ACA experience for the 2017 rate development compared to [redacted] morbidity load in the 2016 rate development.

- Health Insurance Fee – 2016 rates had a [redacted] load priced in to cover the federal health insurer tax. For the 2017 benefit year, this fee has been eliminated so the load is removed.

- Exchange User Fee – 2016 rates assumed [redacted] of members would purchase plans on the exchange. Beginning in 2017, PPIC will only offer individual plans off exchange, so the 3.5% Exchange User Fee no longer applies.

- Administrative costs, taxes and fees, profit and risk loads – These retention items, which exclude reinsurance contribution and risk adjustment fees, [redacted] from [redacted] in 2016 to [redacted] in 2017.

- Other Factors – Other factors includes changes in plan benefits, changes in the methodology of determining pricing relativities among plans, and changes in determining the plan design behavior factors of plans.

The premium rate development is discussed in more detail later in this memorandum.

Prospective Trend

The annualized Medical Trend (defined by the OCI as "the combined effect of medical provider price and / or capitation changes, utilization changes, medical cost shifting, and new medical procedures and technology") expected for the 12 months directly following the effective rate of the filing is [redacted]

The annualized Insurance Trend (defined by the OCI as "the combined effect of underwriting wear-off, deductible leveraging, anti-selection resulting from rate increases, discontinuance of new sales, and any other factor affecting claims") expected for the 12 months directly following the effective rate of the filing is [redacted]

3. EXPERIENCE PERIOD PREMIUM AND CLAIMS

PPIC is a managed care organization, contracting with provider networks to provide medical and pharmacy benefits to its members. PPIC contracts with some providers on a capitated basis, and with others on a fee-for-service basis. PPIC's contractual arrangements for capitated services and actual claims for non-capitated services are directly incorporated into the development of the 2017 rates.

Paid Through Date

The claims incurred in the experience period for both non-capitated and capitated services reflect payments through March 15, 2016.

Premiums (Net of MLR Rebate) in Experience Period

The earned premium reported in Worksheet 1, Section I of the URRT reflects the sum of member level non-grandfathered premium from PPIC's enrollment records for the experience period (calendar year 2015), adjusted to account for estimated 2015 risk adjustment receipts. PPIC's 2015 individual loss ratio exceeded the MLR requirement. Therefore, an adjustment for MLR rebates is not included.

Allowed and Incurred Claims During the Experience Period

Table 1 provides a breakdown of the allowed and incurred claims during the experience period, as illustrated in the Worksheet 1, Section I of the URRT.

Table 1
Physicians Plus Insurance Corporation
Allowed and Incurred Claims Incurred During the Experience Period

	From Issuer's Claim System	Outside Issuer's Claims System	Incurred But Not Paid (IBNP)	Total
Experience Period Incurred Claims	$6,200,392	$807,727	$132,629	$7,140,748
Experience Period Allowed Claims	$7,442,695	$1,195,715	$160,711	$8,799,121

PPIC processes all medical claims internally. Prescription drug claims are processed by a separate external vendor.

The allowed claims are provided directly from PPIC's claim records. The capitation payments are converted to a fee-for-service equivalent basis.

PPIC developed the completion factors used in the rate development. I reviewed the factors using generally accepted actuarial development methods for estimating claim liabilities. Consideration is given for liabilities calculated using a claim cost or loss ratio method for recent incurral months prior to the valuation date that have less data available (e.g., 1 - 3 months).

4. BENEFIT CATEGORIES

Categories are assigned based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- Inpatient Hospital includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an 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.
- Other Medical includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.
- Prescription Drug includes prescriptions not billed by a facility or professional.

5. PROJECTION FACTORS

PPIC rates rely on 2014 individual non-ACA experience (credibility manual) and 2015 ACA and non-ACA experience (experience period) with each year weighted equally.

Changes in the Morbidity of the Population Insured

The experience in Worksheet 1, Section II of the URRT displays the combined 2015 individual ACA and non-ACA allowed claims experience, per the URRT instructions. I apply a morbidity load of [redacted] only to the individual non-ACA experience since I estimate the non-ACA membership is much healthier than the ACA membership. I determine the morbidity load by estimating the risk scores for the 2015 non-ACA and ACA enrollment from the HHS-HCC Risk Adjustment Model and normalizing for demographics. Because the [redacted] morbidity adjustment is applied only to the non-ACA experience, the final factor used is [redacted] to account for the fact that Worksheet 1, Section I experience contains both ACA and non-ACA allowed claims.

Changes in Benefits

The covered benefits underlying PPIC's 2015 individual non-ACA experience are increased to meet the essential health benefits (EHB) mandated in the 2017 ACA covered benefits. Prescription drugs and maternity benefits were covered through riders, which were optional and not included on all plans. In addition to those adjustments, there are non-EHB adult vision benefits offered in the individual ACA plans.

The average benefit plan underlying the experience period composites to a richer benefit than the expected plan distribution in 2017. The impact on the average utilization of services due to differences in average cost sharing requirements during the experience period vs. the projection period are reflected in the 2017 rate development.

Changes in Demographics

I model PPIC's projected 2017 member demographics (age and gender) based on PPIC's 2015 ACA population distribution. I model PPIC's projected 2017 ACA metal plan mix based on the 2015 benefit year distribution by metal level. PPIC's projected 2017 members are, on average, older than the experience period members.

Other Adjustments

PPIC has negotiated 2017 provider discount levels different from those underlying the 2015 experience. I reflect these changes in the projected costs. I model the 2017 region mix based on PPIC's 2015 ACA region distribution.

Trend Factors (Cost / Utilization)

[redacted] I develop the trend assumptions to reflect PPIC's expectations regarding increases in utilization of services and provider unit costs. I also consider general industry reports regarding recent trends in medical inflation.

6. CREDIBILITY MANUAL RATE DEVELOPMENT

PPIC rates rely on 2014 individual non-ACA experience (credibility manual) and 2015 ACA and non-ACA experience (experience period) with each year weighted equally. I use the 2014 individual non-ACA experience to develop the credibility manual rate.

Source and Appropriateness of Experience Data Used

The credibility manual rate utilization and unit cost as shown in URRT Worksheet 1, Section II are based on PPIC's 2014 individual non-grandfathered, non-ACA experience. The 2014 non-ACA plans represent claims paid under the same provider network plans and medical management practices as the ACA plans.

Adjustments Made to the Data

Changes in the Morbidity of the Population Insured

I develop a morbidity adjustment to reflect that 2017 individual market health status is different from the pre-ACA individual market health status that underlies the 2014 non-grandfathered, non-ACA experience of the manual rate.

I apply a morbidity load of [redacted] to the 2014 individual non-ACA experience since I estimate the non-ACA membership is healthier than the ACA membership. I determine the morbidity load by estimating the risk scores for the 2014 non-ACA enrollment from the HHS-HCC Risk Adjustment Model and normalizing for demographics.

Changes in Benefits

The covered benefits underlying PPIC's 2014 individual experience are increased to meet the essential health benefits (EHB) mandated in the 2017 covered benefits. Prescription drugs and maternity benefits were covered through riders, which were optional and not included on all plans. In addition to those adjustments, there are non-EHB adult vision benefits offered in the individual ACA plans.

The average benefit plan underlying the credibility manual composites to a richer benefit than the expected plan distribution in 2017. The impact on the average utilization of services due to differences in average cost sharing requirements during the experience period of the credibility manual vs. the projection period are reflected in the 2017 rate development.

Changes in Demographics

I model PPIC's projected 2017 member demographics (age and gender) based on PPIC's 2015 ACA population distribution. I model PPIC's projected 2017 ACA metal plan mix based on 2015 enrollment year. PPIC's projected 2017 members are, on average, older than the experience period members.

Other Adjustments

PPIC has negotiated 2017 provider discount levels different from those underlying the 2014 experience. I reflect these changes in the projected costs. I model the 2017 region mix based on PPIC's 2015 ACA population distribution.

Trend Factors (Cost / Utilization)

[redacted] I develop the trend assumptions to reflect PPIC's expectations regarding increases in utilization of services and provider unit costs. I also consider general industry reports regarding recent trends in medical inflation.

Inclusion of Capitation Payments

Capitated claims are included based on a fee-for-service equivalent basis.

7. CREDIBILITY OF EXPERIENCE

PPIC's 2014 and 2015 individual, non-grandfathered, non-ACA experience includes approximately 61,000 combined member months. The 2014 non-grandfathered non-ACA experience contains more member months than the 2015 non-grandfathered non-ACA experience and I assign equal weight to each year of experience since the 2015 non-grandfathered non-ACA experience is more recent. I assign 100% credibility to the combined 2014 and 2015 experience.

8. PAID TO ALLOWEDALLOWED RATIO

The paid to allowed ratio shown in Worksheet 1, Section III of the URRT is developed by calculating the average ratio of paid (i.e., after member cost sharing) to allowed (i.e., before member cost sharing) claims for each plan, weighted by projected member months by plan. Appendix A uses membership consistent with the projections by plan in Worksheet 2, Section IV of the URRT. Table 2 shows the paid to allowed ratio by metal level.

Table 2
Physicians Plus Insurance Corporation
Paid to Allowed Ratio

Metal Level	Member Months[1]	Paid Claims PMPM[1]	Allowed Claims PMPM[1]	Paid to Allowed Ratio[2]
Platinum				
Gold				
Silver				
Bronze				
Catastrophic				
Total				

[1] *Member month-weighted average by metal level from Worksheet 2, Section IV.*
[2] *The total paid-to-allowed ratio is consistent with Worksheet 1, Section III.*

9. RISK ADJUSTMENT AND REINSURANCE

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

I use the Wisconsin risk adjustment simulation study conducted by Milliman to estimate 2015 risk transfers. That estimate is very close to the actual transfer calculated by CMS and communicated in the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* report issued by CMS on June 30, 2016 so I make no adjustments to the original estimate.

The experience period "Net Amount of Reinsurance" reported in URRT Wksh 2, Section III is from the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* report issued by CMS on June 30, 2016, adjusted to be net of reinsurance user fees.

Projected Risk Adjustments (Net of User Fees) PMPM Development

I assume a 2017 risk adjustment transfer [redacted] of premium for metallic plans and a risk adjustment transfer [redacted] for catastrophic plans. I also include the risk adjustment administrative fee of $0.13 PMPM per the URRT instructions.

The [redacted] metallic [redacted] assumption is based on Milliman's Wisconsin risk adjustment simulation study, removing the impact of CSR factors since PPIC will only be offering plans off the exchange in 2017. The [redacted] catastrophic [redacted] assumption is based on Milliman's Wisconsin risk adjustment simulation study. Milliman used 2015 data from Wisconsin issuers to develop an estimate of 2015 risk adjustment transfers. The inputs to the federal risk adjustment transfer payment formula from this study are shown in Exhibit 2. I assume the same percent transfer in the projection period as in the experience period of 2015, with the exception of adjusting to remove the impact of CSR membership.

Projected Risk Adjustment (Net of User Fees) PMPM Allocation

I allocate the projected risk adjustment (net of user fees) proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer factor as a constant multiplicative factor across plans.

10. NON-BENEFIT EXPENSES AND PROFIT AND RISK

Administrative Expense Load

Table 3 displays PPIC's estimated administrative expenses of [redacted] PMPM. Administrative expenses are developed based on PPIC's 2015 actual expenses. General administrative expenses are increased to reflect PPIC's projected 2017 expenses. This estimate is entered as a percent of premium that does not vary by plan in Worksheet 1, Section III of the URRT. This amount does not include any profit, risk load, taxes, or assessments described below.

Table 3
Physicians Plus Insurance Corporation
Summary of Administrative Expenses

	Administrative Expenses	
Description	**PMPM**	**% of Premium**
General Admin	[redacted]	[redacted]
Commission	[redacted]	[redacted]
Commercial Reinsurance Recoveries	[redacted]	[redacted]
Commercial Reinsurance Premiums	[redacted]	[redacted]
Quality Improvement	[redacted]	[redacted]
Total	[redacted]	[redacted]

Contribution to Surplus (or Profit) and Risk Load

I build in [redacted] of premium for pre-tax profit, [redacted]. Note that we are showing post-tax profit in URRT Worksheet 1 per instructions. [redacted]

The target contribution to surplus does not vary by product or plan. I consider the uncertainty of estimated claims in the 2017 market and federal MLR requirements in the target. PPIC filed a pre-tax profit and risk load of 2.6% last year.

Taxes and Fees

Table 4 displays the projected taxes and fees that may be subtracted from premiums when calculating PPIC's loss ratio for MLR purposes (with the exception of the risk adjustment administrative fee of $0.13 PMPM, which is not included in this section). The composite value is displayed in Worksheet 1, Section III of the URRT.

Note that taxes and fees in 2017 rates do not include a load for the federal Health Insurer Tax.

Table 4
Physicians Plus Insurance Corporation
Summary of Taxes and Fees

Item	PMPM	% of Premium
Comparative Effectiveness Research Fee	[redacted]	[redacted]
Federal Income Tax	[redacted]	[redacted]
Total		

There is no exchange fee because PPIC is offering all plans off the exchange.

Exhibit 3 displays the overall net expense factor.

11. PROJECTED LOSS RATIO

The projected loss ratio based on federally prescribed MLR methodology, excluding allowable adjustments, such as for credibility, quality improvement expenses, and high deductible is [redacted], as shown in Exhibit 4.

12. SINGLE RISK POOL

The experience includes all non-grandfathered individual plans, including transitional plans. Transitional plan members are not expected to enroll in ACA compliant plans during the projection period as displayed in Table 5 below.

Table 5
Physicians Plus Insurance Corporation
Transitional Product Nonrenewal Dates

Transitional Product - OCI Product Name	Anticipated Nonrenewal Date
Individual Closed Non-GF HDHP HMO	12/31/2017
Individual Closed Non-GF HMO	12/31/2017
Individual Open Non-GF HDHP HMO	12/31/2017
Individual Open Non-GF HMO	12/31/2017

13. INDEX RATE

Index Rate Development

The index rate represents the estimated total combined allowed PMPM claims of all non-grandfathered plans within PPIC's individual Wisconsin market related to essential health benefits (EHBs). The index rate is not adjusted for risk adjustment transfers, reinsurance fees / recoveries, or Exchange fees.

The experience period index rate is equal to the experience period total allowed claims PMPM (combining ACA and non-ACA experience), less ACA non-EHB benefits. Section 3 describes the development of the experience period allowed claims PMPM. The experience period index rate PMPM removes non-EHBs from the experience period allowed claims. The index rate for January 1, 2015 through December 31, 2015 is $311.00, as shown in Worksheet 1, Section II of the URRT.

I develop the 2017 projected index rate by adjusting the credibility manual rate experience period allowed PMPM claims for trend, benefit, morbidity, network, and demographic differences. The projected index rate for January 1, 2017 through December 31, 2017 is [redacted], as shown in Worksheet 1, Section III of the URRT. The projected index rate does not equal the projected allowed claims PMPM since there are additional benefits offered beyond the EHB.

14. MARKET ADJUSTED INDEX RATE

The market-adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 CFR Part 156, §156.80(d)(1). Table 6 summarizes the factors applied to the index rate in the projection period to determine the market-adjusted index rate. The impact of the market adjustments is calculated on an allowed basis to be consistent with the index rate by dividing the paid PMPM totals by the paid to allowed average factor.

Table 6
Physicians Plus Insurance Corporation
Market Adjusted Index Rate Development

Index Rate	[redacted]	*(1)*
Net Risk Adjustment	[redacted]	*(2)*
Net Transitional Reinsurance	[redacted]	*(3)*
Exchange Fee	[redacted]	*(4)*
Sum of Market Impact Reforms (Paid)	[redacted]	*(5) = (2) + (3) + (4)*
Paid to Allowed Average Factor	[redacted]	*(6)*
Impact of Market Reforms (Allowed)	[redacted]	*(7) = (5) / (6)*
Market-Adjusted Index Rate	[redacted]	*(8) = (1) + (7)*

15. PLAN ADJUSTED INDEX RATE

The market-adjusted index rate is adjusted to compute the plan-adjusted index rates using the following allowable adjustments:

Actuarial Value and Cost Sharing Adjustment

The actuarial pricing values and cost-sharing factors are developed using an internal Milliman cost relativity model, which is based on Milliman's *Health Cost Guidelines (HCGs)*. This model estimates actuarial equivalent relative values of different benefit plans using estimated medical costs calibrated to PPIC (including service area, provider reimbursement, degree of health care management, etc.). The portion of the cost that is expected to be recouped through the tobacco surcharge is incorporated into the actuarial value and cost sharing adjustment. Appendix B displays this development.

The tobacco surcharge is removed from the Index Rate. The tobacco rating factors vary by age ranging from 1.000 for children to as high as 1.180 for adults. Exhibit 5 outlines the application of the tobacco rating factors by age and gender and includes the development of the tobacco surcharge adjustment as shown in Appendix B.

Provider Network, Delivery System, and Utilization Management Adjustment

PPIC provided their estimated provider network discounts based on their contractually negotiated reimbursement arrangements.

Adjustment for Benefits in Addition to the EHB

I make an adjustment for non-EHBs since PPIC's plans include adult vision services.

Adjustment for Distribution and Administrative Costs

Distribution and administrative costs are developed and applied to each plan as a percent of premium. These administrative costs are allowable plan-level adjustments under 45 CFR Part 156 § 156.80 (d) (2) (iv), which states that "actuarially justified plan-specific factors" include "Administrative costs, excluding Exchange user fees."

The development of the plan-adjusted index rates is shown in Appendix C. Exhibit 3 shows the development of the net expense factor.

Catastrophic Plan Adjustment

The adjustment is developed to reflect the impact on the Plan Adjusted Index Rate of the projected difference in demographic characteristics of those enrolling in a catastrophic plan as compared to the entire single risk pool.

Appendix C shows the development of the plan-adjusted index rates.

16. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates to calibrate rates for the expected age and geographic distributions expected to enroll in the plan. The single calibration factor is applied uniformly across all plans.

Age Curve Calibration

The approximate weighted average age factor of the single risk pool represents an average age of approximately [redacted]. The age curve factor calibration is applied to all plans. The age calibration factor is the

multiplicative inverse of the weighted average of the standard federal age curve and PPIC's 2017 projected membership. Exhibit 6 shows the development of the age calibration factor.

Geographic Factor Calibration

PPIC applies geographic rating factors to its plans as shown in Table 7. The geographic rating factors are developed based on projected provider reimbursements, and composite to a 1.000 factor.

Table 7
Physicians Plus Insurance Corporation
Geographic Factors

Rating Area	Factor
Rating Area 2	0.992
Rating Area 7	1.088
Rating Area 11	1.088
Rating Area 14	1.088
Rating Area 15	1.088

The development of the calibrated plan-adjusted index rates are shown in Appendix D.

17. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The consumer-adjusted premium rate is the final premium rate for a plan charged to an individual utilizing the rating and premium adjustments as articulated in the applicable market reform rating rules. It is the product of the calibrated plan adjusted index rate, the geographic rating factor, the age rating factor, and the tobacco factor. The age factors used by PPIC are identical to those prescribed by CMS. Industry research regarding tobacco use and differences in health costs for smokers by age is used as the basis of our adjustment factors. Family premiums are calculated on a per-member basis consistent with 45 CFR Part 147 § 147.102.

Attachment A displays a sample rate calculation.

18. AV METAL LEVELS

The AV Metal Values included in Worksheet 2, Section I of the URRT are developed using the CMS Actuarial Value Calculator. Attachment B displays the AV Calculator screenshots of each metal plan.

19. AV PRICING VALUES

Appendix E provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and a breakdown of the components attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2), to arrive at the plan level rate.

Appendix B provides the actuarial values and cost sharing factor calculation, which is the product of the non-normalized actuarial value and the normalized benefit design behavior change factors from our pricing models. The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's benefit design on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We use the Milliman *HCGs* to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same

demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

20. MEMBERSHIP PROJECTIONS

Marketing Method

The products in this filing will be sold:

- Only to individuals
- Off the Federally Facilitated Exchange (FFE) only
- Through licensed independent agents

Development of Membership Projections

The projected membership (as displayed in Worksheet 2, Section IV of the URRT) is determined by considering the size of the projected Wisconsin individual market in 2017 in the plan's service area and an assumed penetration rate of this market. The size of the market is estimated based on the following:

- Historical sales and underwriting data for PPIC individual business.
- Anticipated activity in the Wisconsin individual health insurance market due to various health care reform provisions.
- Exchange enrollment based on data released by HHS.

PPIC's penetration rate in the market is determined based on PPIC's input from their 2016 ACA individual sales to date. All projected membership will be off exchange since PPIC will no longer be offering individual plans on the exchange. Accordingly, I project no enrollment in cost sharing reduction (CSR) plans.

21. TERMINATED PRODUCTS

Exhibit 7 shows the list of ACA terminated plans.

22. PLAN TYPE

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

23. WARNING ALERTS

The following two warning alerts appear in Worksheet 2, Section III of the URRT:

- Plan Adjusted Index Rate (row 55) - This variance has two causes:
  - The experience Plan Adjusted Index Rate reported in Worksheet 2, row 55 for single risk pool compliant plans is based on the Plan Adjusted Index Rate filed for 2015, consistent with URRT instructions. Thus, unlike the premium reported in Worksheet 1, it is not based on actual experience.
  - The experience Plan Adjusted Index Rate reported in Worksheet 2, row 55 for non-single risk pool compliant plans is zero, consistent with URRT instructions. The experience premium entered in Worksheet 1 is the premium for all non-grandfathered experience, consistent with

URRT instructions, so a non-zero amount is included for non-single risk pool compliant plans in the Worksheet 1 experience premium.

- Total Premium (row 57) – The experience Plan Adjusted Index Rate reported in row 55 of Worksheet 2 for single risk pool compliant plans is based on the Index Rate filed in 2015, the market adjustments filed in 2015 and the allowable plan adjustments in 2015, consistent with URRT instructions. Thus, unlike the premium reported in Worksheet 1, it is not based on actual experience.

24. RELIANCE

In performing this analysis, I relied on data and other information provided by PPIC. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review is beyond the scope of the assignment.

A data reliance letter is attached to this rate submission.

25. ACTUARIAL CERTIFICATION

This certification includes:

__ Prescribed Wording Only
_X_ Prescribed Wording with Additional Wording
__ Revised Wording

PRESCRIBED WORDING:

I, Erik C. Huth, am a member of the American Academy of Actuaries (Academy) and I meet the Academy qualification standards for rendering this opinion.

I certify that, to the best of my knowledge and judgment:

- The entire rate filing is in compliance with the applicable laws of the state of Wisconsin and with the rules of the Office of the Commissioner of Insurance,
- The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations,
- The index rate and allowable modifiers as described in 45 CFR § 156.80 (d)(1) and 45 CFR § 156.80(d)(2) are used in the development of plan-specific premium rates,
- The essential health benefit portion of premium, upon which advanced payment of premium tax credits (APTCs) are based, is appropriate and is developed in accordance with Actuarial Standards of Practice,

- The methodology used to calculate the AV Metal Value for each plan complies with federal regulations,
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area,
- The entire rate filing, including development of the projected index rate and all rating factors, complies with all applicable Actuarial Standards of Practice,
- The projected index rate and rating factors are reasonable in relation to the benefits provided and the population anticipated to be covered, and
- The premium schedule, including the projected index rate and rating factors, is not excessive, deficient, nor unfairly discriminatory.

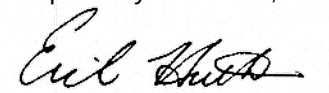
ADDITIONAL WORDING:

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of 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 the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT but does not provide an actuarial opinion regarding the use of those items in our process to develop proposed premium rates. However, it does certify rates are developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Respectfully submitted,



Erik C. Huth, FSA, MAAA
Consulting Actuary
Milliman, Inc.

ECH/zk