

ACTUARIAL MEMORANDUM

I. GENERAL INFORMATION

Company Identifying Information

Company Legal Name:	Sentara Health Plans
State:	Virginia
HIOS Issuer ID:	20507
Market:	Small Group
Effective Date:	January 1, 2027
Experience Period:	January 2025 to December 2025
Projection Period:	January 2027 to December 2027

Company Contact Information

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II. SCOPE AND PURPOSE

The purpose of this memorandum is to provide actuarial justification for a premium rate revision on the ACA-compliant small group comprehensive major medical policies offered by Sentara Health Plans, SHP. This memo is intended to fulfil requirements for the Part III Actuarial Memo as well as the Virginia Memo requirements. Virginia specific requirements may be found in sections 3, 4, 14 and Exhibits A, B, E.

Proposed rates are applicable for the effective date specified in Section I. The proposed rate revision reflects the impact of a number of factors, including:

- Anticipated medical cost and utilization trends
- Benefit changes and leveraging of fixed member cost sharing values
- Changes to reflect the applicable provisions of ACA-related taxes and fees
- Updated impacts of network arrangements and area factors

Changes vary by benefit plan and rating area to reflect a combination of benefit changes, provider network changes, changes in the anticipated impact of fixed cost-sharing items given increasing medical costs (i.e., paid to allowed), and updating of regional rating areas. These factors were calculated, in accordance with the current BOI requirements, to reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

This actuarial memorandum has been prepared for the purpose of demonstrating compliance with applicable federal and state insurance laws and statutes and may not be appropriate for other purposes.

Renewability

These benefit plans are Guaranteed Renewable in accordance with applicable federal and state insurance regulations.

Issue Age Limits

Coverage is available to eligible employees of small employers and their dependents purchasing one of these policies, irrespective of age. Employee and spouse eligibility is subject to various conditions, but not age. Dependent children are eligible for coverage up to and including age 25, subject to specified exceptions as required under requirements of state laws and regulations (e.g., disabled dependent children).

General Marketing Methods

These products will be marketed through direct marketing representatives, web-based marketing, and independent insurance brokers. None of these benefit plans will be available for sale through the "Small Business Health Options Program" exchange (SHOP).

Description of Agent Commissions

Agents receive Per Contract Per Month commission payments that vary by group size, new vs. renewing.

III. PROPOSED RATE INCREASE(S)

The single risk pool for SHP Virginia small group plans was established in accordance with the requirements in 45 CFR part 156, §156.80(d). The single risk pool reflects covered lives in all non-grandfathered products sold in the Virginia small group market by SHP. There are no transitional members in the SHP small group risk pool for the experience period.

This submission is for the following rate revisions effective on the Effective Date specified in Section I:

- The following table gives the rate revisions to existing SHP small group medical ACA-compliant products as presented by HIOS Plan ID in the applicable line item of Worksheet 2 in the URRT. The average proposed rate change by product number for all plans to be marketed in the projection period vs. the cumulative average rate change over the past 12 months for these plans are:

Product number	Annual Rate Change
	Rate
20507VA125	██████
20507VA128	██████
Overall	██████

The variance in rate increase of the products is due to changes in the member cost sharing of the plans within the product as well as member count differences between the benefit plans that make up the products. The annual rate change listed above uses the same Market Adjusted Index Rate for all products. The AV and Cost Sharing Design of Plans changed between experience and the projection period. The change in AV and Cost Sharing Design of Plan uses the same population for pricing all benefits and thus morbidity differences between products cannot be a factor in the Annual Rate Change difference.

New HMO and POS benefit plans to be available for sale during the proposed projection period have been developed using ACA data from the experience period. To the extent that current membership on terminating plans are proposed to be mapped into one of the new plans, the applicable rate change is illustrated in the URRT and included in the previously noted average.

The following table provides information regarding current and proposed average annual premium per policy and per member for existing plans. Proposed premiums are those for the effective date specified in Section I.

Average Annual Premiums		
	Current Rate Basis	Proposed
Per Policy:	██████████	██████████
Per Member:	██████████	██████████
Average Increase		██████████

A summary of rate revisions for these benefit plans is included in Attachment A.

The cumulative impact of changes during a given calendar year will impact small group members at their annual renewal. Attachment B illustrates the 12-month impact for renewing members in each of the calendar quarters of 2027 for proposed rates. Note that Attachment B includes the renewal rate change that is applicable for any member in terminating plans that is mapped into continuing or new plans in 2027.

IV. EXPERIENCE PERIOD PREMIUM, CLAIMS and ENROLLMENT

Claims Paid Through Date

Incurred claims presented in Worksheet 1, Section I of the URRT for the experience period are based on claims paid through March 2026.

Current Date:

As of March 2026, there were ██████████ members and ██████████ of premium in small group plans.

Allowed and Incurred Claims Incurred During the Experience Period

Processed fee-for-service (FFS) allowed and paid claims reflect the applicable values from SHP's claim payment system for claims incurred during the experience and paid through period the 'Claims Paid Through Date' stated above for those services covered on a FFS basis (i.e., not capitated).

Total allowed claims were calculated as a combination of the following:

- $[\text{Allowed Claims Incurred and Processed (FFS)} * \text{Completion Factor}] + [\text{Capitation PMPM} * \text{Member Months}]$

Total incurred claims were calculated as a combination of the following:

- $[\text{Paid Claims Incurred and Processed (FFS)} * \text{Completion Factor}] + [\text{Capitation PMPM} * \text{Member Months}]$

Incurred but Not Paid Claims (FFS) are calculated as follows, for allowed and paid values, respectively:

- $[\text{Allowed Claims Incurred and Processed (FFS)} * \text{Completion Factor}] - \text{Allowed Claims Incurred and Processed (FFS)}$
- $[\text{Paid Claims Incurred and Processed (FFS)} * \text{Completion Factor}] - \text{Paid Claims Incurred and Processed (FFS)}$

The completion factors were calculated using a claim triangle with both paid and incurred date and applying a lag ratio-based completion factor calculation method. Pharmacy claims are considered to be fully complete given one month of runout. The completion factors used were based on the entire block of

group business including small group, mid-market, and large group. The main reasons for using the entire block were that the group business has similar benefits, completion patterns, and grants more credibility to the completion factor.

The following table provides a breakdown of the allowed and incurred claims during the experience period, as presented in the Worksheet 1, Section I of the URRT.

		Allowed	Incurred
	Processor	Claims	Claims
Processed Claims	Issuer		
(Fee-for-Service)	External		
Incurred but Not Paid Claims	n/a		
(Fee-for-Service)			
Capitated Claims	n/a		
Pharmacy Rebate	n/a		
Total			

V. BENEFIT CATEGORIES

Each claim processed on a fee-for-service basis during the experience period is assigned to the applicable benefit category in Worksheet 1, Section II of the URRT. The categorization methodology looks at detailed claims records and assigns the applicable category based on a combination of a number of items including specialty codes, place of service, form types, facility type, DRG codes, provider types, and types of service indicators. Core drivers for assignment in each service category are as follows:

- Inpatient – DRG
- Outpatient – Procedure and revenue codes
- Professional – Procedure code
- Prescription Drugs – NDC code and rebates received from drug manufacturers

The Inpatient & Outpatient categories contain only facility costs with no related professional fees. The Professional category reflects non-facility provider costs (i.e., Primary and Assistant Surgeons, Anesthesia, etc.).

The capitation line item reflects the negotiated capitation rates for applicable services.

VI. PROJECTION FACTORS

Premium rates do not include the impact of persistency or interest. The basic formula is as follows:

Premium = Expected Claim Costs – ACA Net Risk Adjustment Transfers + Expenses, Taxes and Fees + Profit & Risk Margin

Each of these components is described in more detail below.

Expected Claim Costs / Morbidity

Expected claim costs were developed based on the experience period small group allowed claim experience, with benefit relativities by plan determined using the *Milliman Health Cost Guidelines (HCGs)*.

Expected allowed claim levels in the projection period were developed by applying various adjustment factors to experience, as follows:

Trend Factors

The utilization and cost trend factors shown in Worksheet 1, Section II reflect an allowed claim trend of [REDACTED]. Trends were developed based on SHP small group experience, the Milliman *HCGs*, and general industry knowledge regarding recent trends in medical and pharmacy inflation.

Adjustments made to historical data are:

- Adjusted historical claims for best estimate risk adjustment payment adjusted to an allowed claims level
- Normalized for member dispersion between geographic regions

Separate trend factors for utilization and cost were estimated based on relative values from the *HCGs*.

SHP allowed charge trends were reviewed (combined utilization and cost) by service category in comparison to the *HCG* developed values to test for reasonability of final assumptions.

Adjustments to Trended EHB Allowed Claims PMPM

- Demographic Shift: The difference in demographic and geographic area mix between the experience period and that expected in the projection period. The projection period expected distribution is based on enrolled members as of March 2026. A demonstration of the calculation of the adjustment for geographic factors and age adjustments is shown in Attachment C.
- Other: Transplant costs, which are covered under a capitation arrangement, are still in the Sentara claims system so that member cost sharing can be adjudicated properly. These claims must be removed so as to avoid the double counting of transplant costs which are also included in the capitation amounts. The removal of transplant claims reduced claims [REDACTED].
- Other: Provider Network Arrangements: Additional adjustments were made to the cost trend to reflect the aggregate impact of the effect of the provider network in the projection period vs. the experience period. The application of the provider network arrangement decreased cost [REDACTED].
- Benefits: Breast Exams: Adjustments included for future impact of breast exam mandated benefits of [REDACTED].

VII. MANUAL RATE ADJUSTMENTS

SHP's small group experience is considered to be fully credible for purposes of rate development. As such, a manual rate was not developed and zeroes have been entered into the credibility manual rate section of the URRT, in accordance with URRT instructions.

VIII. CREDIBILITY OF EXPERIENCE

SHP's small group experience in aggregate is considered to be fully credible for purposes of rate development. As shown in Section 1 of the URRT, there are over 60,000 member months included in the experience data, which supports assigning 100% credibility for the purposes of rate development. As such, a 100% credibility factor to the projected experience is assigned.

IX. ESTABLISHING THE INDEX RATE

The URRT experience period index rate is \$696.72. The index rate is based on the total combined claims costs for providing EHBs only for the single risk pool of the VA Small Group market. The experience period does not contain non-single risk pool plans.

X. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE (MAIR)

Risk Adjustment Payment/Charge

We are assuming a market wide increase in premium from the experience period to the projection period of [REDACTED] from 2025 to 2027. The risk adjustment is anticipated to change proportional to the change in the premium levels. The effect of the Model Weight Change from 2025 to 2027 is anticipated to be [REDACTED] for Sentara and [REDACTED] for the total market. Including adjustments made to the transfer formula coefficients, the anticipated incurred basis risk adjustment in the projection period is set to be a receivable of [REDACTED] PMPM.

The Risk Adjustment Payment/Charge used in the development of the MAIR is on an Allowed Basis and adjusted to be an EHB only level. The anticipated incurred basis projected risk adjustment is therefore divided by the single risk pool projected paid to allowed factor to increase the amount to an allowed basis and then multiplied by the EHB percent of total claims. The average paid to allowed factor is [REDACTED]. The EHB percent of total claims is [REDACTED]. The resulting Risk Adjustment Payment/Charge applied in Wskht1 of the URRT is [REDACTED] PMPM.

Exchange User Fees

The SHP Small Group product is not sold on the exchange and thus no exchange user fees are included in the calculation of premium at any point in the calculation.

XI. PLAN ADJUSTED INDEX

Actuarial value and cost-sharing design of the plan

Benefit relativities by plan are determined using the *Milliman Health Cost Guidelines (HCGs)*. Benefit relativities do consider changes in utilization due to differences in cost-sharing. The utilization is adjusted using assumptions out of the HCG. The HCG utilization values only consider the impact of variance in cost-sharing between benefit plans and does not reflect any differences due to health status.

Network

Anticipated cost impact of the network of a Select plan compared to other network options.

Benefits in addition to EHB

The benefits offered in addition to EHB are Vision and Abortion services. These services increase claims [REDACTED]

Benefits in addition to EHB for PANDAS and PANS coverage are covered in 2027. These services increase claims [REDACTED]

Benefits in addition to EHB for Sex-trait Modification Procedures coverage are covered in 2027. These services increase claims [REDACTED]

SHP includes state mandated benefits in addition to EHB for hearing aids for minors in 2027. These services increase claims [REDACTED]

The implementation of VA HB1214 is expected to increase claims by [REDACTED].

Administrative Expense

Administrative expenses were determined based on SHP and SHIC's 2027 budget projections. The [REDACTED] of premium is the average for all plans. Some of the administrative expenses do not scale with premium or claims costs and are better distributed as an even PMPM amount per plan. The administrative expenses have been adjusted for this with each plan having a portion of the admin expense spread as an even PMPM per plan and a portion distributed as a % of premium.

Profit & Risk Load

A Profit and Risk Load target value of [REDACTED] in aggregate was determined based on company targets, continuing uncertainty of the small group market in the projection period, and in consideration of federal MLR requirements. Target values vary by benefit plan to reflect the varying risk profiles of products with out of network components.

Taxes and Fees

The following table provides a breakdown of projected taxes and fees as a percent of premium.

Premium Tax	[REDACTED]
Health Insurer Fee	[REDACTED]
Research Trust Fund Fee	[REDACTED]
Federal Income Tax	[REDACTED]
Risk Adjustment Fee	[REDACTED]
Total	[REDACTED]

XII. CALIBRATION

Age Curve Calibration

The age curve calibration factor is the member weighted average of the federal age factors with the projected membership distribution by age in the projection period. A factor of zero (0) is applied for the distribution of members expected to pay no premium due to the three under age 21 child dependent cap.

Attachment D demonstrates the calculation of a premium rate from the PAIR using the age curve.

Attachment E demonstrates the calculation of the age curve calibration factor.

Geographic Factor Calibration

The geographic curve calibration factor is one divided by the member weighted average of geographic factors with the projected membership distribution.

The geographic rating area factors were developed based on a combination of the following information:

- Historical risk adjusted loss ratio experience by geographic rating area for SHP's Small Group business.
- Manual geographic rating area factors developed using a combination of SHP risk-adjusted group experience and the Milliman HCGs adjusted for anticipated provider network contracts.

SHP elects to create regional rates across multiple Virginia ACA rating areas. The area factor for a given multi-area region reflects the weighted average of factors for each ACA rating area developed using the analysis described above. The multi-area region includes rating areas 1, 3, 5, 8, 11 and 12.

None of the proposed area factors set forth in this rate filing for a rating area exceed more than 15 percent of the weighted average of the proposed area factors among all rating areas in which SHP offers health benefit plans.

Attachment C demonstrates the geographic factor calibration.

Attachment D demonstrates the calculation of a premium rate from the PAIR using the geographic factor.

Tobacco Use Rating Factor Calibration

Tobacco Use Rating factors are not used in the SHP rating and thus no calibration is needed.

XIII. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

For renewals and new business sold in the projection period the consumer adjusted premium rates are calculated by multiplying the Calibrated Plan Adjusted Index Rate by the age factor and geographic factor that is specific to the member. In the event that a family has more than 3 children under the age of 21, only the three oldest children have the age factor applied to calculate their specific premium rate. The remaining children (in excess of three) pay zero premium.

For renewals and new business sold in the remaining quarters of the projection period the consumer adjusted premium rate must also be multiplied by the following quarterly increase:

Renewal Quarter and Quarter for New Business Sales	Quarterly Premium Adjustment
Q2	██████
Q3	██████
Q4	██████

The small group decision maker has the option to have their group's premium set at a composite rate for the whole group. The composite rates are established according to the 'Composite Premiums in the Small Group Market in Virginia' regulation established by the Virginia Bureau of Insurance.

Attachment F provides a comparison of current and revised premium rates by benefit plan and rating region comparing Q4 2026 vs. Q1 2027. Illustrated rates are reflective of PMPM values for a 21-year old. There is no change to the age slope and thus the rate change at the benefit and region level is the same for each age.

Benefit relativities were adjusted to reflect benefits in the projection period, resulting in an average increase of ██████ to 2027 values, varying by plan.

XIV. PROJECTED FEDERAL LOSS RATIO

The projected loss ratio based on the federally prescribed MLR methodology, excluding adjustments for credibility, is ██████.

XV. PROJECTED LOSS RATIO

The anticipated loss ratio for new business is [REDACTED]. The anticipated loss ratio for in force business is [REDACTED]. It is determined to be the same as that for new business, as is consistent with single risk pool requirements under state and federal regulations.

The projected loss ratio was calculated as the ratio of expected incurred claims to expected earned premiums during the rating period for all small group plans combined. Expected incurred claims include the risk adjustment program transfer, but not the fees related to the risk adjustment and reinsurance programs. It is determined to be the same as that for new business, as is consistent with single risk pool requirements under state and federal regulations.

The anticipated loss ratio for these policy forms in 2025 and 2026 was [REDACTED] and [REDACTED], respectively. The minimum standard for reasonability for small group benefit plans in Virginia is 75%.

XVI. AV METAL VALUES

Where possible, the AV Metal Values were entirely based on the AV Calculator. The AV calculator only has one slot for entering Mental Health Outpatient member cost sharing values. For plans where Mental Health Outpatient services with Office Visit cost sharing as a copay (or coinsurance) and non-Office Visit Outpatient services are by another form of member cost sharing such as coinsurance (or copay if this is what is different from the OV cost share) then an estimate was calculated to combine the two values for a single entry into the AV calculator. The estimate was calculated using actual claims utilization and cost experience data to approximate a single value that represents the two forms of member cost sharing combined. As a qualified actuary under related federal requirements, I certify that the actuarial value (AV) of each plan as calculated by the federal AV calculator is in compliance with the federal requirements for determining the metal level of a plan. The resulting metal level for each plan is presented in the rate sheets attached to this filing submission. The actuarial certifications required by 45 CFR 156.135 are included with this filing.

XVII. MEMBERSHIP PROJECTIONS

Membership projections, as presented in Worksheet 2, Section IV of the URRT were developed by SHP based on consideration for the following:

- Enrolled distribution of business as of March 2026
- Projected new sales activity and procurement of membership in existing and new areas.

XVIII. TERMINATED PLANS

Terminated plans and mappings can be found in Attachment G.

XIX. PLAN TYPE

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT. They are all consistent with the available options in the drop-down box in Worksheet 2.

XX. WARNING ALERTS

The URRT is generating a warning stating that typically the current premium and current enrollment are greater than zero. Current premium and current enrollment are as of March 2026. The plans for which these warnings are generated are either terminated plans which did have enrollment or premium in the prior benefit year or they are renewing plans which did not have enrollment or premium by March 2026.

The following columns marked as warnings are renewing plans which did not have enrollment or premium as of March 2026: W-Z, BK.

XXI. RELIANCE

In support of this rate development, various data and analyses were provided by other members of Sentara's actuarial staff, including data and analysis related to cost of care, valuation, and risk adjustment. I have reviewed the data and analyses for reasonableness and consistency.

XXII. ACTUARIAL CERTIFICATION

This memorandum may be considered a statement of actuarial opinion. I am an Actuary with Sentara Health Plans. I am a member of the American Academy of Actuaries, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify to the best of my knowledge and judgment:

1. The projected index rate is
 - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102).
 - Developed in compliance with the applicable Actuarial Standards of Practice.
 - Reasonable in relation to the benefits provided and the population anticipated to be covered.
 - Neither excessive nor deficient based on my best estimates of the small group market.
2. 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.
3. The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
4. The AV Calculator was used to determine the AV Metal Values shown in Part I of Worksheet 2 in the URRT for all plans except those specified in the certification. Where an alternate methodology was used to calculate the AV Metal Value, a copy of the actuarial certification required by 45 CFR 156.135 is included. The certification indicates that the values were developed in accordance with generally accepted actuarial principles and methodologies.

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 that 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 presented in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

The results are projections based upon best estimates. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

To the best of my knowledge and judgment, the rate filing is in compliance with the applicable laws and regulations of this Commonwealth and the premiums are reasonable in relation to the benefits provided.



July 8, 2026