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PART III ACTUARIAL MEMORANDUM

SMALL GROUP RATE FILING

Effective January 1, 2027

Created for: Chinese Community Health Plan
Prepared by: Perr&Knight



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EXHIBIT 1. GENERAL INFORMATION

Document Overview

This document contains the Part III Actuarial Memorandum for Chinese Community Health Plan's (CCHP) small group block of business, effective January 1, 2027. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT) and the Part II Rate Justification.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of California Department of Managed Health Care (DMHC), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CCHP's small group rate filing. However, we recognize that this certification may become a public document. Perr&Knight makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Perr&Knight under any theory of law.

It is important to note that the premium rate analysis completed here is based on current law and regulations promulgated at the time. Significant changes to health care law that could affect the 2027 market are under consideration at the federal and state level and may change between now and the rate filing date, or subsequent to it. Anticipating all such changes is beyond the scope of this analysis, other than as noted below.

The rates and plan offerings supported by this Actuarial Memorandum are consistent with current regulations and guidance. CCHP reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed.

Company Identifying Information

Company Legal Name: Chinese Community Health Plan
State: The State of California has regulatory authority over these policies.
HIOS Issuer ID: 47579
Market: Small Group
Effective Date: January 1, 2027

Company Contact Information

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EXHIBIT 2. PROPOSED RATE CHANGES

CCHP is proposing an average rate increase of 18.6%. Rate increases range from 17.9% to 19.7% depending on the plan. Rate increases vary by plan due to shifts in the estimated relationship between benefits and cost sharing levels by plan and claims costs. The rate increase does not vary by geographic area. Area factors are unchanged between 2026 and 2027.

Appendix 1 contains a detailed build-up of the proposed rate increase. This appendix illustrates the development of our proposed index rate, starting from 2025 experience data. This index rate supports our proposed rate change. Below is a high-level discussion of adjustments to the 2025 experience period.

Table 2.1 summarizes proposed rate increases by product:

Table 2.1
2027 Summary of Proposed Rate Increases

	San Francisco	San Mateo
Platinum 90 HMO	18.8%	18.8%
Gold 80 HMO	18.5%	18.5%
Silver 70 HMO	18.3%	18.3%
Bronze 60 HMO	19.6%	19.6%
Bronze 60 HDHP HMO	17.9%	17.9%
Ruby 10 HMO Platinum	18.3%	18.3%
Ruby 20 HMO Platinum	18.1%	18.1%
Ruby 40 HMO Platinum	19.7%	19.7%
Opal 25 HMO Gold	18.1%	18.1%
Opal 50 HMO Silver	17.9%	17.9%
Platinum 90 HMO INF	18.7%	18.7%
Gold 80 HMO INF	18.4%	18.4%
Silver 70 HMO INF	18.2%	18.2%
Bronze 60 HMO INF	19.5%	19.5%
Bronze 60 HDHP HMO INF	18.0%	18.0%
Ruby 10 HMO Platinum INF	18.3%	18.3%
Ruby 20 HMO Platinum INF	18.1%	18.1%
Ruby 40 HMO Platinum INF	19.5%	19.5%
Opal 25 HMO Gold INF	18.1%	18.1%
Opal 50 HMO Silver INF	17.9%	17.9%
Total	**18.6%**	

Table 2.2 summarizes the main drivers behind rate changes from the 2026 rate to the 2027 projection period:

Table 2.2 Rate Change Key Drivers	
Change from 2026 to 2027	**Rate Change**
1. Change in starting allowed costs	0.7%
2. Change in utilization and unit cost trends	-3.1%
3. Change in projected benefits	1.3%
4. Change in projected morbidity	7.7%
5. Change in projected area mix	-0.6%
6. Change in projected age mix	0.6%
7. Change in non-benefit expenses (e.g., HIPF, admin, commissions)	2.7%
8. Change in projected risk adjustment transfer	9.3%
Total Rate Change	**18.6%**

Each of the drivers is explained in more detail below:

1. **Change in starting allowed costs**

   Starting costs increased 0.7% from 2026 to 2027.

2. **Change in utilization and unit cost trends**

   Claims costs were increased for anticipated changes due to medical/prescription drug inflation and increased medical/prescription drug utilization, particularly for high-cost specialty drugs. Below are the percentage increases for these changes. The 2025 to 2026 and 2026 to 2027 trends are reported in Worksheet 1, Section II of the URRT. Historical pharmacy trends were used to assist in trend development. See Table 2.3 below for the trends used.

Table 2.3 Chinese Community Health Plan Annualized Allowed Claim Trends				
Service Type	**Underlying Unit Cost**		**Utilization**	
	2025 to 2026	**2026 to 2027**	**2025 to 2026**	**2026 to 2027**
Inpatient Hospital		[redacted]		
Outpatient Hospital				
Professional				
Other Medical				
Capitation				
Prescription Drug				
Total				

The capitation adjustment was derived by projecting category-of-service-level PMPMs by medical group from 2025 into 2027. The projected PMPMs were then weighted with projected membership by medical group and compared to the experience PMPMs weighted by experience membership by medical group. The ratio of the composite PMPMs by category of service is reported as the capitation adjustment. The result of this calculation can be seen in Appendix 1.

3. Change in projected benefits

Effective January 1, 2027, benefits have changed based on state requirements and business decisions. Changes were made to deductibles, maximum out of pocket payments, and specialist copays. The following table describes notable changes in benefits between 2026 and 2027. The highlighted cells indicate a benefit change.

Table 2.4 Chinese Community Health Plan Select Benefit Plan Changes						
Plan Name	Deductible (Combined or Med/Rx)		MOOP		SPC Copay	
	2026	2027	2026	2027	2026	2027
Platinum Copay Plan	$0	$0	$4,500	$4,500	$30	$30
Gold Copay Plan	$250/$0	$300/$0	$7,800	$8,200	$55	$60
Silver Copay Plan	$3,200/$300	$3,000/$350	$9,500	$9,500	$90	$90
Bronze Copay Plan	$6,300/$500	$6,300/$500	$8,200	$8,575	$95	$95
Bronze HDHP	$7,100	$7,800	$7,100	$7,800	$0	$0
Ruby 10	$0	$0	$3,900	$5,000	$30	$40
Ruby 20	$0	$0	$3,700	$4,600	$20	$28
Ruby 40	$0	$0	$3,000	$3,300	$40	$40
Opal 25	$2,100/$250	$2,100/$250	$6,100	$6,100	$35	$35
Opal 50	$2,500/$700	$2,500/$700	$9,100	$9,100	$100	$100

Changes in benefits and plan mix from 2025 to 2027 have resulted in an aggregate utilization adjustment of 1.013, as shown in Worksheet 1, Section II of the URRT.

4. Change in projected morbidity

We project a 7.7% overall increase in morbidity for CCHP's risk pool between 2025 and 2027 (two year, not annual) due to changes in the age and metal level distributions of the risk pool over that time, as well as an anticipated higher percentage of members using capitated providers.

5. Change in projected area mix

We project a -0.6% change in membership mix by area between 2026 and 2027.

6. Change in projected age mix

Changes in age mix are expected to change utilization over time. This impact (combined with the change in projected area mix) is 1.000, as shown in Worksheet 1, Section II of the URRT. The change in age mix also affects the allowable rating factor, as discussed in Exhibit 11.

7. Change in non-benefit expenses (e.g., admin, commissions)

Appendix 2 details the non-claims expenses contained in the proposed rate increase. Administrative expense assumptions are expected to be higher in 2027 as compared to 2026. CCHP performed a detailed assessment of 2025 expenses and projected them to 2027.

8. Change in projected risk adjustment transfer

The development of the risk adjustment transfer payment is discussed in Exhibit 9.

Single Risk Pool

CCHP rates are developed using a single risk pool, established according to the requirements in 45 CFR section 156.80(d) and reflects all covered lives for every non-grandfathered product/plan combination, in the State of California small group health insurance market.

EXHIBIT 3. EXPERIENCE AND CURRENT PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

The experience reported on Worksheet 1, Section I of the URRT shows CCHP's earned premium and allowed and paid claims for the period of 1/1/2025 through 12/31/2025, with claims paid through 2/28/2026. The current enrollment and premiums are reported as of 2/28/2026.

Premiums in Experience Period

The premiums earned during the experience and as reported on Worksheet 1, Section I of the URRT are from CCHP's audited financial statements for CY2025. The premiums are not adjusted for MLR rebates, and CCHP does not expect to pay any MLR rebates.

Method for Determining Allowed Claims

Worksheet 1, Section I of the URRT shows our best estimate of the amount of claims that were incurred during the 12-month experience period. To determine allowed claims, the total paid claims (described below) were divided by the modeled paid to allowed ratio for CCHP's mix of plans in 2025, based on a pricing model.

All claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not reported allowed claims was added to the processed amount to arrive at a final estimate of total claims. No estimate of incurred but not reported claims was added to the capitated claims.

Method for Determining Paid Claims

All paid claims processed both in and out of the claim system were included. Of this amount, 100% was processed through the claim system. An estimate of incurred but not paid claims was added to the processed amount to arrive at a final estimate of total paid claims. Capitated amounts, paid outside the claims system, were taken directly from provider contracts. Rx rebates were subtracted from paid pharmacy claims.

Method for Determining Incurred But Not Reported Paid Claims

We used the development approach to calculate the IBNP claim liability estimate. Our methodology has provided for both reported and unreported claims. We developed claim completion factors from recent historical experience using an eight-month completion ratio averaging method, in which the eight most recent factors are averaged, with the minimum and maximum values removed. Within this approach, we examined estimates of liability based upon several methods of estimating ultimate incurred claims for the most recent incurral months. We based our best-estimate liability on several factors, including historical completion ratios, historical levels of PMPM incurred costs, trends in incurred costs, and potential seasonal variations.

Method for Determining Paid Cost Sharing

All paid claims processed both in and out of the claim system were included. We estimated the members cost sharing using the modeled paid to allowed ratios in the base period.

EXHIBIT 4. BENEFIT CATEGORIES

We assigned the experience data utilization and cost information to benefit categories as shown in Worksheet 1, Section II of the URRT based on place and type of service using a detailed claims mapping algorithm.

Small group members can select a medical group as their primary delivery system. Depending on their choice, some claims are adjudicated under a partial capitation budget and others are adjudicated using a FFS fee schedule. The encounters under the partial capitation are replaced by the capitation amount paid to the provider groups and reported as "Capitation." Services under a full capitation arrangement, namely pediatric dental and vision, are also reported and projected in the Capitation category.

Inpatient Hospital

The inpatient hospital category includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

The outpatient hospital category includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility. Also includes the budgeted amounts under the partial capitation, based on member selection of medical group.

Professional

The professional category 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. Also includes the budgeted amounts under the partial capitation, based on member selection of medical group.

Other Medical

The other medical category includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. Also includes the budgeted amounts under the partial capitation, based on member selection of medical group.

Capitation

The capitation category includes all services provided under one or more capitated arrangements. It includes all services provided under the capitated pediatric dental and vision benefits, as well as partial

capitation arrangements with two medical groups covering some or all of outpatient, professional, and other medical. The partial capitation dollars reflect the contracted amounts.

Prescription Drug

The prescription drug category includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

EXHIBIT 5. PROJECTION FACTORS

This section includes a description of each factor used to project the experience period allowed claims to the projection period, and supporting information related to the development of those factors.

Changes in the Morbidity of the Population Insured

We project a 7.7% overall increase in morbidity for CCHP's risk pool between 2025 and 2027 (two year, not annual) due to changes in the age and metal level distributions of the risk pool over that time, as well as an anticipated higher percentage of members using capitated providers.

Changes in Benefits

We made the following adjustments to reflect the expected differences in benefits between the experience period and projection period, as shown in the Plan Design Changes column of Worksheet 1, Section II of the URRT:

- There are no newly mandated benefits required under state law, which are not reflected in the experience period claims.
- There were no significant benefits covered in the experience period claims that will not be covered in the projection period.
- We anticipate changes in the average utilization of services due to differences in average cost sharing requirements during the experience period and average cost sharing requirements in the projection period.

We used a proprietary methodology along with the historical experience of CCHP's small group block of business, in order to estimate the benefit changes for each of the items listed above.

Changes in Demographics

The rate projection is based on 2025 experience and reflects the average demographics and geographic mix of the 2025 enrollees. The development of the 2027 Index Rate reflects the anticipated differences in the demographic and geographic mix of the population, as compared to the 2025 experience period. San Mateo is projected to be 8.0% more costly than San Francisco. This differential was also 8.0% in the 2026 filing. This factor only reflects area-specific practice patterns and provider reimbursement levels. Alameda County is projected to be 2.5% less costly than San Francisco. The composite age factor increased from 1.655 in the 2026 filing to 1.686 in the 2027 filing. The increase in the age factor is due to an increase in average age seen in the emerging experience.

Age and area were the only demographic factors used in this filing.

Trend Factors (Cost/Utilization)

The trend factors reflect CCHP's expectations regarding increases in in-network contractual reimbursement and the impact of trends in both projected in-network and out-of-network costs. Table 2.3 documents CCHP's projected trends by category. The factors only reflect trend applicable to the single risk pool; they have been normalized and/or adjusted when appropriate to account for other changes such as changes in age, benefit changes, seasonality patterns, and non-recurring events.

Small group members can select a medical group as their primary delivery system, and some are adjudicated under a partial capitation budget and others are adjudicated using a FFS fee schedule. Under the partial capitation, CCHP pays a capitation amount for the furnishing of some professional and outpatient services. CCHP had membership growth in their capitation arrangements in 2025 and they are projected to increase the proportion of membership in their capitation arrangements in 2027.

Inpatient and outpatient hospital trends were developed based on a comparison of current and projected hospital contracts by service type, as well as expected changes in the enrollee selection of hospitals in the service area. Professional and other medical unit costs were developed by evaluating the impact of anticipated changes in fee schedules over time.

Prescription drug utilization and unit cost trends were based on a combination of industry survey assumptions by drug tier (generic, brand, and specialty) and an analysis of historical pharmacy trends by CCHP management. We blended the industry survey trends with the experience trends using a 40%/60% weight, respectively, for both utilization and unit cost.

EXHIBIT 6. MANUAL RATE ADJUSTMENTS

Not applicable. CCHP's experience in the base period is fully credible, for the purposes of the rate projection.

EXHIBIT 7. CREDIBILITY OF EXPERIENCE

The credibility assigned to the base period experience is 100%.

EXHIBIT 8. ESTABLISHING THE INDEX RATE

The following table provides support for the average paid to allowed ratio consistent with membership projections by plan included in Worksheet 2.

Table 8.1 Chinese Community Health Plan Paid to Allowed Average Factor Support Exhibit	
	Worksheet 2 Section IV
Allowed PMPM	$542.26
Paid PMPM	$422.97
Average Paid to Allowed Ratio	78.0%

The Index Rate for the experience period is a measurement of the average allowed claims PMPM for essential health benefits (EHBs). This value is located on Worksheet 1, Section II of the URRT. The experience period Index Rate reflects the actual mixture of regional mix, plan enrollment, and the risk morbidity in the Single Risk Pool during the experience period. The experience period Index Rate has not been adjusted for payments and charges under the risk adjustment, federal and state reinsurance programs, or for Exchange User Fees.

The Index Rate for the Projection Period (calendar year 2027) is reflected in Worksheet 1, Section II of the URRT. It was developed following the specifications of 45 CFR part 156.80(d)(1). The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for EHBs for 2027 and has not been adjusted for payments and charges under the risk adjustment program or for Marketplace user fees. The Index Rate for the Projection Period will remain unchanged until a renewal filing effective January 1, 2028.

The development of the Index Rate for the Projection Period is found in Worksheet 1, Section II of the URRT. This reflects the 12-month projection period shown in Worksheet 1, Section II of the URRT, and the anticipated claim level of the projection period with respect to trend, benefits, and demographics.

EXHIBIT 9. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

Appendix 4 summarizes the calculation of the market adjusted index rates.

The Market Adjusted Index Rate is not calibrated, indicating that this rate reflects the average demographic characteristics of the single risk pool.

Each of the modifiers in the Market Adjusted Index Rate were developed as follows:

- Net Risk Adjustment: This adjustment includes the impact of the estimated risk adjustment transfer payment (including high-cost risk pool assessment) of $332.06 PMPM as addressed below. In Appendix 4 these amounts are shown on an allowed basis using the projected 2027 paid to allowed ratio (Total is $425.70).
- Net Transitional Reinsurance: This adjustment is $0 since the Transitional Reinsurance program will not be effective during 2027.

Experience Period Risk Adjustments PMPM

Experience period risk scores were calculated using 2025 CCHP claims and enrollment data, paid through 2/28/2026.

The actual risk adjustment liability is $302.91 PMPM for 2025. This number also includes an estimate for the RADV.

Projected Risk Adjustments PMPM

The risk score for 2027 is projected to be lower than the state average risk score based on historical experience, which is estimated to lead to a payment transfer of $332.06 PMPM into the pool.

CCHP's average risk is projected to be under the state average risk level. As a result, premium levels have been set at the anticipated state average risk level with the expectation that a portion of this premium will be paid to those carriers with higher risk levels.

The anticipated risk transfer payment is applied to the Index Rate as a market level adjustment. The overall impact of projected risk adjustment transfers is a premium increase of $332.06 PMPM, which is applied as a market level adjustment.

Beginning in 2018, a high-cost risk pool assessment is required for risk adjustment covered plans to fund the new high-cost risk pool. We assume this assessment will be treated as an adjustment to the risk adjustment payment (rather than a non-benefit expense). We have estimated the 2027 impact of this

assessment as [redacted] of premium, with recoveries at [redacted] of the assessment. This leads to a net impact of [redacted] of premium, or [redacted] PMPM.

An estimate of the adjustment for risk adjustment data validation (RADV) is included in the projected risk adjustment PMPM.

Experience Period ACA Reinsurance Recoveries Net of Reinsurance Premium

The federal transitional reinsurance program was a temporary program that ended in 2016. Since this program is not expected to continue in 2027, experience period reinsurance contributions and reinsurance recoveries are zero. As a result, we did not project any federal transitional reinsurance contributions or recoveries for 2027.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Not applicable.

EXHIBIT 10. PLAN ADJUSTED INDEX RATE

The Market-Wide Adjusted Index Rate is adjusted to compute the Plan Adjusted Index Rate using the following allowable adjustments:

Actuarial value and cost sharing adjustment

- The CMS Actuarial Value Calculator was used to determine the AV metal value for each plan.
- The AV and cost sharing pricing adjustment was developed utilizing the HCGs. Relativities between plans were based on the differences in cost and utilization for varying levels of cost sharing.

Provider network, delivery system and utilization management adjustment

- There are no expected differences in the provider network and/or utilization management between plans.

Adjustment for distribution and administrative costs

- This adjustment is not explicit in Appendix 4 because distribution and administrative costs do not vary by plan.

Impact of specific eligibility categories for the catastrophic plan

- This adjustment is not explicit in Appendix 4 because we have assumed no impact from the specific eligibility categories for the catastrophic plan.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool and therefore are not calibrated.

Experience Period Plan Adjusted Index Rates

The experience period plan adjusted index rate can be found in Worksheet 2, Section III of the URRT.

Non-Benefit Expenses, Profit, and Risk

Please refer to Appendix 2 for a detailed build-up of all projected non-benefit expenses, profit, and risk.

Administrative expense assumptions increased on a PMPM basis between the 2026 and 2027 filings, but decreased as a percentage of premium. This PMPM for general administrative overhead changed from [redacted] in the 2026 filing to [redacted] in the 2027 filing. CCHP performed a detailed assessment of 2025 expenses and projected them to 2027.

The proposed rates reflect a [redacted] after-tax risk/profit margin applied to all products and plans. On a gross basis, this margin is equal to a [redacted] total risk/profit margin, plus the impact of the non-deductibility of the HIPF. This assumption was [redacted] on a gross basis in the 2026 filing. The revised gross margin target

reflects the company's current and projected tangible net equity (TNE) position. CCHP develops a target gross margin for its multiple insurance products in order to build capital and surplus levels adequate to the size and volatility of those lines.

We have also assumed [redacted] in additional loading to account for members who fail to pay premiums, but for whom CCHP must pay claims during their premium grace period. We estimated this value using historical data for premiums that were written-off for members in this premium grace period.

Taxes and Fees

Appendix 2 provides details concerning projected taxes and fees. The taxes and fees are applied as a constant percentage for all benefit plans. The taxes and fees below are subtracted from premiums for the purpose of calculating MLR.

The risk adjustment user fee in 2027 is [redacted]

Beginning in 2018, a high-cost risk pool assessment is required for risk adjustment covered plans to fund the new high-cost risk pool. We assume this assessment will be treated as an adjustment to the risk adjustment payment (rather than a non-benefit expense). We have estimated the 2027 impact of this assessment as [redacted] of premium, with recoveries at [redacted] of the assessment. This leads to a net impact of [redacted] of premium, or [redacted] PMPM.

The Patient-Centered Outcomes Research Institute (PCORI) fee is included as [redacted] PMPM for the 2027 rate filing year based upon our understanding of the existing PCORI schedule and trending using the IRS inflation methodology.

The federal and state taxes are [redacted] PMPM. There is also a local business tax of [redacted] of premiums, or [redacted] PMPM.

Table 10.1 Chinese Community Health Plan Summary of Taxes and Fees	
Description	**2027**
Risk Adjustment User Fee	[redacted]
High-Cost Risk Pool Assessment, net of recoveries	[redacted]
Patient-Centered Outcomes Research Institute Fee	[redacted]
Federal and State Income Tax	[redacted]
Managed Care Organization Tax	[redacted]
Local Business Tax	[redacted]
Total	[redacted]

The Comparative Research Effectiveness Fee is $0 in 2027. Per guidance from the Department of Managed Health Care (DMHC), the Managed Care Organization tax was set to $0.00 PMPM for 2027.

EXHIBIT 11. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates from Exhibit 10 to calibrate rates for the expected age and geographic distributions expected to enroll in the plan. The single calibration factor is applied uniformly across all plans.

Age Curve Calibration

The approximate weighted average age, rounded to a whole number, for the single risk pool is 48. The weighted average age curve calibration factor is 1.686. This age factor reflects the updated child age bands effective in 2018. The increase in the age factor is due to an increase in average age seen in the emerging experience as well as expected continued aging of the population as seen for the past few years.

In order to determine the calibration factor for age, the projected distribution of members by age was determined. The weighted average of the factors in the age curve was then calculated using this distribution. The average age was then determined by finding the age of a member that would have the closest factor to the weighted average age curve calibration factor. Prior to applying the allowed rating factors for age, geography and tobacco, the Plan Adjusted Index Rates need to be divided by the age curve calibration factor.

CCHP's CY2027 age and tobacco rating factors are shown below in Table 11.1. The age rating factors used by CCHP are identical to those prescribed by CMS. Rates reflect no impact due to tobacco use per California regulations.

Table 11.1
Chinese Community Health
Plan Age and Tobacco Factors

Age Band	Age Rating Factor	Tobacco Factor		Age Band	Age Rating Factor	Tobacco Factor
0-14	0.765	1.000		40	1.278	1.000
15	0.833	1.000		41	1.302	1.000
16	0.859	1.000		42	1.325	1.000
17	0.885	1.000		43	1.357	1.000
18	0.913	1.000		44	1.397	1.000
19	0.941	1.000		45	1.444	1.000
20	0.970	1.000		46	1.500	1.000
21	1.000	1.000		47	1.563	1.000
22	1.000	1.000		48	1.635	1.000

Table 11.1 Chinese Community Health Plan Age and Tobacco Factors						
23	1.000	1.000		49	1.706	1.000
24	1.000	1.000		50	1.786	1.000
25	1.004	1.000		51	1.865	1.000
26	1.024	1.000		52	1.952	1.000
27	1.048	1.000		53	2.040	1.000
28	1.087	1.000		54	2.135	1.000
29	1.119	1.000		55	2.230	1.000
30	1.135	1.000		56	2.333	1.000
31	1.159	1.000		57	2.437	1.000
32	1.183	1.000		58	2.548	1.000
33	1.198	1.000		59	2.603	1.000
34	1.214	1.000		60	2.714	1.000
35	1.222	1.000		61	2.810	1.000
36	1.230	1.000		62	2.873	1.000
37	1.238	1.000		63	2.952	1.000
38	1.246	1.000		64+	3.000	1.000
39	1.262	1.000				

Geographic Factor Calibration

In order to determine the calibration factor for geography, the projected distribution of members by area was determined. The weighted average of the area factors was then determined using this distribution. The area factors used are reflective of differences in delivery costs (including unit cost and provider practice pattern differences) only, and do not reflect any difference in population morbidity. Prior to applying the allowed rating factors for age, geography and tobacco, the Plan Adjusted Index Rates need to be divided by the geography calibration factor.

Additional information regarding the area rating factors can be found on Exhibit 12.

Appendix 4 demonstrates the calibration factors for each plan.

EXHIBIT 12. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. It is the product of the Plan Adjusted Index Rate, the geographic rating factor, the age rating factor and the tobacco status rating factor. All rating factors are described and shown below.

CCHP's 2027 geographic rating factors are shown below. The geographic factors used incorporate differences in delivery costs (including unit cost and provider practice pattern differences) only, and do not reflect any difference in population morbidity.

Table 12.1
Chinese Community Health Plan
Geographic Rating Factors

Area	Area Rating Factor
Rating Area 4	0.9787
Rating Area 6	0.9543
Rating Area 8	1.0570

The premium for family coverage is determined by summing the consumer adjusted premium rates for each individual family member, provided at most three child dependents under age 21 are considered.

Below is an example of how to arrive at the January 1, 2027 rate for an age 34 individual in rating area 4. Note this rate is using the rounded values in the URRT and does not match the actual rate exactly.

Table 12.2
Chinese Community Health Plan
Sample Consumer Adjusted Premium Rate Development

Calibrated Plan Adjusted Index Rate for Gold 80 HMO plan	$636.52
Age factor for a 34-year-old	1.214
Area 4 factor	0.9787
Tobacco factor	1.000
Consumer Adjusted Premium Rate	**$756.28**

EXHIBIT 13. PROJECTED LOSS RATIO

The projected medical loss ratio (MLR) is 84.2%. This loss ratio is calculated based on the MLR methodology as prescribed by 45 CFR 158. Please see Appendix 3 for more details.

No additional state-specific projected loss ratio demonstration is required in the State of California.

EXHIBIT 14. AV METAL VALUES

The AV metal values included in Worksheet 2, section I of the URRT are entirely based on the AV Calculator. Table 14.1 below summarizes these values for each product.

Note that several of the benefit designs offered by CCHP are standardized plans promulgated by Covered California: Standard Copay (Platinum, Gold, and Silver) and Standard Coinsurance (Bronze, Bronze HDHP, Catastrophic). Therefore, our results confirm the work of Covered California contracted actuaries for complying with the Federal AV Metal Values.

Table 14.1
Chinese Community Health Plan Actuarial Values

Plan	Actuarial Value	Actuarial Value Source
Platinum 90 HMO	91.7%	Federal AV Calculator
Gold 80 HMO	82.0%	Federal AV Calculator
Silver 70 HMO	72.0%	Federal AV Calculator
Bronze 60 HMO	65.0%	Federal AV Calculator
Bronze 60 HDHP HMO	64.9%	Federal AV Calculator
Ruby 10 HMO Platinum	91.8%	Federal AV Calculator
Ruby 20 HMO Platinum	92.0%	Federal AV Calculator
Ruby 40 HMO Platinum	91.9%	Federal AV Calculator
Opal 25 HMO Gold	82.0%	Federal AV Calculator
Opal 50 HMO Silver	71.9%	Federal AV Calculator

EXHIBIT 15. MEMBERSHIP PROJECTIONS

The projected membership (as displayed in Worksheet 2, Section IV of the URRT) was determined in conjunction with CCHP management. Membership by plan was projected based on current 2026 membership levels, with some adjustments.

No portion of the Silver plan enrollment is eligible for cost sharing reduction in the Small Group market; therefore, no estimation for this was determined.

EXHIBIT 16. TERMINATED PRODUCTS

No products will be terminated prior to the effective date.

EXHIBIT 17. PLAN TYPE

There are no differences between the plans of CCHP and the plan type selected in the drop-down box in Worksheet 2, Section I of the URRT.

EXHIBIT 18. EFFECTIVE RATE REVIEW INFORMATION

Because the proposed average rate increase of 18.6% exceeds the 10% threshold established under 45 CFR 154.200, a Rate Increase Justification is submitted in conjunction with this Actuarial Memorandum.

EXHIBIT 19. RELIANCE

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

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

A formal business plan from CCHP was not available at the time of rate filing. Company strategy and pricing goals were communicated by CCHP during the development of 2027 rates.

We relied on data and assumptions provided by CCHP and prepared under the supervision and review of CCHP management.

EXHIBIT 20. ACTUARIAL CERTIFICATION

I am a Director of A&H Actuarial with the firm of Perr&Knight, Inc. Chinese Community Health Plan engaged me to provide the opinion herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and 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 2027 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 shown in Worksheet 3 of the URRT reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.
4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.

The 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 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 2027 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2027 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court

decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

The information provided in this actuarial memorandum is in support of the items illustrated 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.

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

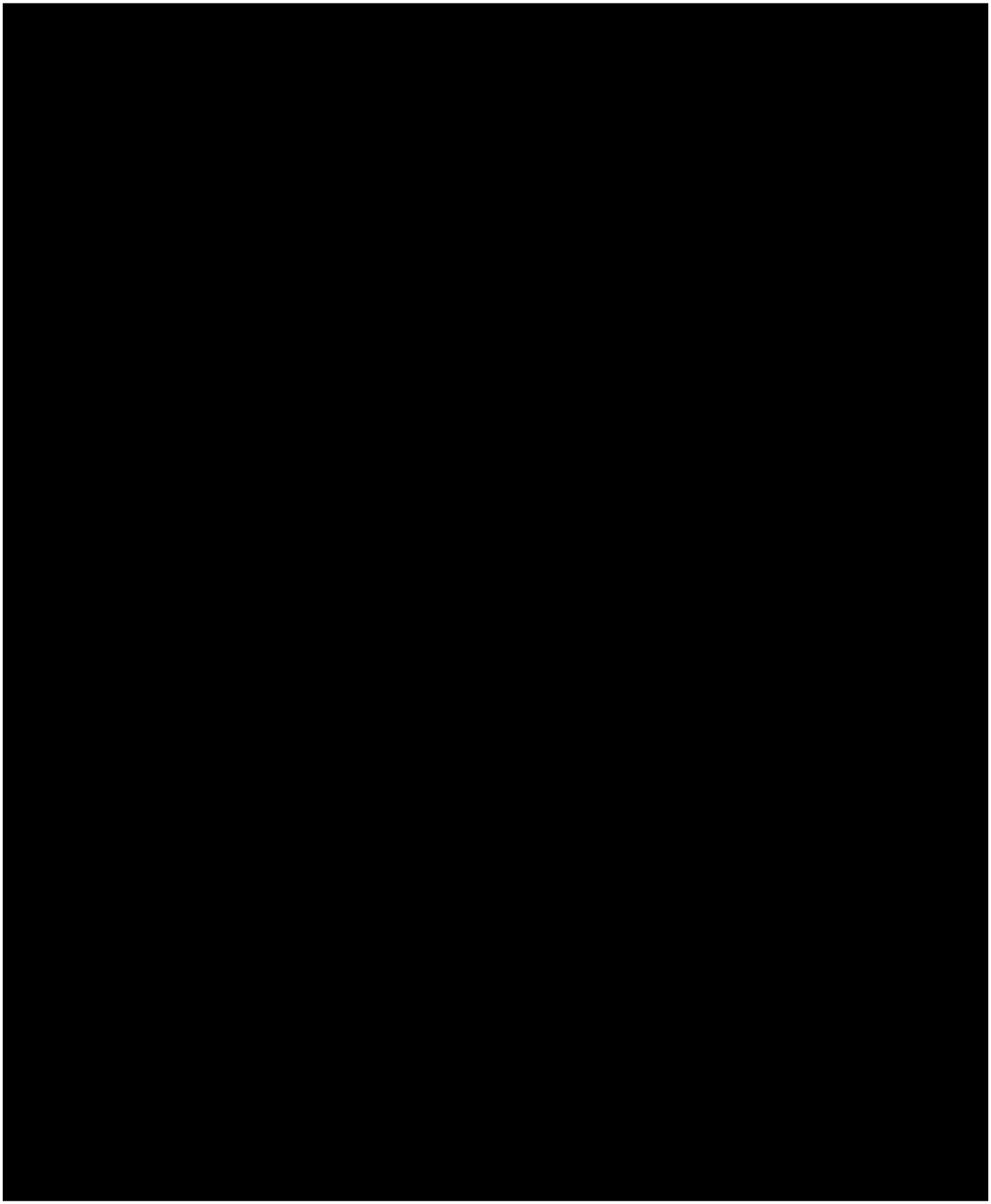
Signed: 

Name: Jennifer Choe, ASA, MAAA

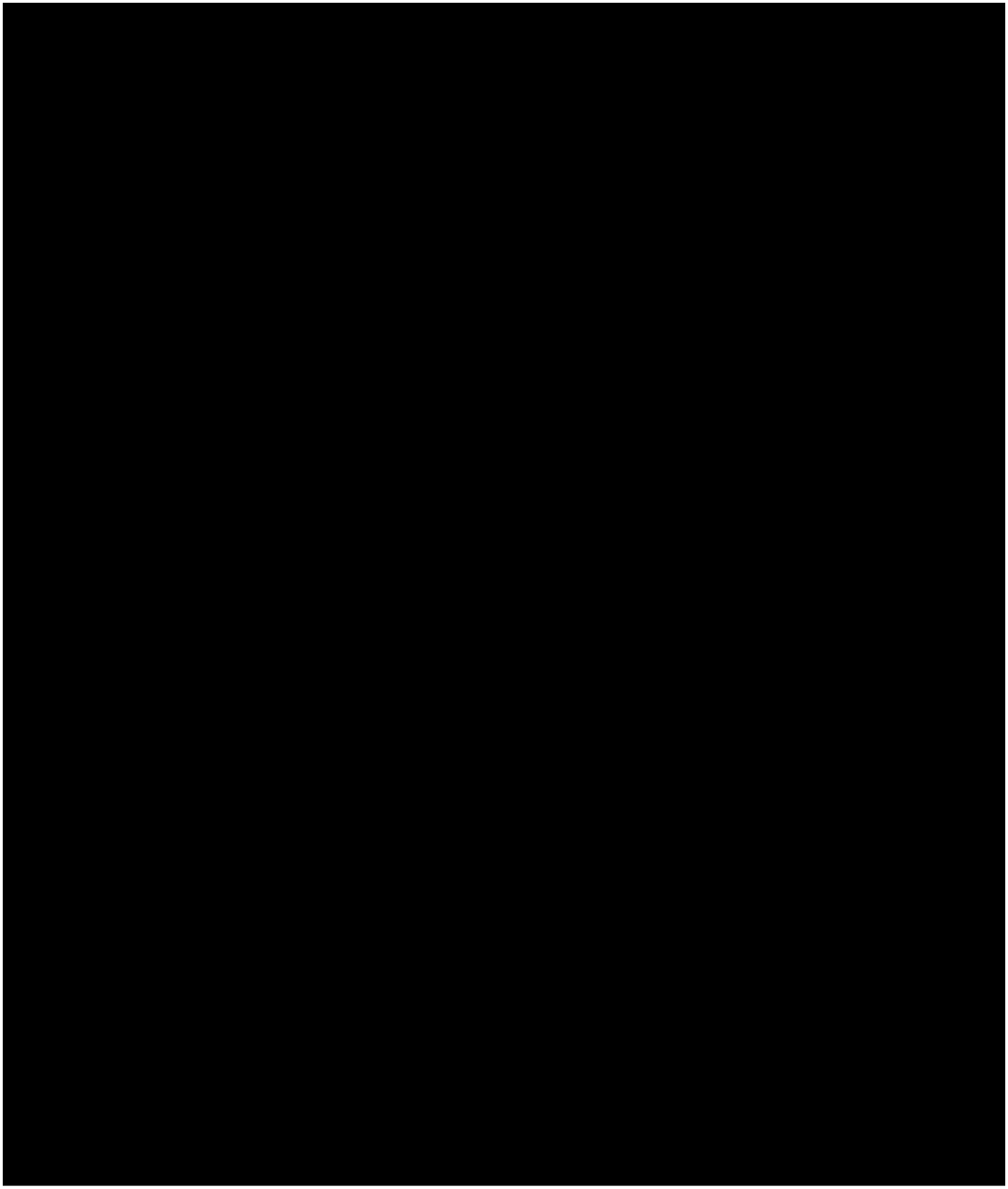
Title: Director | A&H Actuarial

Date: July 10, 2026

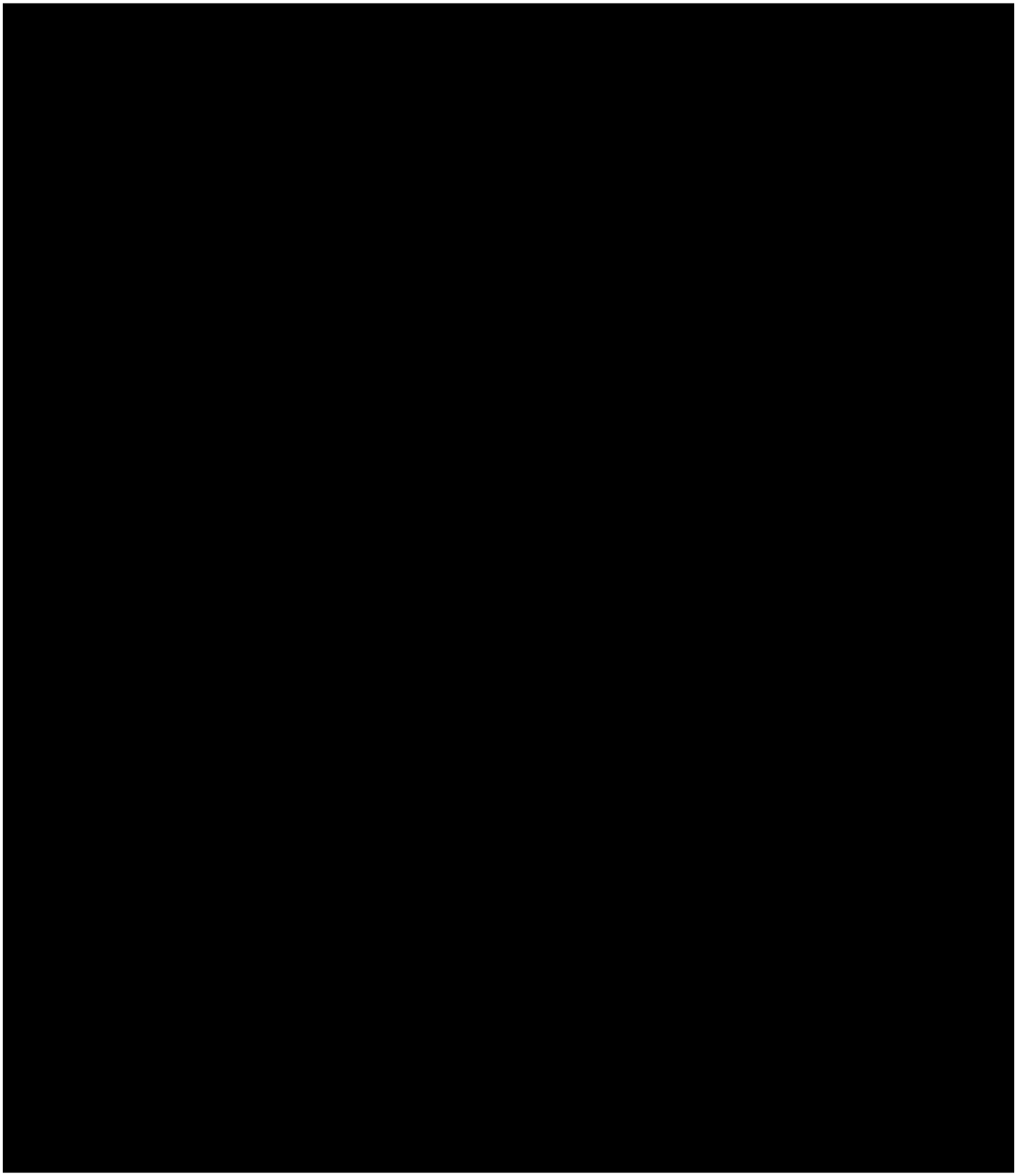
Appendix 1
Chinese Community Health Plan
CY 2027 Rate Projection
Small Group



Appendix 2
Chinese Community Health Plan
Development of CY 2027 Non-Claims Expenses



Appendix 3
Chinese Community Health Plan
2027 MLR Projection



Appendix 4
Chinese Community Health Plan
Small Group Index Rate to Base Rate

