Part III Actuarial Memorandum

Blue Cross and Blue Shield of Texas
Small Group Rate Filing
Effective January 1, 2026

Confidential and proprietary information pursuant to, including but not limited to, Tex. Gov't Code Ann. §§ 552.110, §§ 552.1101(a), 5 U.S.C. §§ 552(b)(4) and (b)(6), 45 C.F.R. §§ 5.31 (d) and (f), and the Trade Secrets Act (18 U.S.C.§1905). BCBSTX objects to any release of this information if requested, requests immediate notification of any request for this information, and requests that TDI promptly seek an Attorney General Opinion Decision if this information is requested.

Introduction

This actuarial memorandum supports a rate filing on behalf of Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association for the Small Group medical policies.

This actuarial memorandum and certifications do not guarantee the adequacy of the proposed rates. Rather, they certify that the proposed rates would be adequate if the assumptions were realized. In particular, in the event of any change to and/or modifications by statute, regulation, court decision, agency sub-regulatory guidance, implementation, administration, and/or interpretation, the proposed rates may not be adequate. In such circumstance, the proposed rates would be subject to amendment, revision and/or withdrawal (in whole or in part), if determined necessary by BCBSTX, the attestor(s), and/or the certifying actuary.

This actuarial memorandum has been prepared for the sole purpose of demonstrating compliance with regulatory authority, including the Department of Health and Human Services' Part III Actuarial Memorandum and Certification Instructions, and is not intended for and may not be appropriate for any other purpose.

4.2 General Information

Company Identifying Information

Company Legal Name	Blue Cross and Blue Shield of Texas
State	Texas
HIOS Issuer ID	33602
Market	Small Group
Effective Date	January 1, 2026

Company Contact Information

Primary Contact Name	[redacted]
Primary Contact Telephone	[redacted]
Primary Contact Email	[redacted]

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4.3 Proposed Rate Changes

For groups renewing during the first quarter of 2026, we propose a 18.1% increase across the entire block of BCBSTX Small Group ACA-compliant metallic plans effective January 1, 2026. The premium rate changes will vary by plan, area, and quarter.

As reported in the 2026 Unified Rate Review Template (URRT), the member-weighted average rate action across all four quarters is a 15.7% increase.

The average rate increase is calculated using the 2025 rate tables, the proposed 2026 rate tables and the membership distribution by plan, age and area as of April 30, 2025. The calculation does not include any new or terminating plans nor any mapping of members to available plans.

Reason for Rate Increases:

- Base Period Experience reflects the impact of restating 2025 pricing due to additional experience availability and a better understanding of how assumptions unfolded. The base experience has runout through April 30, 2025. This reflects the impact of the change in risk adjustment payment assumptions (i.e., BCBSTX's share of the population risk relative to the market).

- Pricing Trend represents the expected increase in claims costs resulting from changes in utilization and unit cost as well as the impact of fixed member cost sharing amounts. This includes changes in expected claims cost due to changes in expected drug rebates.

- Population Morbidity reflects the expected increase in claims costs resulting from changes in the health status of the small group single risk pool.

- Provider Networks & Cost Sharing represents the expected change in claims costs resulting from adjustments to our contracted networks and service providers as well as the impact of plan provision changes.

- Other reflects changes not discussed above including but not limited to expected 2026 taxes, fees and administrative expenses compared to those for the 2025 rates. Additional information can be found in Section 4.4.4.

Components of Increase	
Base Period Experience	1.3%
Pricing Trend	8.5%
Population Morbidity	6.1%
Provider Networks & Cost Sharing	-0.4%
Other	-0.3%
Total	15.7%

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The cost relativities among products are different from the experience period to the prospective rating period due to anticipated non-uniform changes in network reimbursement levels. Additionally, the rates vary by plan due to the leveraging and utilization differences driven by variations in member cost sharing. Therefore, the proposed rate changes may vary by area, plan, and quarter. Morbidity was removed from impacting the variance in rate changes across products and plans by 1) normalizing for risk in the development of the area and network factors and 2) using a standardized set of allowed claims for all plans when calculating the paid to allowed ratios.

The minimum and maximum rate increases included in SERFF are set to match the minimum and maximum values among renewing plans from Wksh 2 Section I of the URRT.

4.4 Market Experience

The single risk pool includes all covered lives for every small group non-grandfathered product/plan combination including transitional products. Transitional product experience has been removed from the experience period and projection period base rate calculations. We do not anticipate a significant number of the members in those policies will be enrolled in metallic plans during the projection period.

4.4.1 Experience and Current Period Premium, Claims, and Enrollment

Paid Through Date:

Payments have been made through April 30, 2025, on claims incurred during calendar year 2024.

Current Date:

Current enrollment and premiums are as of April 30, 2025.

Allowed and Incurred Claims Incurred During the Experience Period:

Allowed claims and incurred claims are pulled from the same source(s) and calculated using a similar methodology. Only claim amounts for accounts in the Small Group single risk pool for claims which have already been processed are included in our claims data (incomplete claims).

A set of completion factors is applied to the incomplete claims to develop the expected allowed and incurred claims for the experience period.

Both allowed and incurred claims were adjusted for drug manufacturer rebates and provider incentives.

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The allowed claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = $5,099,431,919
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = -$445,384,145
- Best estimate of claims incurred but not paid as of the Paid Through Date = $36,829,397

The incurred claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = $4,136,645,306
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = -$453,963,530
- Best estimate of claims incurred but not paid as of the Paid Through Date = $28,165,764

Claims paid outside the claim system consist primarily of drug manufacturer rebates.

The same methodology was used to develop the estimate of claims incurred but not paid for both allowed claims and incurred claims in the experience period. The methodology incorporates estimates based upon developed completion factors. Consideration is given to additional relevant information not fully reflected in the pricing model. Model results are evaluated for reasonableness and actuarial judgment may be applied.

The claims used to develop completion factors reflect the experience period claims for the information submitted. The incurred but not paid claims are not unusually high or unusually low relative to the experience period claims paid.

4.4.2 Benefit Categories

The claims experience that appears on Worksheet 1, Section II, is broken into six benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, Capitation and Prescription Drug. We used a combination of claim/procedure specific attributes (including but not limited to ICD-9, ICD-10, Revenue Codes, CPT4, HCPCS and NDCs) to determine the category into which each claim in the experience period falls.

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Benefit Category	Category Description
Inpatient Hospital	Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse disorder, 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 services, 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.
Capitation	Includes all services provided under one or more capitated arrangements.
Prescription Drug	Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

4.4.3 Projection Factors

The projection factors used in the URRT have been calculated in accordance with Section 4.4.3 of the most recent Unified Rate Review (URR) Instructions.

4.4.3.1 Trend Factors

Trend Factors (cost/utilization):

As reported in Worksheet 1 of the URRT, the cost and utilization trend factors are split by Year 1 and Year 2. Year 1 reflects the factors to trend allowed claims from 1/1/2024 through 12/31/2024 by 13 months to 2/1/2025 through 1/31/2026. Year 2 reflects the factors to trend allowed claims from 2/1/2025 through 1/31/2026 by 12 months to 2/1/2026 through 1/31/2027.

The annualized trend applied to experience period allowed claims is 6.5%. This figure does not include the impact of changes in drug rebates, which is described in Section 4.4.3.2. Trend differs from the prior filing due to changes in experience, as well as projected changes in unit cost, utilization, and service mix.

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

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from group accounts from PPO products. The data includes various categories of services representing inpatient, outpatient, professional, other medical providers, 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 (EHBs). Although the underlying dta is derived from PPO products only, this trend is appropriate for our non-PPO business because the network factors account for differences in trend from our PPO network to our other networks.

Small group businesses renew throughout the calendar year. To reflect the fact that not all policies renew in the first month of the quarter, we trended the experience claims to the middle month of each quarter in the projection period. Rates effective 1/1/2026 through 3/31/2026 are based on experience trended to the 12 month period starting 2/1/2026. Quarterly rate increases are based on an additional 3 months of trend per quarter.

4.4.3.2 Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment:

We anticipate changes in the market-wide population morbidity from the experience period to the projection period due to the growth of the level-funded products in the Small Group market. We have seen the Small Group ACA single risk pool deteriorate over recent years as healthier members move to the level-funded market. The “Population Morbidity Adjustment” is 6.1%.

Demographic Shift:

This reflects the changes in the projected allowed costs because of expected differences in the distribution of member ages, areas, provider networks, and benefit plans between the experience period and projection period. The Demographic Shift adjustment is 0.0%.

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Plan Design Changes:

The factors used to adjust for changes in benefits from the experience period to the projection period were developed using an internal model. All benefits covered in the experience period will also be covered in the projection period. The adjustment due to Plan Design Changes is 0.0%.

Other Adjustments:

The "Other Adjustment" is 2.4%, and includes the following:

Changes in Provider Networks

This reflects changes in negotiated networks between the experience and projection periods. The adjustment due to changes in provider networks is 0.2%.

Changes in Drug Rebates

This reflects expected changes in drug rebates, relative to the pre-rebate prescription drug allowed claims, between the experience and the projection period. The adjustment due to changes in drug rebates is 2.2%.

4.4.3.3 Manual Rate Adjustments

No manual rate was needed as the experience period claims are deemed fully credible as discussed in Section 4.4.3.4.

4.4.3.4 Credibility of Experience

Full credibility has been assigned to the Base Period Experience, appropriately adjusted to reflect the material changes anticipated between the experience period and the projected period.

This assignment of full credibility is consistent relative to:

(1) Actuarial Standard of Practice No. 25, Credibility Procedures, specifically Section 3.4, "Professional Judgment," the ASOP states, "…in some situations, an acceptable procedure for blending the subject experience with the relevant experience may be based on the actuary assigning full, partial, or zero credibility to the subject experience without using a rigorous mathematical model," and
(2) A review of the Medical Loss Ratio (MLR) credibility standards, as described in 45 CFR Part 158, §158.230(c)(1). An MLR calculation is fully credible if it is based on the experience of 75,000 or more life-years.

There is an average of approximately 512,000 members in the 2024 base period experience. As such, we felt that applying 100% credibility was appropriate.

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There are no material changes from the prior credibility procedures.

4.4.3.5 Establishing the Index Rate

As reported in Worksheet 1 of the URRT, the index rate for this filing is $944.47. It represents the estimated total allowed claims per member per month (PMPM) for the single risk pool for EHBs in the Texas Small Group market.

For the experience period, the index rate equals the total allowed charges PMPM, less coverage for benefits in excess of the EHBs.

For the projection period, the index rate equals the total expected allowed charges PMPM, less coverage for benefits in excess of EHBs.

BCBSTX Small Group Quarterly Trend Increases:

These rates incorporate allowed claims trend that is updated quarterly and are effective through December 31, 2026. The index rate will increase 1.40% each quarter. This quarterly index rate increase differs from the quarterly premium rate schedule increase, which is described in section 4.4.6.

4.4.3.6 Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate (MAIR) is the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules on an allowed basis (grossed up by the expected paid to allowed ratio). These modifiers include federal risk adjustment and Exchange user fees.

The MAIR is calculated by subtracting the reinsurance and risk adjustment amounts from the index rate and dividing by 1 minus the Exchange user fee percentage.

The table below provides a summary of the development of the projection period MAIR as shown on Worksheet 1 of the URRT:

	January 1, 2026 Eff Date Filing
Projected Index Rate	$944.47
Reinsurance	$0.00
Risk Adjustment Payment/Charge	$5.49
Exchange User Fees	0.0%
Market-wide Adjusted Index Rate	$938.98

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Reinsurance:

The 2016 benefit year was the final year of the Federal Reinsurance Program, as stated in the 2026 Notice of Benefit and Payment Parameters. As a result, neither the Experience Period nor the Projection Period include Reinsurance payments/contributions.

Risk Adjustment Payment/Charge:

Positive amounts are payable to the carrier; negative amounts are payable by the carrier.

The Experience Period Risk Adjustment transfer payment is the risk adjustment transfer payment from the Summary Report on Permanent Risk Adjustment Transfers for the 2024 Benefit Year.

The 2024 Risk Adjustment Data Validation (RADV) results will not be known until 2026. Since the program is budget-neutral, we assume our RADV adjustment will be $0 until additional information is known. We also assume that the net high-cost risk pool charge and payments in 2026 will be $0.

The projected risk adjustment for the 2026 plan year is set at 0.51% of premium. We assume the risk level of our business relative to that of our competitors for the 2026 plan year will be similar to the 2024 plan year.

The estimated risk adjustment transfers were allocated uniformly to all plans as a percentage of premium. For the purposes of Worksheet 1, Section II and Worksheet 2, Section IV, we have converted the percentage of premium as described to a market level dollar amount.

The development of final projected risk adjustment receivable PMPM is shown in the table below:

	January 1, 2026 Eff Date Filing
Projected Average Q1 Premium	$865.99
Risk Adjustment Payment/Charge as % of Premium	0.51%
Risk Adjustment Payment/Charge PMPM (Incurred Basis)	$4.42
Projected Paid to Allowed Ratio	80.5%
Risk Adjustment Payment/Charge PMPM (Allowed Basis)	$5.49

Exchange User Fees:

No plans are being offered on the Exchange.

The Exchange user fee equals 1.5% of premium sold through the SHOP Marketplace, per regulation. We have assumed 0.0% of premium will be sold through the SHOP Marketplace,

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resulting in an assumption that Exchange user fees account for 0.0% of the Small Group single risk pool premium.

4.4.4 Plan Adjusted Index Rate

The Plan Adjusted Index Rate (PAIR) is the MAIR adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR 156.80(d)(2). Only the following adjustments were made:

- Actuarial value and cost sharing design of the plan, which includes a uniform leveraging increase assumption applied equally to all plans and quarters,
- The plan's provider network, delivery system characteristics, and utilization management practices,
- Benefits provided under the plan that are in addition to EHBs, and
- Administrative costs, excluding Exchange user fees.

As provided in Worksheet 2 of the URRT, the PAIR is the MAIR multiplied by the product of the "AV and Cost Sharing Design of Plan," "Provider Network Adjustment," and "Benefits in Addition to EHB" components, divided by 1 minus the sum of "Administrative Expense," "Taxes and Fees" and "Profit & Risk Load." These components are described below.

AV and Cost Sharing Design of Plan:

The AV and Cost Sharing Design of Plan considers differences in cost sharing and the resulting induced demand. Paid to allowed ratios are created using the same claim distribution for each plan design.

The AV and Cost-Sharing Design of Plan takes into account the benefit and utilization differences due to differences in cost-sharing. Furthermore, paid to allowed ratios used in the rate development reflect the percentage of allowed claims expected to be BCBSTX's liability based on the plan provisions and underlying claim mix for a standardized population and do not reflect differences in health status.

Induced demand factors by metallic are based on the Federal Benefit Richness curve.

Provider Network Adjustment:

The Provider Network Adjustment reflects changing unit cost and practice patterns by network, due to providers joining, terminating, and renegotiating rates throughout the year. Changes in signed and expected contracts are reflected. In developing the network factors, we normalize our experience for benefit richness and risk levels, therefore removing the impact of morbidity from our factors. The remaining difference in PMPMs reflects unit cost and practice patterns between different networks. The calculated network factors were normalized to obtain

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provider network adjustments that average to 1 and are the same for all plans within the same network.

Benefits in Addition to EHB:

Texas requires group business insurance carriers to offer coverage for in vitro fertilization (IVF) procedures. This coverage is not an EHB under the federal definition. Riders for optional coverage are not allowed per the URR Instructions. Therefore, to comply with the Texas state requirement, BCBSTX offers a mirrored version of each non-IVF plan except that the mirrored version includes IVF coverage. Each of these mirrored plans is given a unique SCID in accordance with the URR Instructions. BCBSTX has established the following plan factor loads for these plans by metallic level:

Metallic Level	Plan Factor Load
Platinum	1.25
Gold	1.35
Silver	1.40
Bronze	1.45

Administrative Costs:

Administrative Costs include Administrative Expenses, Taxes and Fees, and Profit & Risk Load.

Administrative Expenses

The administrative expense load built into the pricing of the Small Group products is based on allocated expenses as they exist in the current operating model, adjusted for expected 2026 membership, expected expense inflation, and other budgeted adjustments related to the Small Group block of business. Additionally, all Small Group premiums include a flat load to account for commissions, which incorporate the expected external sales commission percentage, and total expected expenses related to internal distribution costs for direct business.

The source data is based on allocated expenses applicable to each line of business as they exist in the current operating model which has been adjusted for expected expense inflation, expected membership in 2026, and changes in operations because of the regulatory changes. Membership in 2026 is described in Section 4.6.2.

Administrative expenses are allocated uniformly as a percentage of premium across all products and plans.

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Taxes and Fees

All taxes and fees, whether calculated as a PMPM, PMPY or percentage of premium, are allocated uniformly as a percentage of premium across all products and plans.

The following Taxes and Fees may be subtracted from premiums for purposes of calculating MLR:

Tax/Fee	January 1, 2026 Eff Date Filing
State Premium Tax	1.64% of premium
State Assessments	0.04% of premium
Risk Adjustment User Fee	0.03% of premium
PCORI Fee	0.04% of premium

Profit & Risk Load

The target contribution to surplus, inclusive of underwriting gain/loss margin and any additional risk margin, is 2.07% of the billed premiums. Target margins does not vary by metal level.

4.4.5 Calibration

Age Curve Calibration:

The approximate age curve calibration factor associated with the projected single risk pool is 0.6919. It was developed using the projected membership for the single risk pool as of April 30, 2025. The index rate includes an adjustment for the difference between the projected average age factor and the experience average age factor.

The age curve calibration factor is calculated as follows:

$$ACCF = \frac{\sum Mbrs}{\sum Mbrs * AF}$$, where

ACCF = Age Curve Calibration Factor

Mbrs = Projected Members

AF = CMS Rating Age Factor for a given subset of members; 0 for members not expected to pay premium

The age curve calibration adjustment is not plan-specific. The same factor was applied to all plans in the projected single risk pool.

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This calculation reflects the uncollected premium for families with more than three dependents under age 21.

A demonstration of how the PAIR and the age curve are used to generate the schedule of premium rates for each plan is described in Section 4.4.6.

Geographic Factor Calibration:

Experience period geographic factors are developed based on past claims segmented by employer rating area and are adjusted for differences in morbidity and benefit level by area. Each experience period factor is then adjusted for provider contracting changes between the experience period and the projection period and blended with prior year factors to limit disruption.

In developing the geographic factors, we normalize our experience for benefit richness and risk levels, therefore removing the impact of morbidity from our factors. The remaining difference in PMPMs reflects unit cost and practice patterns between different areas.

The geographic factors used are displayed in URRT Worksheet 3.

The geographic calibration factor associated with the projected single risk pool is 0.9891.

The geographic calibration factor is calculated as follows:

$GCF = \frac{\sum Mbrs}{\sum Mbrs * GF}$, where

GCF = Geographic Calibration Factor

Mbrs = Projected Members

GF = Projected Geographic Factor for a given subset of members

The geographic factor calibration adjustment is not plan-specific. The same approximate average geographic factor was applied to all plans in the projected single risk pool.

Tobacco Use Rating Factor Calibration:

BCBSTX Small Group rates do not vary by tobacco use; therefore, the calibration factor is 1.0000.

4.4.6 Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by first multiplying the PAIR by the age calibration factor, the geographic calibration factor, and the tobacco calibration factor. The

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result can then be multiplied by the individual's specific age factor and geographic factor to determine the approximate Consumer Adjusted Premium Rate. The premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are considered.

CAPR = Consumer Adjusted Premium Rate

$$\text{CAPR} = \text{PAIR} \times \text{Age Calibration} \times \text{Geographic Calibration} \times \text{Tobacco Calibration} \times \text{Age Factor} \times \text{Geographic Factor}$$

Example Q1 2026 Rate Calculation for age 40 in Rating Area 1

Plan: Blue Choice Bronze PPO 833, 33602TX0430052
Plan Adjusted Index Rate = $721.89
Age Calibration = 0.6919
Geographic Calibration = 0.9891
Tobacco Calibration = 1.0000
Age 40 Factor = 1.2780
Rating Area 1 Factor = 0.9999

$$\text{CAPR} = \$721.89 \times 0.6919 \times 0.9891 \times 1.0000 \times 1.2780 \times 0.9999 = \$631.31$$

The Premium Rate listed in the Rates Template is $631.29. Any differences are due to the intermediate rounding of values implied in the URRT's rate development and actual rate development.

Small Group Plan Premium Rates:

The quarterly filed rates incorporate allowed claims trend and benefit leveraging. These rates are updated quarterly and are effective through December 31, 2026. The rate schedule will increase 1.63% each quarter.

4.5 Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 89.23%. The MLR calculation is in accordance with the formula in the HHS Notice of Benefits and Payment Parameters.

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

Which simplifies to,

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

Confidential and proprietary information pursuant to, including but not limited to, Tex. Gov't Code Ann. §§ 552.110, §§ 552.1101(a), 5 U.S.C. §§ 552(b)(4) and (b)(6), 45 C.F.R. §§ 5.31 (d) and (f), and the Trade Secrets Act (18 U.S.C.§1905). BCBSTX objects to any release of this information if requested, requests immediate notification of any request for this information, and requests that TDI promptly seek an Attorney General Opinion Decision if this information is requested.

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
- *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.

The following are the values for each component listed above stated as a percentage of premium:

- *i* = 87.76%
- *q* = 0.43%
- *p* = 100%
- *t* = 1.64%
- *f* = 0.10%
- *n* = 0.00%
- *r* = 0.51%
- *c* = 0.00%

$$\left[\frac{(87.76\%+0.43\%+\ 0.00\%\ -\ 0.51\%)}{\{100\%-(1.64\%+0.10\%)\}}\right] = 89.23\%$$

The projected MLR is greater than 80.0%.

4.6 Plan Product Information

4.6.1 AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template are based entirely on the AV Calculator results. While certain member cost sharing features may not be fully compatible with the AV Calculator parameters and potentially remain unaccounted for, the impact of these features is likely small enough that no plan's metallic status would be impacted.

4.6.2 Membership Projections

BCBSTX assumes the current level of Small Group membership for the single risk pool membership. We assume membership will remain mostly flat with new sales offset by normal lapses during the year. Current enrollment is as of April 30, 2025.

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4.6.3 Terminated Plans and Products

Please see Appendix I for a table that shows a list of all plans that will be terminated prior to January 1, 2026, and either have experience included in the single risk pool during the 2024 experience period or were made available thereafter.

4.6.4 Plan Type

All health plans fit the plan types listed in the drop-down box in Worksheet 2, Section I of the URRT.

4.7 Miscellaneous Instructions

4.7.2 Reliance

I have relied upon financial data, summaries and analyses prepared by responsible officers and employees of Health Care Service Corporation, and my analysis included such review of the assumptions as I considered necessary.

4.7.3 Actuarial Certification

I, Robert Hastings, am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries in good standing, and I meet the qualification standards necessary to prepare and certify rate filings for health plan entities.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice, including:

- ASOP No. 1, Introductory Actuarial Standard of Practice
- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

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I hereby certify to the best of my knowledge that:

1. I am a member of the American Academy of Actuaries.

2. The projected Index Rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
    b. Developed in compliance with the applicable Actuarial Standards of Practice,
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
    d. Neither excessive nor deficient.

3. 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.

4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. 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.

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

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

Respectfully submitted,



Date: September 5, 2025

Confidential and proprietary information pursuant to, including but not limited to, Tex. Gov't Code Ann. §§ 552.110, §§ 552.1101(a), 5 U.S.C. §§ 552(b)(4) and (b)(6), 45 C.F.R. §§ 5.31 (d) and (f), and the Trade Secrets Act (18 U.S.C.§1905). BCBSTX objects to any release of this information if requested, requests immediate notification of any request for this information, and requests that TDI promptly seek an Attorney General Opinion Decision if this information is requested.

Appendix I

Terminated Plans and Products

Original SCID	Original Plan Name	Metal AV	Mapped SCID	Mapped Plan Name
33602TX0471177	Blue Advantage Gold HMO 103	0.791	33602TX0470995	Blue Advantage Gold HMO 919
33602TX0471179	Blue Advantage Gold HMO 103	0.791	33602TX0470997	Blue Advantage Gold HMO 919
33602TX0471182	Blue Advantage Gold HMO 103	0.791	33602TX0471000	Blue Advantage Gold HMO 919
33602TX0471184	Blue Advantage Gold HMO 103	0.791	33602TX0471002	Blue Advantage Gold HMO 919
33602TX0471185	Blue Advantage Gold HMO 103	0.791	33602TX0471003	Blue Advantage Gold HMO 919
33602TX0471186	Blue Advantage Gold HMO 103	0.791	33602TX0471004	Blue Advantage Gold HMO 919
33602TX0471189	Blue Advantage Gold HMO 103	0.791	33602TX0471007	Blue Advantage Gold HMO 919
33602TX0471194	Blue Advantage Gold HMO 103	0.791	33602TX0471012	Blue Advantage Gold HMO 919
33602TX0471195	Blue Advantage Gold HMO 103	0.791	33602TX0471013	Blue Advantage Gold HMO 919
33602TX0471196	Blue Advantage Gold HMO 103	0.791	33602TX0471014	Blue Advantage Gold HMO 919
33602TX0471197	Blue Advantage Gold HMO 103	0.791	33602TX0471015	Blue Advantage Gold HMO 919
33602TX0472463	Blue Advantage Gold HMO 103	0.791	33602TX0472417	Blue Advantage Gold HMO 919
33602TX0472529	Blue Advantage Gold HMO 103	0.791	33602TX0472483	Blue Advantage Gold HMO 919
33602TX0472397	Blue Advantage Gold HMO 103	0.791	33602TX0472351	Blue Advantage Gold HMO 919

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