

[REDACTED]  
Date: May 28, 2026  
Submitted via SERFF

Health Care Service Corporation  
Blue Cross Blue Shield of Illinois  
Rate Filing Actuarial Memorandum and Justification Review Standards

**SCOPE AND PURPOSE OF FILING**

This rate filing is to comply with the Illinois Department of Insurance (DOI) Company Bulletin 2015-06 addressing transition policies and follows the format requested in the “Checklist for Second Renewal of Existing Policy Plans.” The filing is also intended to demonstrate the reasonableness of rates in relation to premiums. The filing may not be appropriate for other purposes.

The scope of this filing is for Blue Cross Blue Shield of Illinois (BCBSIL), a division of Health Care Service Corporation, fully-insured non-grandfathered regulated small group pre-packaged benefits. This block of business is filed with the DOI under policy forms GB16HCSC (HMO) and GB10HCSC (non-HMO). BCBSIL defines the fully-insured regulated small group block as protected by the Small Employer Health Insurance Rating Act (215 ILCS 93/1 through 99).

The purpose of this filing is to acknowledge a change in the base rate which increases the rate schedule [REDACTED] effective September 1, 2026. The last set of rates was filed in SERFF under ILCP-134540115.

**i) PROPOSED EFFECTIVE DATE**

This filing impacts renewal manual rates with effective dates September 1, 2026 and later.

**ii) REQUESTED RATE INCREASE**

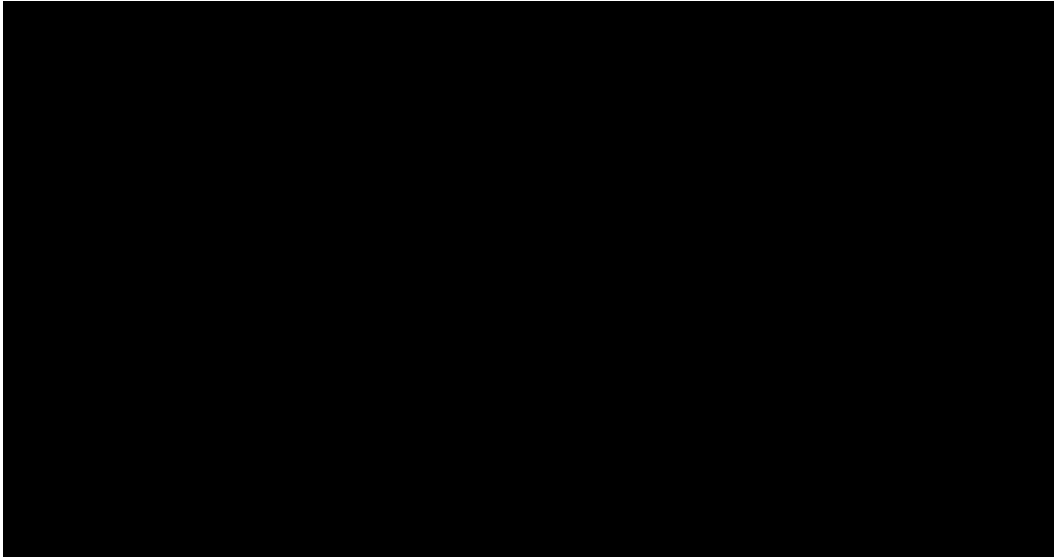
The proposed rate action for this block is a [REDACTED] to the rate schedule of [REDACTED]. For a group renewing between September 1, 2026 and August 31, 2027, the resulting average annual rate schedule change is approximately [REDACTED].

**iii) REASON FOR RATE INCREASE**

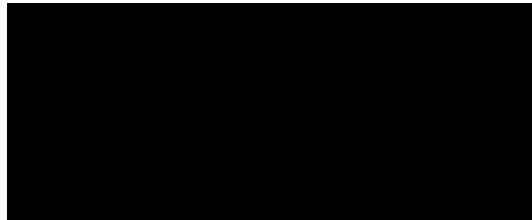
The proposed rate action reflects updated base experience and trend.

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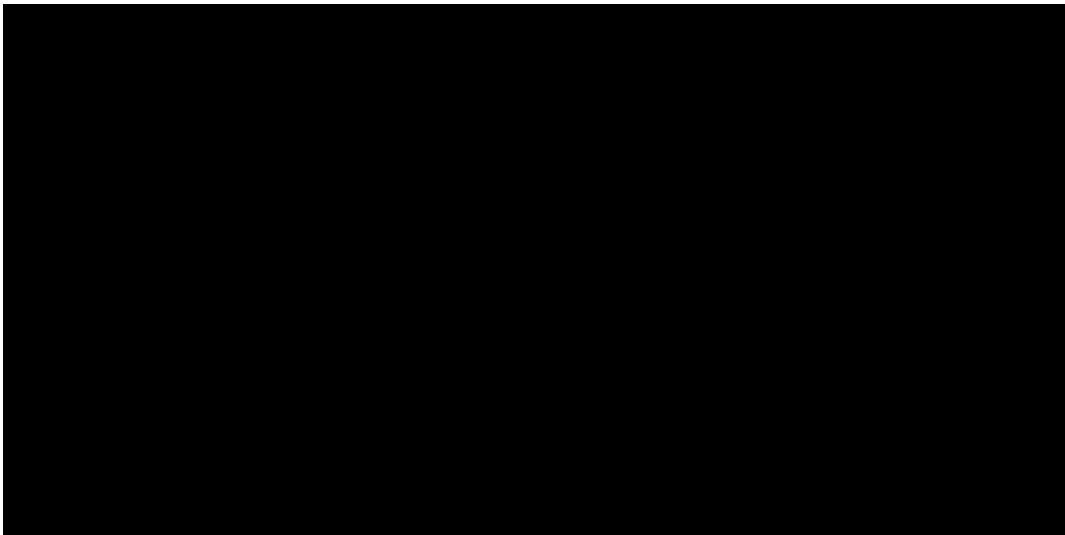
**iv) HISTORICAL RATE INCREASES**



**v) TARGET LOSS RATIO**



**vi) HISTORIC LOSS RATIOS**



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**BENEFIT DESCRIPTION**

**a) Type of Policy**

This fully-insured non-grandfathered regulated small group block of business is filed with the DOI under policy forms GB16HCSC (HMO) and GB10HCSC (non-HMO). This block is closed and only applies to renewals.

**b) Benefits**

This block of business includes PPO, HMO, HDHP and HSA benefit designs. For the PPO, HDHP, and HSA designs: deductibles range from \$0 to \$5,000, coinsurance amounts range from 0% to 50%. If there are copays the office visit copays range from \$10 to \$50 and emergency room copays are \$150. For the HMO designs: office visit copays range from \$10 to \$70 and emergency room copays are \$150.

**c) Renewability**

This block of business is guaranteed renewable.

**d) General Marketing Method**

These policies are closed to new business.

**e) Underwriting Method**

The manual rates may be adjusted based upon the utilization risk associated with the group's health status as determined by the underwriter.

**f) Premium Classifications**

Premium rates are developed using a composite four tier rate structure and Medicare carve-out rates. BCBSIL's standard Non-Medicare rating tiers are: employee only, employee plus spouse, employee plus child(ren) and employee plus family. The composite rates are calculated using employee and employer demographics. The age and gender of the employees combined with the rating area, SIC, group size, out-of-state membership of the employer are used to develop the composite rates. The benefit relativities and underwriting risk assessment are also used in the development of the accounts specific rates. Finally, the rate schedule includes automatic increments that advance the rates depending on rate effective year/month. As of this filing, the monthly increment is [REDACTED] and rates increase by this factor with the passage of each future month.

**g) Age Basis and Issue Age**

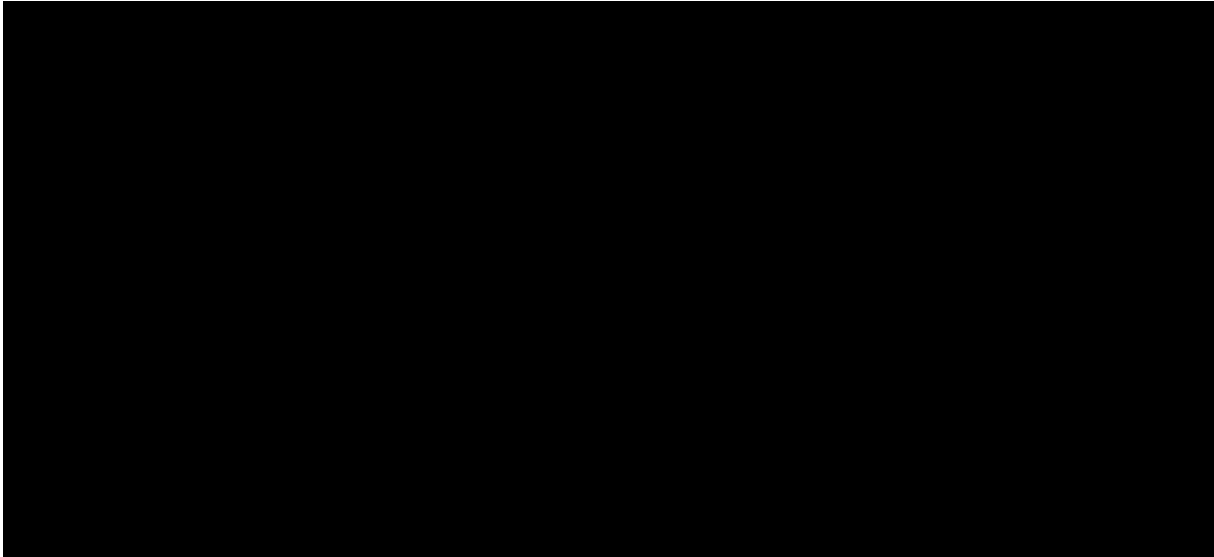
The manual rates are calculated based on the attained ages as of the effective/renewal date.

**vii) MARKET**

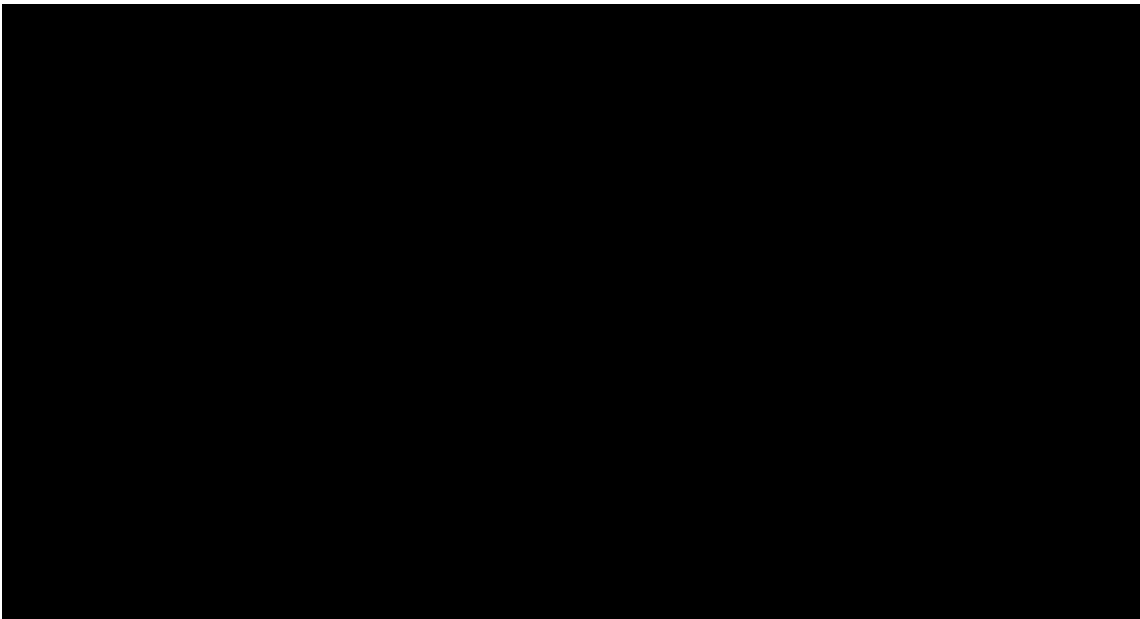
This filing applies to the regulated small group market.

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**viii) AVERAGE ANNUAL PREMIUM**



**ix) HISTORICAL FINANCIAL EXPERIENCE**



**x) DESCRIPTION AND DEMONSTRATION OF BASE RATE INCREASE**

The proposed rate action is acknowledging unfavorable trends and experience, which results in increasing the rate schedule [REDACTED] effective September 1, 2026.

The trend factors utilized in projecting our experience period claims forward are based on existing insured business in this state. The underlying data used in developing trend is derived from group accounts from PPO products. The data includes various categories of services representing inpatient, outpatient, professional, other medical providers,

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and prescription drugs. The categories have been selected to include encounters/services that are of a credible size, and separate unrelated types of encounters (ER visits, maternity admits, preventive visits, etc.).

The source data has adjustments applied:

- to normalize for age, gender, and morbidity,
- for number/type of days of the week and holidays,
- for any one-time events not anticipated to reoccur during the projection period,
- for anticipated changes to the provider contracts that differ from those underlying the experience period, and
- for anticipated changes to prescription drug mix, unit cost and utilization.

The data selected is appropriate for the single risk pool because the underlying population is group business from this issuer in this state. Such data reflects the medical policy, utilization management, provider contracts and adjudication practices of the issuer, but does not include the effects of medical underwriting. The benefits provided are comprehensive and cover a broad range of services which are consistent with essential health benefits.

**xi) DESCRIPTION AND DEMONSTRATION OF ALL CHANGES IN RATING FACTORS**

There are no other changes to the rating factors from what is currently filed.

**xii) BASE PERIOD EXPERIENCE**

**a) Base Period from and through dates**

The base period experience data is incurred from November 1, 2024 through October 31, 2025.

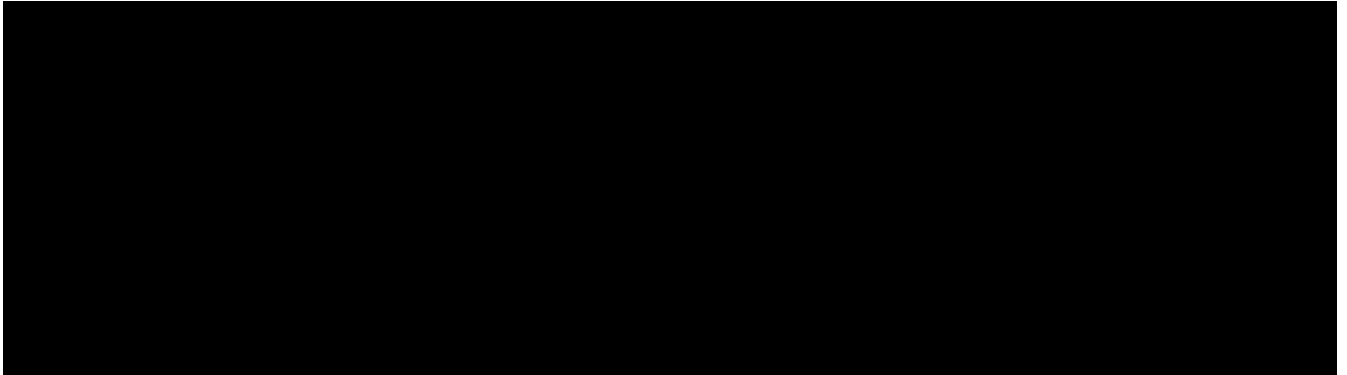
**b) Paid through date**

The base period experience data is paid through March 31, 2026.

**c) Completion methodology and average factors and IBNR**

Allowed claims and incurred claims are pulled from the same source(s) and calculated using a similar methodology. Only the allowed claim amounts for small group accounts/members for claims which have already been processed are included in our claim data (incomplete allowed claims). A set of completion factors are then applied to the incomplete allowed claims to develop the expected allowed claims for the experience period. The completion factors to be applied to the incomplete allowed claims are developed using a similar process as the completion factors to be applied to paid claims.

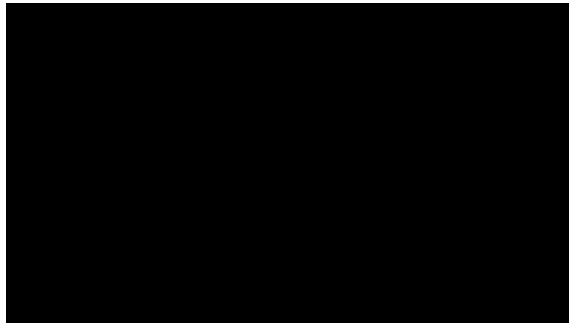
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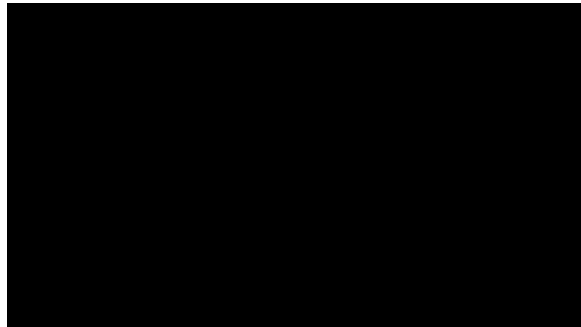
**d) Contract reserves**

There are no contract reserves set up for these policies.

**e) Allowed Claims Experience**



**f) Paid Claims Experience**



**g) Member months**

The base period experience member months are [REDACTED].

**h) Credibility Analysis**

With an average of [REDACTED] members in our Small Group non-ACA metallic market, we have assigned full, 100% credibility to our base experience data. The plans were all rated together and as such, no pooling was necessary.

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**i) Treatment of Large Claims and Pooling Charges**

Large claims were included in the experience period, as the experience in aggregate is deemed 100% credible.

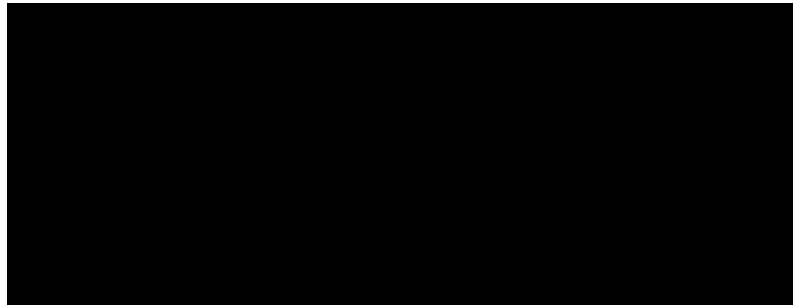
**xiii) TREATMENT OF REINSURANCE**

Reinsurance recoveries do not apply to the Small Group market.

**xiv) PROJECTED POLICYHOLDERS**

We are projecting [REDACTED] members in 2026.

**xv) TREND PROJECTION FACTORS**

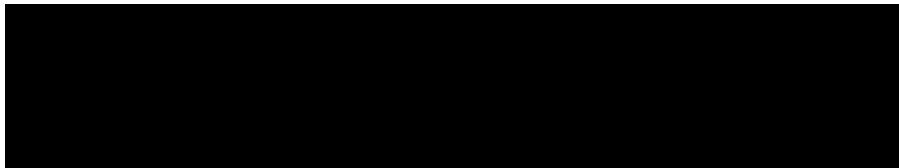


**xvi) EXPERIENCE ADJUSTMENTS**

- a)** All benefits covered in the experience period will also be covered in the projection period.
- b)** The assumptions for changes in demographics are developed by comparing the population mix from the experience period to the assumed population mix in the projection period. For rating, we assumed the population mix remained constant.

**xvii) HISTORIC TRENDS**

Actual vs Expected trend for the past 3 years is as follows:



**xviii) SUMMARY OF CHANGES FROM PREVIOUS FILING**

Benefits and rating factors remained constant from the previous filing. Administrative costs were updated as follows.

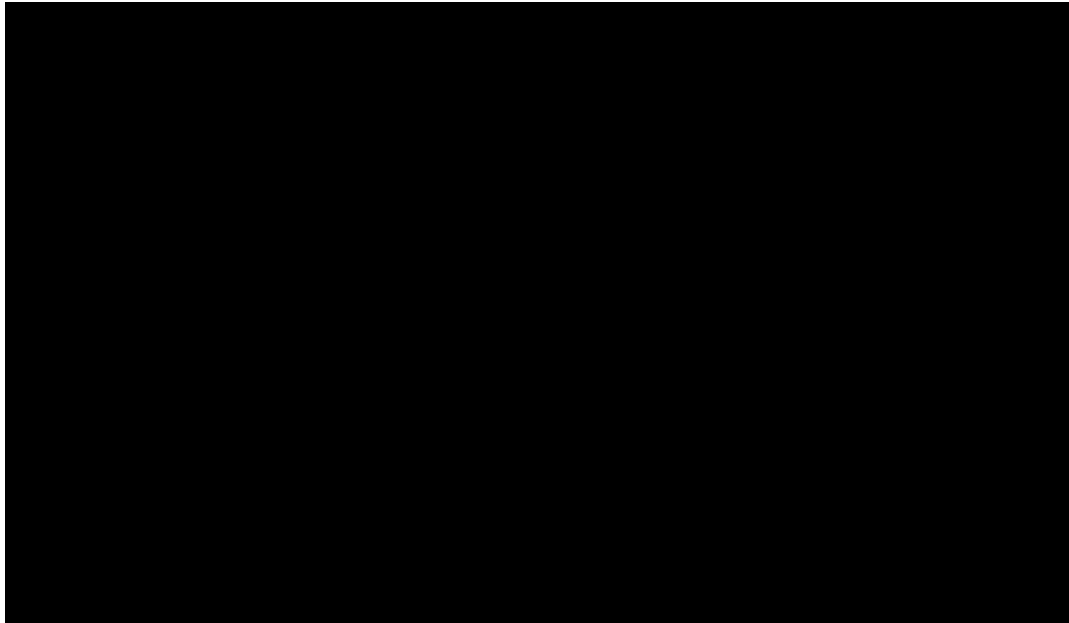
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**xix) PROJECTED LOSS RATIO WITH AND WITHOUT PROPOSED RATE INCREASE**

The projected traditional loss ratio in 2026 is [REDACTED] and in 2027 is [REDACTED]. Without this proposed change, the projected loss ratio in 2026 is [REDACTED] and in 2027 is [REDACTED].

**xx) CUMULATIVE, FUTURE AND LIFETIME LOSS RATIOS**



There is no Lifetime Loss Ratio requirement for this block of business.

**xxi) COMPANY'S REBATE MLR FOR MARKET**

The projected loss ratio for 2026 using the Federally prescribed MLR methodology is [REDACTED] for the Single Risk Pool.

**xxii) EXPLANATION WHEN THE FUTURE LOSS RATIO IS NOT CONSISTENT WITH THE FEDERAL REBATE MLR**

The MLR calculation is in accordance with the formula in the HHS Notice of Benefits and Payment Parameters.

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$$MLR = \left[ \frac{(i + q + n - r)}{\{(p - n + r) - t - f - (-n + r)\}} \right] + c$$

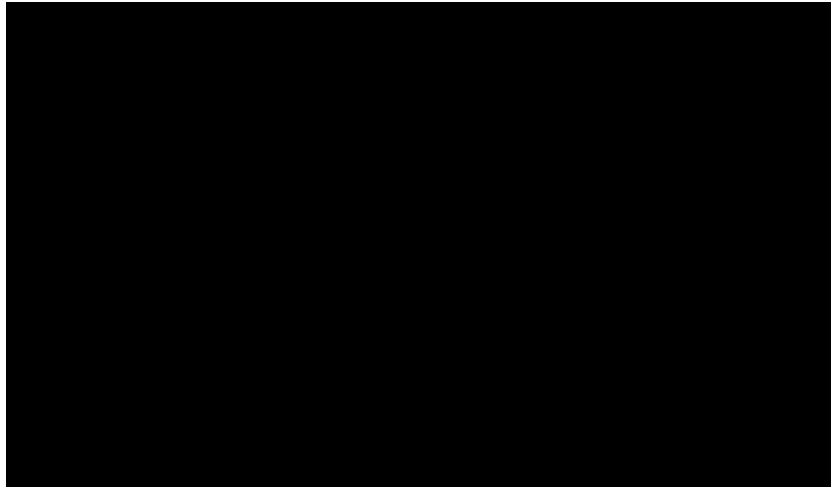
Which simplifies to,

$$MLR = \left[ \frac{(i + q + n - r)}{\{p - (t + f)\}} \right] + c$$

Where,

- i = incurred claims
- q = expenditures on quality improving activities
- p = earned premiums
- t = Federal and State taxes and assessments
- f = licensing and regulatory fees, including transitional reinsurance contributions
- s = issuer's transitional reinsurance receipts
- n = issuer's risk corridors and risk adjustment related payments
- r = issuer's risk corridors and risk adjustment related receipts
- c = credibility adjustment, if any.

Below are the MLR calculations for the single risk pool as well as for the closed, non-metallic business.



**xxiii) ADMINISTRATIVE COSTS**

The following assumptions were used in the pricing of this block of business:

- Commissions are expected to be [REDACTED] of premium
- Acquisition and maintenance expenses are expected to be [REDACTED] of premium
- Taxes and Assessments are expected to be [REDACTED] of premium

**xxiv) RATE FILING DISCLOSURE FORM**

The rate filing disclosure is not applicable.

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**xxv) ACTUARIAL CERTIFICATION**

I, [REDACTED] am an employee of Blue Cross Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company. I am a Member of the American Academy of Actuaries, and a Fellow of the Society of Actuaries, and I meet the qualification standards appropriate for this Rate Filing Actuarial Memorandum and Justification Review Standards. I certify that, to the best of my knowledge, this rate filing is in compliance with the applicable laws and regulations of the State of Illinois and the applicable federal statutes and complies with all applicable Actuarial Standards of Practice.

The rates referenced in this filing reflect the negotiated prices from the provider contracts and the expected utilization experience of the plan.

I have relied upon financial data and summaries prepared by responsible officers and employees of Blue Cross Blue Shield of Illinois. In other respects, my analysis included such review of the assumptions as I considered necessary.

For preparation of the rates, items identified above:

- (i) are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles.
- (ii) are in compliance with applicable laws and regulations of the State of Illinois.
- (iii) are in compliance with applicable federal statutes.
- (iv) make a good and sufficient provision for all unpaid claims of the organization under the terms of its contracts and agreements.
- (v) include appropriate provision for all actuarial items which ought to be established.

To the best of my knowledge and judgment, the referenced rates are reasonable in relation to the anticipated experience of Blue Cross Blue Shield of Illinois and are neither excessive, inadequate nor unfairly discriminatory.

[REDACTED]

05/28/2026

Date