Part III Actuarial Memorandum

Sutter Health Plan

Small Group Rate Filing

Effective January 1, 2027

Prepared for:
Sutter Health Plan

Prepared by:
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EXHIBIT 1. GENERAL INFORMATION

Document Overview

This document contains the Part III Actuarial Memorandum for Sutter Health Plan (SHP)'s 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).

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 SHP's small group rate filing. However, we recognize that this certification may become a public document. Milliman 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 Milliman under any theory of law.

Future modifications in legislation, regulation and/or court decisions may affect the extent to which the premium rates are neither excessive nor deficient. Sutter Health Plan 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: Sutter Health Plan
State: The State of California has regulatory authority over these policies.
HIOS Issuer ID: 64210
Market: Small Group
Effective Date: January 1, 2027

Company Contact Information

Primary Contact Name: Andrew Chung
Primary Contact Telephone Number: 765-430-3088
Primary Contact Email Address: Andrew.Chung@sutterhealth.org

EXHIBIT 2. PROPOSED RATE CHANGES

Premium Rate Development Approach

In order to develop the 2027Q1 rates, we analyzed Sutter Health Plan's (SHP) block of business for the period of January 1, 2025 through December 31, 2025 paid through mid-February 2026. We added IBNP estimates to the FFS claim amounts. FFS and Rx claims were trended to the 2027Q1 effective dates at the trend rates included in the URRT.

SHP has two capitation arrangements: separate PMPM capitation for pediatric vision / pediatric dental, and a percent of premium capitation. The projected 2026 PMPM capitations are known and thus trended at the known rate increase from 2025 to 2026 with additional projected trend from 2026 to 2027. The percent of premium capitation was trended at the filed premium rate increases from 2025 to 2026 and projected from 2026 to 2027. Behavioral health services changed from a capitation arrangement to fee-for-service in 2026 and SHP provided the projected claims cost for these services in 2026 and 2027. For consistency between rate filings, we compare the existing capitation PMPMs to the estimated FFS PMPMs when calculating trends for behavioral health services.

The projected claims experience was calibrated to the standard 3:1 age slope, benefit design factors, and area factors.

Attachment 1 documents all the loads that were applied to the trended claims. Attachment 1 starts with the projected paid claims PMPM (at the projected age, area, and benefit factors). This is different than what is in the URRT, which represents allowed claims. Loads for administrative cost, taxes, and fees are applied to get to the projected premium rate.

Proposed Rate Increase

Attachment 2 summarizes the proposed rate increase by plan effective January 1, 2027 relative to the rates in effect January 1, 2026. The aggregate 12-month rate increase to renewing plans is 1.19% relative to rates filed in 2026Q1 when weighted by the current enrollment and current premium PMPMs shown in Worksheet 2, Section I of the URRT. The following describe the drivers of the rate change.

Medical and Prescription Drug Inflation & Utilization Trend

Claims costs were increased for anticipated changes due to medical/prescription drug inflation and increased medical/prescription drug utilization. These are reported in Worksheet 1, Section II of the URRT. Note that the trend shown in Attachment 2 will not match what is in the URRT since it reflects the change in trend on paid dollars informing the rate development, while the URRT shows the projected trends on allowed dollars.

New Taxes, Fees and Administrative Expenses

The Protect Access to Health Care Act of 2024, an initiative measure enacted by Proposition 35, as approved by voters at the November 5, 2024, California statewide general election, extends the imposition of the Managed Care Organization (MCO) provider tax beyond January 1, 2027, subject to receipt of any necessary federal approvals. Senate Bill No. 125[1] (SB 125) effective June 29, 2026, imposes a MCO provider tax on health plans, for the 2027, 2028, and 2029 calendar years, but prohibits DMHC from collecting the tax until the Director of Health Care Services certifies that the tax is a federally permissible health care-related tax meeting specified federal requirements, or until the department receives federal approval that the tax is a permissible health-care related tax, as specified. Per DMHC guidance to health plans, health plans should not include this cost in rate filings until CMS approves the tax structure. We assumed $0.00 PMPM for the MCO Tax.

Prospective Benefit Changes

Attachment 2 shows there is a 2.5% expected decrease due to benefit changes from CY2026. Benefit changes mirror Covered CA's plan design. Changes in the modeling of benefit relativities produced some differences by plan, but the overall plan relativity was calibrated to the 2026 relativity.

Revised Risk Adjustment Transfer Payment Projection

With the release of the 2025 final report, in conjunction with actual CY2025 membership and diagnoses data, SHP now has a better understanding of their 2025 risk adjustment transfer payment, which is used as the basis for projecting the 2026 and 2027 risk adjustment transfer payments. Our risk adjustment estimates include an estimate of the impact of RADV because the BY2025 RADV results are not available yet. While we note that the most recent actual RADV results (2024) had a minimal

[1] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB125

impact on RATP in California's IND and SG markets, we are providing RATP estimates with a larger RADV impact to demonstrate the financial impact under historically reasonable levels where SHP was not a RADV outlier.

Revised Margin Targets

SHP is projecting a margin of 2.22%, which is slightly lower than what was filed for 2026Q1 (2.47%).

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

The experience reported on Worksheet 1, Section I of the URRT shows SHP's earned premium, incurred and paid claims, and enrollment for the period of 1/1/2025 through 12/31/2025, with claims paid through mid-February 2026 with an adjustment for IBNP. Current enrollment and current premium on Worksheet 2, Section II are reported as of February 2026.

Premiums in Experience Period

We summarized the premiums for 1/1/2025 through 12/31/2025 using detailed member-level data provided by SHP and stored in their data warehouse. No MLR rebates are anticipated to be refunded to enrollees, so we did not include an adjustment for MLR rebates in the experience period premium amounts.

Method for Determining Allowed Claims

All allowed 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 allowed claims. No estimate of incurred but not reported claims was added to the prescription drug claims or capitated claims.

Method for Determining Paid Claims

Similarly to the allowed 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 reported claims was added to the processed amount to arrive at a final estimate of total paid claims. No estimate of incurred but not reported claims was added to the prescription drug claims or capitated claims.

Method for Determining Incurred But Not Reported Paid Claims

Incurred claims were calculated by applying a completion factor to the paid claims from the experience period. The completion factors were developed using the lag development method. The completion factors for paid and allowed claims are the same and are not unreasonably high or low relative to the experience period claims. The completion factors are applied only to FFS claims, which represents a small portion of SHP’s total claims and thus have a very minimal impact. No completion factors were applied to capitation or prescription drug claims.

Method for Determining Paid Cost Sharing

Member cost sharing was determined by using the cost sharing fields present in SHP’s detailed claims-level historical data.

Current Period Enrollment and Claims

The current period member months and claims in Worksheet 2, Section II of the URRT are from February 2026, which is the latest month of enrollment data available at the time the rates were developed.

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 Part 1 URRT based on a detailed claims mapping algorithm summarized below.

Note that the majority of SHP's claim costs are capitated, and as a result, most of the claims cost fall into that category. Only out-of-area (OOA) emergency claims fall into the inpatient, outpatient, physician, and other medical categories described below.

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.

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.

Other Medical

The other medical category includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation

The capitation category includes all services provided under one or more capitated arrangements.

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 trend factors used to project the experience period Index Rate to the projection period, and supporting information related to the development of those factors.

Trend Factors (Cost/Utilization)

This development of the 2027Q1 rates reflects an annual trend rate in Year 1 of 25.08% and an annual trend rate in Year 2 of 13.18%, which was developed using the following data source and methodology:

- FFS trends were set based on a review of SHP's 2025 historical experience and with consideration for future contract changes. These were set at 8.0% annually.

- Prescription drug trends were developed based on a review of SHP's historical 2025 experience with consideration for SHP's PBM contract and expected manufacturer rebates. Manufacturer rebates are expected to trend at the same rate as prescription drug costs. Therefore, prior to and after accounting for rebates, prescription drug trends were set at 9.0% from 2025 to 2026 and 13.0% from 2026 to 2027.

- SHP has two separate capitation arrangements. One is for pediatric dental and vision, which was set to 1.0% annually based on known and projected contract changes and review of historical rate changes. The remaining, and largest, capitation expense is set at a percent of premium, and thus the trend was set to a target percent of premium for 2027Q1 rates, taking into account the target premium increase.

- Behavioral health services were previously covered by a third capitation arrangement but are changing to fee-for-service in 2026. SHP provided separate PMPM cost estimates for 2026 and 2027.

Morbidity Adjustment

We are projecting no change in morbidity from the experience period to the projection period.

Demographic Shift

Worksheet 1 of the URRT is based on CY 2025 experience, and reflects the average demographics (age) and geographic mix of the CY2025 enrollees. Our development of the 2027Q1 Index Rate reflects the anticipated differences in demographic and geographic mix of the population, which was based on SHP's forecasted membership through 2027. The forecasted membership mix is similar to the CY 2025, but not the same. In particular, there are notable membership shifts forecasted in response to recent filed rate changes and to the rate changes by rating area in this filing, such as decreases in Central Valley relative to Sacramento. As a result, an adjustment is applied to account for this change.

Plan Design Changes

Benefit relativities adjust for the cost sharing on each plan design. These benefit relativities include induced utilization based on benefit richness, but do not include any adjustments based on the health status of the population expected to enroll in any given plan. The benefit relativities are used to adjust for changes in benefits between the experience period and the 2027Q1 projection period. Since these adjustments are applied to claims on an allowed basis, and we do not expect plan design changes to impact total allowed dollars for a plan, we have applied no adjustment on Worksheet 1 of the URRT.

Other Adjustments

We are projecting no other adjustments from the experience period to the projection period.

EXHIBIT 6. MANUAL RATE ADJUSTMENTS

Not applicable. SHP's CY 2025 experience reflects over 383k member months. We treated SHP's experience as fully credible for the purposes of the rate projection based on the credibility threshold discussed in Exhibit 7 below.

EXHIBIT 7. CREDIBILITY OF EXPERIENCE

Description of the Credibility Method Used

The CMS guidelines used for Medicare Advantage/Prescription Drug Plans (MA/PD) were used to determine the credibility of the experience. These guidelines specify 24,000 member months as 100% credible for medical and specify the following formula for determination of partial credibility:

(n / 24,000)^(1/2) for medical and
(n / 60,000)^(1/2) for prescription drugs

where n = member months in the experience period.

Since prescription drug and medical coverage are both covered, and medical services make up a significantly larger portion of the costs, the above medical formula was used for the determination of partial credibility. The use of the CMS MA/PD credibility is appropriate given that both MA/PD and Commercial cover similar benefit categories.

Resulting Credibility Level Assigned to the Base Period Experience

The credibility assigned to the base period is based on over 383k members in CY 2025 and is therefore assigned 100% credibility.

EXHIBIT 8. ESTABLISHING THE INDEX

The Index Rate for the experience period is a measurement of the average allowed claims PMPM for EHB benefits. The experience period Index Rate reflects the actual mixture of risk morbidity that SHP received 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 and reinsurance programs, or for Exchange User Fees.

The only Non-EHB services offered by SHP are infertility treatment and orthotic shoes on their “Plus” plans. These plans made up 0.81% of SHP membership in CY 2025. We identified services in the experience period associated with orthotic shoes and infertility treatment using HCPCS associated with those services. Our review found there was no additional infertility or orthotic shoe claim expenses associated with the non-EHB services offered by SHP. The experience period Index Rate is equal to the experience period total allowed claims PMPM since there were no services provided beyond the EHB benefits in the experience.

The Index Rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The Projection Period Index Rate reflects the projected 2027Q1 mixture of plan enrollment. To arrive at the projected index rate, the experience index rate was adjusted for changes in plan design, demographics, utilization, and cost trends. The Projection Period Index Rate has not been adjusted for payments and charges projected under the risk adjustment program, or for Exchange User Fees.

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

The Market Adjusted Index Rate is calculated by adjusting the Index Rate by the net risk adjustment.

All SHP's business is off exchange, so there is no exchange user fee and the transitional reinsurance program ended in 2016 and was not included. Risk Adjustment is described in more detail below.

Experience Period Risk Adjustments PMPM

The following methodology was used to estimate final risk adjustment transfers for CY 2025:

The experience period risk adjustment transfer amount is based on the June 30, 2026 final CY2025 report published by the HHS Center for Consumer Information and Insurance Oversight and actuarial judgment. We apply an additional adjustment to account the impact of RADV based on historical experience. The RADV-adjusted CY2025 risk adjustment transfer is a payment of $23.85 PMPM from SHP. This includes the net impact of the High Cost Risk Pooling program.

Projected Risk Adjustments PMPM

The projection period risk adjustment transfer amount was based on our experience period estimate, accounting for assumed statewide average premium and morbidity trends and membership mix changes from the experience period to the projection period. The projected risk adjustment transfer is a payment of $10.08 PMPM from SHP.

The anticipated risk transfer payments, gross of risk adjustment fees assumed to be $0.18 PMPM for CY 2027, are applied to the Index Rate as a market level adjustment. The overall impact of projected risk adjustment transfers is a premium increase of $10.08 PMPM, which is grossed up to an allowed level of $11.66 for reporting in Worksheet 1 of the URRT.

Paid to Allowed Ratios

The following table provides support for the average projected paid to allowed ratio. The average projected allowed and incurred PMPM reflects the member month weighted average from Worksheet 2, Section IV of the URRT.

Table 9.1
Sutter Health Plan
Average Paid to Allowed Factor Support

Description	Value
Average projected allowed PMPM	$757.69
Average projected incurred claims PMPM	$655.19
Average projected paid-to-allowed ratio	**86.5%**

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 Milliman Health Cost Guidelines (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 benefits in addition to the EHBs
  - California requires that separate HIOS plan IDs be created for plans with infertility and orthotic shoe benefits. For these plans, we identified these as benefits in addition to the standard EHB coverage, including expanded infertility benefit coverage under SB 729. The additional cost of orthotics and pre-SB 729 infertility was applied as a PMPM to the relativities, consistent with the most recent SHP small group filing. Further cost for expanded infertility coverage under SB 729 was applied as a 25.0% premium load, also consistent with the most recent SHP small group filing, resulting in total increased premiums of between 26.5% and 27.4% relative to the plans without infertility and orthotic shoe benefits.

- Adjustment for distribution and administrative costs
  - Adjustment is developed to indicate the impact of non-benefit expenses. This adjustment varies between CalChoice and Small Group Direct plans accounting for CalChoice plans' higher administrative expense.

- Impact of specific eligibility categories for the catastrophic plan
  - Not applicable for Small Group.

The adjustments above, as well as the calculation of the Plan Adjusted Index Rates, is shown on Worksheet 2, Section III. The Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool and are therefore not calibrated.

Non-Benefit Expenses, Profit, and Risk

The following table summarizes retention components included in rate development.

Sutter Health Plan Sutter Health Plan Administrative Expenses for Small Group – 2027Q1					
		% of Premium			
Retention Description	**PMPM**	**Direct**	**CalChoice**	**Basis**	**Annotation**
Administrative Expense Load					
Commissions		7.00%	12.00%	% of Premium	(1)
Percent of Premium Admin Cost		7.90%	4.90%	% of Premium	(2)
Subtotal: Administrative Expense Load		**14.90%**	**16.90%**		**(3) = (1) + (2)**
Profit and Risk Load					
Risk Margin		2.22%	2.22%	% of Premium	(4)
Subtotal: Profit and Risk Load		**2.22%**	**2.22%**		**(5) = (4)**
Taxes and Fees					
Health Insurer Fee		0.00%	0.00%	% of Premium	(6)
Risk Adjustment User Fee	$0.18			PMPM	(7)
PCORI Fee	$0.35			PMPM	(8)
MCO Tax	$0.00			PMPM	(9)
Subtotal: Taxes and Fees	**$0.53**	**0.00%**	**0.00%**		**(10) = (6) + (7) + (8) + (9)**
Total Retention	**$0.53**	**17.12%**	**19.12%**		**(11) = (3) + (5) + (10)**

Percent of Premium Administrative Loads – SHP projects general administrative costs at 7.9% of premium for direct and CalChoice plans. The CalChoice administrative load accounts for some services that SHP would otherwise perform, and thus the cost load has been reduced by 3% to reflect the lower internal administrative expense. In addition, SHP projects a 7.0% administrative load for direct plans and 12% for CalChoice to reflect commissions. In total, SHP projects administrative expense loads at 14.9% of premium for direct plans and 15% of premium for CalChoice plans.

Risk Margin – SHP projects a 2.22% Risk Margin. This load was applied to all plans.

Taxes and Fees – Sutter is not-for-profit and is therefore not required to pay State of California premium and federal income tax. Sutter is subject to the following fees:

- The Risk Adjustment User Fee is set at $0.18 PMPM. This was normalized by age and area to a 1.0 factor. This was then converted into a percent of premium to be consistent with the required URRT inputs on Worksheet 2 Section III.
- The PCORI Fee is set at $0.35 PMPM. This was normalized by age and area to a 1.0 factor. This was then converted into a percent of premium to be consistent with the required URRT inputs on Worksheet 2 Section III.
- The MCO Tax is assumed to be $0.00 PMPM, consistent with DMHC guidance to health plans.

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, geographic, and tobacco use distribution 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 45. The weighted average age curve calibration factor is 1.433.

To determine the calibration factor for age, the projected distribution of members by age was used. 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 (which is not applicable), the plan adjusted Index Rates need to be divided by the age curve calibration factor.

Geographic Factor Calibration

To determine the calibration factor for geography, the projected distribution of members by area was used. 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.

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.

- Age Factors – The standardized age factors developed by HHS and published in the final market rules were used in the development of the rates.

- Geographic Factors – The geographic factors are shown on Worksheet 3 of the URRT. The majority of SHP's claims expense will be reimbursed under a percent of premium capitation arrangement rather than based on actual expenses. Geographic factors were set to reflect the different reimbursement levels demanded by SHP's capitated providers in each area. SHP plans will be offered to employers in rating areas 1 through 19 for employees within SHP's service areas (1-10). Rating factors are needed for rating areas 11-19 as those will be used to calculate the premium for members enrolled from rating areas 1-10.

  The rating factors for areas 11, 13, and 14 are set equal to rating area 10, which is the closest rating area in SHP's service area. It is assumed that any members enrolling on an SHP plan from rating areas 11, 13, or 14 are most likely to use providers from rating area 10 and therefore have a similar cost profile. For a similar reason, the area factor for rating area 12 was set equal to rating area 9. Rating areas 15 through 19 are not adjacent to any rating areas in SHP's service area and so were set equal to the average geographic factor of all SHP's population assuming that any members enrolled from employers in these rating areas would have a membership mix similar to the existing population – which largely aligns with the CA general population distribution (i.e. more membership in urban areas such as San Francisco and Sacramento than more rural areas).

- Tobacco Factors – California does not allow tobacco rating, thus no factors were used.

The Calibrated Plan Adjusted Index Rates shown represent the premium charged to a 21-year-old with a 1.0 area factor for each specific plan. Because the 21-year-old age factor is 1.000, rates are determined by multiplying the Calibrated Plan Adjusted Index Rate with the respective age and area factors for the individual. The premium for the group is determined by summing the premium rates for each individual within the group, provided at most three child dependents under age 21 are taken into account for each subscriber.

EXHIBIT 13. PROJECTED LOSS RATIO

The projected loss ratio, both including and excluding taxes and fees, can be seen on Attachment 1. The projected loss ratio meets federal MLR requirements.

EXHIBIT 14. AV METAL VALUES

The AV metal values included in Worksheet 2 are based on the 2027 AV Calculator for renewing and new plans. For plans that mirror Covered California's benefit designs, Covered California's AV was used. In these instances, an AV screenshot was not provided.

EXHIBIT 15. MEMBERSHIP PROJECTIONS

The projected membership (as displayed in Worksheet 2, Section IV of the URRT) was determined in conjunction with SHP's staff and based on their forecasted membership shifts through 2027.

EXHIBIT 16. TERMINATED PRODUCTS

No products or plans will be terminated prior to the effective date.

EXHIBIT 17. PLAN TYPE

SHP is only offering HMO products. There are no differences between the plans of SHP and the plan type selected in the drop-down box in Worksheet 2, Section I of the URRT.

EXHIBIT 18. EFFECTIVE RATE REVIEW INFORMATION (OPTIONAL)

Not applicable.

EXHIBIT 19. RELIANCE

In performing this analysis, I relied on data and other information provided by SHP. 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 data reliance letter is attached to this rate submission.

DATA RELIANCE

Sutter Health Plan

Data and Information Relating to the Small Group and Individual Non-Grandfathered Rates Effective 10/1/2026 and 1/1/2027

I, Andrew Chung, Director, Actuarial & Underwriting, Sutter Health Plan, hereby affirm that the data and information prepared for and submitted to Milliman, Inc., were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete. I hereby affirm that the following items are accurately stated, to the best of my knowledge and belief.

- Claims and encounter information including incurred dates, paid dates, and amounts paid
- Historical and projected capitation arrangements and rates
- Historical and projected membership information including age, gender, rating area, and benefit plan
- Group information including risk adjustment factors, renewal date, and rating area
- Medical and pharmacy benefits available to individuals and small groups and associated cost sharing
- Projected medical fee-for-service, pharmacy, and behavioral health trends
- Commission rates, administrative rates, taxes and fees, and margin
- Historical and projected PBM contracts details and rebate levels
- Mapping of plan to HIOS ID for historical years, 2025, and 2026
- Other items provided by Sutter Health Plan and pertinent to the rate development



Andrew Chung
Director, Actuarial & Underwriting
Sutter Health Plan (SHP)

5/19/2026
Date

EXHIBIT 20. ACTUARIAL CERTIFICATION

I am a Consulting Actuary with the firm of Milliman, Inc. Sutter 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 2027Q1 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 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 2027Q1 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 2027Q1 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: Kevin Frodsham, FSA, MAAA

Title: Consulting Actuary

Date: September 18, 2026

Attachment 1
Sutter Health Plan
Medical Loss Ratio (MLR) Calculation

2027Q1 Filing

At Projected Rating Factors	Tax/Fee Indicator	Total SG
Projected Paid Claims (Prelim)		$655.19
Risk Adjustment with HCRP		$10.08
Projected Paid Claims (Incl RATP)		$665.27
Administrative - PMPM:		
Administrative Cost		$0.00
PCORI Fee	Tax/Fee	$0.35
Risk Adjustment User Fee	Tax/Fee	$0.18
State MCO Tax	Tax/Fee	$0.00
Administrative - Percent of Premium:		
Commissions (1)		10.47%
SHP Admin Offset for CalChoice (1)		-2.08%
Health Insurer Fee	Tax/Fee	0.00%
Administrative Cost		7.90%
Margins		2.22%
Final Per Unit Rate		**$817.02**
Claims/Premium Ratio		**81.43%**
Medical Loss Ratio (Premium Excl Tax/Fee)		**81.45%**

(1) This represents blended Small Group Direct and CalChoice Assumptions

Attachment 2
Sutter Health Plan
Small Group and CalChoice Plans - 2027Q1 Filing
Rate Change Exhibit
All Calculations Assume 1.0 Age and Area Factors

Drivers of Change Due to Claims*	Change to Claims	Change to Premium
Change in Base Experience vs Projected	-4.5%	-4.5%
Change in Trend Assumptions	-6.7%	-6.7%
Additional Year of Trend	13.6%	13.6%
Change in RATP Projection	0.4%	0.4%
Total Change	1.8%	1.8%

			Non-Claim Impacts						URRT Rate Change		
Small Group Plan	2027Q1 MMs	2026Q1 Premiums	Change in Claims*	Change in Benefits	Change in Admin	Change in Margin	2027Q1 Rates	Total Change	2.10 Current Enrollment	2.11 Current Premium PMPM	1.11 Cumulative Rate Change %
Platinum MS01 HMO	23,995	$621.38	1.8%	-2.6%	2.2%	-0.3%	$627.98	1.1%	1,335	$790.63	1.1%
Platinum MP01 Plus HMO	1,103	$785.61	1.8%	-2.5%	2.3%	-0.3%	$794.29	1.1%	73	$612.75	1.1%
Gold MS32 HMO	4,976	$528.53	1.8%	-1.7%	2.2%	-0.3%	$539.04	2.0%	416	$687.96	2.0%
Gold MP32 Plus HMO	73	$669.62	1.8%	-1.6%	2.2%	-0.3%	$683.18	2.0%	6	$894.33	2.0%
Gold MS10 HMO	24,207	$569.01	1.8%	-2.0%	2.2%	-0.3%	$578.18	1.6%	1,730	$739.76	1.6%
Gold MP10 Plus HMO	741	$720.14	1.8%	-2.0%	2.2%	-0.3%	$732.02	1.6%	45	$886.48	1.6%
Gold SD42 HDHP HMO	778	$475.43	1.8%	-0.4%	2.2%	-0.3%	$491.23	3.3%	62	$730.53	3.3%
Gold SP42 Plus HDHP HMO	0	$603.23	1.8%	-0.4%	2.2%	-0.3%	$623.41	3.3%	-	$0.00	3.3%
Silver MS45 HMO	13,978	$486.22	1.8%	-2.4%	2.2%	-0.3%	$492.06	1.2%	1,221	$664.25	1.2%
Silver MP45 Plus HMO	224	$616.70	1.8%	-2.4%	2.2%	-0.3%	$624.43	1.3%	17	$878.20	1.3%
Silver SD41 HDHP HMO	8,038	$423.54	1.8%	-3.0%	2.2%	-0.3%	$426.17	0.6%	648	$613.79	0.6%
Silver SP41 Plus HDHP HMO	339	$538.35	1.8%	-2.9%	2.2%	-0.3%	$542.05	0.7%	32	$951.53	0.7%
Bronze MS59 HMO	8,522	$405.34	1.8%	-4.2%	2.2%	-0.3%	$402.51	-0.7%	713	$563.46	-0.7%
Bronze MP59 Plus HMO	182	$515.74	1.8%	-4.2%	2.2%	-0.3%	$512.62	-0.6%	13	$731.75	-0.6%
Bronze SD33 HDHP HMO	8,813	$400.01	1.8%	-2.9%	2.2%	-0.3%	$402.71	0.7%	667	$601.52	0.7%
Bronze SP33 Plus HDHP HMO	24	$509.12	1.8%	-2.8%	2.2%	-0.3%	$512.95	0.8%	2	$419.64	0.8%
Platinum CC01 HMO	44,133	$636.44	1.8%	-2.6%	2.3%	-0.3%	$643.51	1.1%	2,514	$831.46	1.1%
Gold CC32 HMO	20,904	$541.33	1.8%	-1.7%	2.3%	-0.3%	$552.37	2.0%	1,689	$728.52	2.0%
Gold CC10 HMO	54,910	$582.80	1.8%	-2.0%	2.3%	-0.3%	$592.48	1.7%	4,414	$759.03	1.7%
Gold CD42 HDHP HMO	4,018	$486.95	1.8%	-0.4%	2.3%	-0.3%	$503.38	3.4%	313	$628.41	3.4%
Silver CC45 HMO	33,666	$498.00	1.8%	-2.4%	2.3%	-0.3%	$504.22	1.2%	2,775	$672.26	1.2%
Silver CD41 HDHP HMO	24,745	$433.80	1.8%	-3.0%	2.3%	-0.3%	$436.71	0.7%	2,033	$606.70	0.7%
Bronze CC59 HMO	19,637	$415.16	1.8%	-4.2%	2.3%	-0.3%	$412.47	-0.6%	1,601	$526.83	-0.6%
Bronze CD33 HDHP HMO	15,054	$409.70	1.8%	-2.9%	2.3%	-0.3%	$412.67	0.7%	1,202	$574.35	0.7%
Total [1]	313,058	$530.00	1.8%	-2.5%	2.3%	-0.3%	$536.34	**1.2%**	23,521	$694.05	1.19%

*An increase of 1.8% in claims corresponds with between 1.8% and 1.8% increase in premium due to the fixed admin PMPM.

[1] Total is weighted with 2027Q1 projected membership

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$1,500.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	
MOOP ($)	$5,850.00		
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$200.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☐	☐			☑	☐
Specialist Visit	☑	☐		$50.00	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$30.00	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$175.00	☐	☐			☑	☐
Speech Therapy	☑	☐		$30.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$30.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$30.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☐	☐		$60.00	☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Gold MS32/MP32/CC32 HMO
Plan HIOS ID: 64210CA0630104/64210CA0640104/64210CA0630112
Issuer HIOS ID: 64210
AVC Version: 2027_1b

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.97%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.1914 seconds

Final 2027 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
MOOP ($)			$6,000.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$15.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$100.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑	
Specialty Rx Coinsurance Maximum:	$250	
Set a Maximum Number of Days for Charging an IP Copay?	☐	
# Days (1-10):		
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: Gold SD42/SP42/CD42 HDHP HMO
Plan HIOS ID: 64210CA0630106/64210CA0640106/64210CA0630114
Issuer HIOS ID: 64210
AVC Version: 2027_1b

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.71%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.1562 seconds

Final 2027 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			75.00%
MOOP ($)			$8,950.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$35.00	☐	☐			☑	☐
Specialist Visit	☑	☐		$50.00	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$35.00	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$50.00	☐	☐			☑	☐
Speech Therapy	☑	☐		$35.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$35.00	☐	☐			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$35.00	☐	☐			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$30.00	☐	☐			☑	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$20.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$40.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Silver SD41/SP41/CD41 HDHP HMO
Plan HIOS ID: 64210CA0630108/64210CA0640108/64210CA0630116
Issuer HIOS ID: 64210
AVC Version: 2027_1b

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.92%
Metal Tier:	Silver
Additional Notes:	
Calculation Time:	0.1836 seconds

Final 2027 AV Calculator