Network Health Plan
Actuarial Memorandum - Primary
2026 Individual Single Risk Pool Filing
State of Wisconsin

1. **General Information**

Company Identifying Information:

- Company Legal Name: Network Health Plan
- State: Wisconsin
- HIOS Issuer ID: 81413
- Market: Individual
- Effective Date: January 1, 2026
- SERFF IDS: NHPC-134550190

Company Contact Information:

[redacted]

Description of Benefits:
The products associated with this filing cover a wide range of benefits, including all Essential Health Benefits (EHBs) required under the Affordable Care Act (ACA), except for pediatric dental benefits. Stand-alone pediatric dental plans are available to satisfy the EHB requirements. [redacted]

Network Health Plan (Network Health) will offer plans at the bronze, silver, and gold metal levels. Network Health will not offer a Catastrophic plan nor plans at the Platinum metal level. Services will be subject to deductibles, copays, and coinsurances. Member cost-sharing will be limited to out-of-pocket maximums (OOPMs). A range of cost-sharing options will be provided to consumers. Deductible options will range from $0 to $7,750 for single coverage, member coinsurance options will range from 0% to 50%, and OOPM options will range from $700 to $10,000 for single coverage. Some plans will feature copayments for physician services, certain diagnostic tests, urgent care services, and prescription drug fills. Consumers meeting income requirements as detailed under the ACA will be able to access Cost-Sharing Reduction (CSR) plans.

2. **Scope and Purpose, Proposed Rate Change**
Scope and Purpose
   - This filing is a rate change filing
     The purpose of this filing is to file a rate change for the single risk pool products Network Health intends to offer in the individual market with effective dates of January 1, 2026 through December 31, 2026. This actuarial memorandum has been prepared to demonstrate compliance with the applicable laws of the State of Wisconsin and the applicable requirements of the Affordable Care Act (ACA). This actuarial memorandum is not intended for any other purpose.

     The following product IDs are associated with this rate filing: 81413WI046, 81413WI047, 81413WI048, and 81413WI049.

   - Requested rating factor changes
     We are filing updated calibrated Plan Adjusted Index Rates and their corresponding pricing actuarial values (AVs).

   - Plan base rate change and overall rate change
     The average requested rate changes for Product IDs 81413WI046, 81413WI047, 81413WI048, and 81413WI049 [redacted]

[redacted] A summary of the requested base rate changes by product is shown below. Enrollment and premium as of [redacted] was used.

[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

*The minimum and maximum relate to rate table changes and may not reflect actual results experienced by members.

- Description of any significant changes in member cost-sharing:

[redacted]

- Description of any changes to service area: [redacted]
- High-level summary of the provider networks: [redacted]
- Reason rate change is not the same across all products and plans: [redacted]
- Explanation of how the impact of morbidity was removed from impacting the variance in rate changes across products or plans: [redacted]

Reason for Rate Change

[redacted]

Expiration of ARP/IRA Subsidies

The expiration of the enhanced premium tax credits at the end of 2025 will require members to pay higher premiums. As a result, we expect the morbidity of the risk pool to deteriorate as healthier members decide to terminate coverage due to increased costs. We assume a [redacted] increase in the morbidity of the risk pool due to the expiration of the enhanced subsidies. More detail can be found in section 5 under the Changes in Morbidity of the Population Insured heading.

Cost-Sharing Reduction (CSR) Information
This section is meant to comply with CMS guidance released in the bulletin titled Plan Year 2026 Individual Market Rate Filing Instructions, which requires additional information about CSRs. The CSR load and an explanation of how the CSR load was determined can be found in section 15 under the CSR Load heading.

The table below shows the actual CSRs Network Health paid in plan year 2024, the expected CSRs that will be provided to enrollees in 2026, and the expected additional revenue collected from the applied CSR load in 2026. The additional revenue is the increased premium for silver plans to account for the lack of CSR funding. [redacted]

[redacted]

Wisconsin Health Stability Plan (WIHSP) Impact
The overall rate change assuming 100% payment of reinsurance-eligible claims using the 2026 parameters of 50.00% coinsurance with a $50,000 attachment point and $214,738 cap under the WIHSP program [redacted]

The overall rate change assuming 0% payment under the WIHSP program is [redacted]
We performed an internal study using 2024 experience, trended, and adjusted for morbidity and demographic changes applying the 2026 WIHSP thresholds and coinsurance to develop the claims impact. The lower average premium resulting from the presence of the reinsurance program was used in the development of the risk transfer estimate. The difference between the two rate change estimates above includes both the change in risk adjustment transfer and the impact of non-benefit expenses. The estimated reduction in claims due to WIHSP is approximately [redacted] PMPM.

The table below shows a breakdown of the impact of reinsurance by component. We included a small adjustment to morbidity to account for the higher enrollment due to the reinsurance program. The change in risk adjustment is strictly due to the higher expected statewide average premium without reinsurance.

[redacted]

Provider Networks

[redacted]

Prospective Trend

We anticipate the annualized medical trend rate for the 12-month period following the effective date of this filing to [redacted] This annualized trend rate reflects the average annualized trend rate applied to the individual ACA experience as noted in the Projection Factors section of this memorandum. Our 2026 trend is based on forward expectations considering provider contract fee escalators, experience over multiple years, and industry trends.

We anticipate the annualized insurance trend rate for the 12-month period following the effective date of this filing [redacted]

Risk Adjustment Data Validation (RADV)

Confirming the 2026 pricing does not reflect any anticipated impact of the RADV or Risk Corridor.

3. **Experience Period Premium and Claims**

The following information relates to the information shown on Worksheet 1, Section I, of the Part I Unified Rate Review Template (URRT).

Paid Through Date

The experience period includes claims incurred from January 1, 2024 to December 31, 2024 with claims paid through February 28, 2025.

Experience Period Earned Premium

[redacted]

[redacted]

Allowed and Incurred Claims Incurred During the Experience Period
Below is a summary of allowed and incurred claims for the experience period:

[redacted]

[redacted]

4. **Benefit Categories**
The definition used to designate the claims into the correct benefit category are consistent with the preferred definitions in the URRT instructions and are based on information reported on the claim records, such as place of service, provider type, revenue codes, procedure codes, etc.

Inpatient hospital claims are claims associated with non-capitated inpatient facility stays. These reflect medical, surgical, maternity, mental health, substance abuse, and skilled nursing stays. The utilization estimates shown in Worksheet 1 reflect inpatient days, not admissions.

Outpatient hospital claims are non-capitated claims associated with outpatient facility services. These include emergency room visits, surgeries, lab and radiology services, and therapies, among others.

Professional claims are non-capitated claims associated with services provided by primary care physicians, specialists, therapy, the professional component of lab and radiology, and other professional services. Procedure codes and provider types are used to allocate these claims.

Other medical claims are non-capitated claims associated with ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, Part B drugs, and other items.

Prescription drugs include all drugs dispensed by a pharmacy and are shown net of pharmacy rebates.

Network Health has capitated service for non-EHB supplemental benefits for fitness, dental, and vision benefit in the base period.

5. **Projection Factors**

We believe that Network Health's 2024 individual ACA experience [redacted] As a result, rates for the individual market were developed without a manual rate.

Various sources were used in the generation of the projection factors employed in the rate development. The sources include Network Health's historical experience, publicly available data, and other proprietary information.

- **Changes in Morbidity of the Population Insured**

[redacted]

- **Changes in Benefits**

[redacted]

[redacted]

- **Changes in Demographics**
  The table that follows summarizes the development of the "Demographic Shift" projection factors as shown in Worksheet 1, Section II of the URRT.

[redacted]

[redacted]

- **"Other" Projection Factors shown in Worksheet 1, Section II of the URRT**

[redacted]

- **Trend Factors**
  The 2026 ACA trend development analyzed Network Health's large group fully insured business for the purposes of measuring allowed claim cost trends as the network and provider contract terms are common. [redacted]

[redacted]

[redacted]

The blended trend rate from these utilization and unit cost increases yields [redacted] annual trend.

6. **Credibility Manual Rate Development**
The 2024 base period experience is [redacted] credible, so no manual rate was developed.

7. **Credibility of Experience**
With [redacted] member-months of historical experience for calendar year 2024, Network Health's individual market experience [redacted] credible for pricing purposes.

[redacted]

8. **Paid-to-Allowed Ratio**

[redacted]

[redacted]

9. **Risk Adjustment and Reinsurance**

Experience Period Risk Adjustment and Reinsurance Adjustment PMPM

[redacted]

Projected Risk Adjustment PMPM Development

[redacted]

[redacted]

Below is an exhibit summarizing the components assumed in developing the risk adjustment transfer estimate for Network Health. The factors shown below are for informational purposes only.

[redacted]

Projected WI Reinsurance Recoveries

[redacted]

Projected Risk Adjustment and Reinsurance PMPM Allocation:

[redacted]

10. Non-Benefit Expenses and Profit and Risk

Administrative Expense Load

Network Health developed administrative expense assumptions based on a review of historical and projected expense levels. The administrative expenses load includes items such as general administrative expenses, quality improvement expenses, and commissions.

[redacted]

The administrative expense load has been applied as a percentage of premium and does not vary by plan.

Contribution to Surplus and Risk Margin

[redacted]

Taxes and Fees

The table below summarizes the taxes and fees incorporated into the rate development.

[redacted]

Adjustments to reflect federal and state income taxes and exchange user fees have all been applied as a percentage of premium. The risk adjustment user fee was applied as a PMPM amount.

Exchange user fees have been reflected above in the taxes and fees section of non-benefit expenses. However, in practice, exchange user fees are applied as an adjustment to the index rate at the market level, similar to the risk adjustment PMPMs. [redacted]

11. Projected Loss Ratio

The projected loss ratio using the federal MLR requirement is estimated [redacted] Below is a demonstration of its calculation.

[redacted]

12. Single Risk Pool

The base period experience shown in the URRT reflects all covered lives for every individual ACA member with Network Health's service area in the State of Wisconsin. [redacted]

[redacted]

Network Health only writes individual market business under the Network Health Plan legal entity.

13. Index Rate Development

The index rate reported in the experience period reflects all services for EHBs associated with Network Health's ACA individual market members. The Index Rate for the experience period as shown on Worksheet 1 of the URRT [redacted] Below is a summary of the calculation of the index rate for the projection period.

[redacted]

14. Market Adjusted Index Rate

To determine the average premium rates for each plan, the Index Rate must be adjusted to account for market-level items, with the impact of these items spread evenly across the single risk pool. Market-level items adjust for the impact of risk adjustment transfers and exchange user fees.

The impacts of the risk adjustment program, reinsurance, and exchange user fees have been calculated such that after the application of the average paid-to-allowed ratio, the dollar amount of each adjustment PMPM is realized. [redacted]

[redacted]

[redacted]

15. Plan Adjusted Index Rates

Plan-Level Adjustments

[redacted]

Development of AV and Cost-Sharing Adjustments

[redacted]

CSR Load

[redacted]

[redacted]

Benefits in Addition to EHBs

[redacted]

[redacted]

Network Adjustments

[redacted]

Administrative Costs

[redacted]

Plan Adjusted Index Rates

[redacted]

16. Calibration

[redacted]

[redacted]

- **Age Curve Calibration**

[redacted]

[redacted]

- **Tobacco Use Factor Calibration**

[redacted]

[redacted]

- **Geographic Factor Calibration**

[redacted]

17. Consumer-Adjusted Premium Rate Development

In accordance with the ACA, rates in the individual market will only vary by plan, age, tobacco use, family composition, and geography. Appendix B includes a complete listing of the rating factors along with a sample rate calculation.

Individual premiums are calculated for each member in a family unit, with a family unit defined as a primary, spouse, and any child dependents of the primary. The premium for an entire family unit is calculated by summing the individual premiums for all individuals aged

21 and over and the premiums for the oldest three child dependents under the age of 21 for a given primary.

18. AV Metal Values

19. AV Pricing Values

[redacted]

20. Membership Projections

Marketing Method

These products will be marketed to members in the individual market through various marketing channels including brokers, tele sales representatives, an online web portal, and through the exchange.

Development of Membership Projections

[redacted]

Projected enrollment by plan and subsidy level is shown below.

[redacted]

[redacted]

21. Terminated Products

[redacted]

[redacted]

22. Plan Type

The plan type selected in the drop-down box in Worksheet 2, Section I are representative of the proposed plans included with this filing.

23. Reliance

Network Health's ACA Pricing was completed leveraging a pricing model [redacted]

Although the effort was collaborative including numerous department representatives, the reliance for all information will be held by [redacted] Peer review of all assumptions and results was completed by [redacted] The reliance includes all internal claim and financial data including administrative expenses, risk scores, enrollment, and related data.

24. Actuarial Certification

This certification includes:
___ Prescribed Wording Only
_X_ Prescribed Wording with Additional Wording
___ Revised Wording

Additional Wording

The analysis underlying the development of the rates included in this actuarial memorandum is based on our interpretation of current State and Federal laws and regulations. Should these laws and/or regulations be modified our results could be subject to change.

There are significant risks and uncertainties underlying the development of rates for products to be sold in the individual market in 2026 due to the changes resulting from the implementation of the Affordable Care Act, including, but not limited to:

[redacted]

Prescribed Wording

I, [redacted], 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 compliant 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 compliant with all applicable federal statutes and regulations,
- The index rate and allowable modifiers as describes in 45 CFR § 156.80 (d) (1) and (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 was 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 rating 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.

[redacted]

Network Health Plan
June 20, 2025