Filing at a Glance

Company:	QCA Health Plan, Inc.
Product Name:	PY26 AR QCA 70525 Rates
State:	Arkansas
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005B Individual - Point-of-Service (POS)
Filing Type:	Rate
Date Submitted:	06/12/2025
SERFF Tr Num:	CECO-134511635
SERFF Status:	Assigned
State Tr Num:	QHP
State Status:	Under Review
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Reviewer(s):	Donna Lambert (primary), David Dillon, Johnny Flippo
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State Filing Description:

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company	QCA Health Plan, Inc.
SERFF tracking number	CECO-134511635
Submission Date	06/13/2025
Product Name	QualChoice Individual Plans
Market Type	(•) Individual ( ) Small Group
Rate Filing Type	(•) Rate Increase ( ) New Filing

Scope and Range of the Increase:

The 30.1% increase is requested because:

of the following significant factors driving the proposed rate increase: Single risk pool experience, unit cost trend, utilization trend, decreases of morbidity within the single risk pool. Please see details on section 2 of the Actuarial Memorandum.

This filing will impact:

# of Arkansas policyholder's 40,068 # of Arkansas covered lives 45,562

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 30.1 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved -7.0 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 33.5 %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

Age, Plan Selection

Financial Experience of Product

The overall financial experience of the product includes:

The experience includes claims experience incurred in 2024 and paid through March 31, 2025.

The rate increase will affect the projected financial experience of the product by:

Prior to the requested 30.1% rate increase for 2025, the projected MLR is 114.2%. The rate increase decreases the projected MLR to 84.8%.

Components of Increase
The request is made up of the following components:

Trend Increases – 7.1% of the 30.1 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

   This component is 2.5 % of the 30.1 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

   This component is 4.4 % of the 30.1 % total filed increase.

Other Increases – 21.5 % of the 30.1 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

   This component is 1.0 % of the 30.1 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

   This component is 0 % of the 30.1 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

   This component is 4.3 % of the 30.1 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

   This component is 0 % of the 30.1 % total filed increase.

5. Other – Defined as:

   Morbidity and Risk Adjustment

   This component is 15.3 % of the 30.1 % total filed increase.

Part III: Actuarial Memorandum

Redacted
QCA Health Plan, Inc.
Annual Individual Health Rate Filing
Arkansas
Assuming Enhanced Advance Premium Tax Credits (eAPTCs) Have Expired
And CSR Subsidies Are Unfunded
Effective January 1, 2026
Forms: 70525AR007, 70525AR021

Contents

1. General Information

Scope and Purpose

This document contains the Part III Actuarial Memorandum for QCA Health Plan, Inc.'s individual health block of business annual rate filing, effective January 1, 2026. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT). This is a renewal rate filing.

The purpose of this Actuarial Memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT. In combination, these documents support compliance with the market reform rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

Consistent with the October 12, 2017 payment memo from the U.S. Department of Health and Human Services (HHS)[1], the premium rates developed and supported by this Actuarial Memorandum assume that cost-sharing reduction (CSR) subsidies will be unfunded in plan-year 2026 and enhanced Advanced Premium Tax Credits (eAPTCs), as provisioned under the Inflation Reduction Act, expire on December 31, 2025 consistent with current law and regulations in effect or otherwise scheduled to take effect in plan year 2026.

Additionally, these rates assume that CMS' Marketplace Integrity and Affordability rule, published in the Federal Register on March 19, 2025, is finalized as proposed - including key rule changes regarding open enrollment, special enrollment periods, and annual eligibility redeterminations. Rates also reflect benefit designs and cost-sharing structures aligned with the revised de minimis actuarial value (AV) ranges specified in the proposed rule for the 2026 plan year.

Future modifications in legislation, regulation and/or court decisions regarding the funding of CSR payments and eAPTCs, including partial funding relative to current levels, and CMS' Marketplace Integrity and Affordability Rule, may affect the extent to which these premium rates are sufficient and neither excessive nor deficient. The premium rates developed assume that CSR subsidies will be fully funded for ARHOME members.

QCA Health Plan, Inc. asserts that the premium rates developed and supported by this Actuarial Memorandum are based on legislative and regulatory provisions in effect at the time of submission.

QCA Health Plan, Inc. reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed to ensure rates are appropriate. In addition to CSR payments and risk adjustment program payments and disruption, material rating impacts could arise from changes to various factors, including but not limited to:

- Advance Premium Tax Credits, including extension of Advanced Premium Tax Credits as provisioned in the Inflation Reduction Act
- The resumption of Medicaid redeterminations due to the end of the continuous enrollment condition under the Consolidated Appropriations Act, 2023
- Constraints on age rating factors
- Open enrollment and grace periods

[1] https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

- Enrollment of other populations, such as Medicare, Medicaid, and high risk pools
- Taxes and fees, notably the suspension of the ACA Insurer Fee
- Emerging experience as it relates to both claims and risk adjustment, notably the updated HCC coefficients in the 2026 model as laid out in the Final Rule for the 2026 Annual Notice of Benefit and Payment Parameters
- Changes in the funding or enforcement of the current Sec. 1115 Waiver Expansion Program (ARHOME)

If there are material deviations in market level premiums from our projected statewide average premium (SWAP) assumption for 2026 - for example, based on changes in the number of carriers in the market or carriers' pricing assumptions for 2026 - we would like to work with the Arkansas Insurance Department after initial submissions to revise our filing to update our estimated risk adjustment transfer. Market disruption, resulting from changes or carriers' perceived changes in the risk adjustment program, could also necessitate working with the Department to update other critical pricing assumptions such as market morbidity and relative risk.

This information is intended for the sole use by the Arkansas Insurance Department, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of the QCA Health Plan, Inc. individual rate filing. However, we recognize that this certification may become a public document.

These results are actuarial projections. Actual results will vary from those projected in the filing for a number of reasons, including but not limited to changes in membership, claims experience, and random variation from selected assumptions.

Company Identifying Information

- Company Legal Name: QCA Health Plan, Inc.
- State: The State of Arkansas has regulatory authority over these policies
- HIOS Issuer ID: 70525
- Market: Individual
- Effective Date: January 1, 2026

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

Description of Benefits

These products are issued by QCA Health Plan, Inc. as PPO health policies. The major provisions of this form for each plan design and product can be found in Appendix 1.1.

Rate Guarantees

Rates are guaranteed not to change through December 31, 2026.

Renewability
Each policy is renewable by paying the applicable renewal premiums, unless the policyholder no longer meets the eligibility requirements of the policy or QCA Health Plan, Inc. decides to discontinue that specific policy.

Applicability
These rates will apply to both new and renewing business.

General Marketing Method
This product will be sold through agents, direct mailings, the internet, and the State Based Exchange.

Estimated Average Annual Premium
The estimated average annual premium per policy in calendar year 2026 is [redacted].

Distribution of Business
See Appendix 1.2 for the expected age and geographic distributions for these products.

Rate Tables
See Appendix 1.3 for allowable rating factors and Appendices 1.3b and 1.3c for clarification on service area definitions. Appendix 1.4 also includes an example of how rating factors will be applied. Note that for family coverage, rates for children are charged to no more than the three oldest covered children under age 21 consistent with the Family Structure rules of the Patient Protection and Affordable Care Act (ACA).

Impact of eAPTC Expiration
To account for eAPTC expiration prior to the 2026 benefit year, we have assumed rates will increase due to anticipated reductions in enrollment, both at the issuer and single risk pool level. As eAPTCs expire and enrollees subsequently face increased out-of-pocket premiums, we assume healthier individuals who tend to be more price sensitive will leave the market, worsening the average morbidity of the individual risk pool.

2. Proposed Rate Changes

The rate increases for each product offered in the single risk pool by QCA Health Plan, Inc. in the state of Arkansas are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):
The rate projections for 2026 have been updated from the previous year's projections to reflect the most recent assumptions and information available.

The following provides a narrative description of the significant factors driving the proposed rate increase for 2026.

- [redacted]

  The individual single risk pool experience underlying the rate projections has been updated. The current model reflects the projected utilization trend applied to adjusted experience (from 2024 to 2026), including anticipated changes in the average morbidity of the single risk pool. There is a full description of utilization trend and other projection factors applied to experience in Section 6, 'Trend Factors'.

  Risk adjustment transfer experience for 2026 includes consideration of changes to the statewide average premium, the Risk Adjustment program, and QCA Health Plan, Inc. enrollee population morbidity relative to the Arkansas single risk pool.

- [redacted]

- [redacted]

- [redacted]

Federal Policy Assumptions:
The proposed rate increase of [redacted] reflected in this memorandum assumes that:

1. eAPTCs expire at the end of 2025, and
2. CMS' Marketplace Integrity and Affordability rule, as published in the Federal Register on March 19, 2025, is finalized as proposed.

Both policy changes are expected to materially affect projected enrollment and morbidity for plan year 2026 at the issuer and single risk pool level. Most notably, as eAPTCs expire and enrollees face increased out-of-pocket premiums, we assume healthier individuals who tend to be more price

sensitive will exit the market, worsening the average morbidity of the individual risk pool. Shifts in statewide average morbidity, including both above policy changes, are expected to increase the Index Rate by [redacted] between the base and projection periods.

Note that the requested rate change may not be the same across all plans within a product due to changes to the member cost sharing amounts by plan. Additionally, the defunding of CSR subsidies has contributed to the rate levels being higher than if the subsidies were to be funded.

3. Single Risk Pool

The Index Rate is based on the single risk pool defined by the state of Arkansas, which was established according to the requirements in 45 CFR Part 156.80. The single risk pool is defined as including all non-grandfathered individual business in Arkansas.

The single risk pool for the experience period does not include transitional products/plans. The single risk pool for the 2026 projection period does not include members who still remain enrolled in transitional plans.

4. Experience and Current Period Premium, Claims and Enrollment

The following information supports the best estimate of premium and claims for the single risk pool during the experience period, as reported in Worksheet 1, Section I of the URRT. The experience period for this rate filing is incurral year 2024, and includes claims paid through 3/31/2025.

Allowed and Incurred Claims incurred During the Experience Period:
A breakout of the claims shown in Worksheet 1, Section I is provided in Appendix 4.1.

[redacted]

Actual claims run-out may reflect some variability from future expectations. There are no unusually high or low completion factors being applied to allowed or incurred claims resulting from internal shifts in administration practices.

Cost Sharing Reduction (CSR) Subsidies:
Cost-sharing reduction (CSR) subsidies were unfunded for the entirety of the base period. For rating purposes, we assumed that CSR subsidies will continue to be unfunded throughout the projection period. Within Appendix 4.1 we have included estimates for our 2024 experience CSR subsidy payments had they been funded. While these reflect internal estimates for the subsidies for the experience period, we would expect substantial differences between these estimates and projected CSR subsidies in the 2026 plan year, as trend adjustments, portfolio updates, and changes in demographics would meaningfully change projected subsidies. As a result, the prospective rating impact of CSR subsidies becoming funded in plan-year 2026 would also change materially from what is suggested by historical experience. The premium rates developed assume that CSR subsidies will be fully funded for ARHOME members.

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:
The risk adjustment transfer and reinsurance receivables for the experience period are shown on Worksheet 1, Section I of the URRT. The final amounts for risk adjustment and any applicable reinsurance receivables were not known at the time of rate development. These amounts were estimated using data available through [redacted].

Current Enrollment and Premium:
The current enrollment and premium values on Worksheet 2, Section II are reported as of 3/31/2025.

Earned premium in the experience period is not adjusted for taxes, assessments, risk adjustment receivables or payables or MLR rebates.

5. Benefit Categories

The algorithm used to assign utilization data and cost information is summarized as follows.

Inpatient Hospital
Inpatient hospital 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
Outpatient hospital 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
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
Other medical includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.

Capitation
Capitation includes all services provided under one or more capitated arrangements.

Prescription Drug
Prescription drug includes drugs dispensed by a pharmacy and is net of rebates.

6. Trend Factors

This section describes and supports the factors used to project the 2024 experience period allowed claims to the 2026 projection period as shown in Worksheet 1, Section II of the URRT.

Trend Factors:

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]

[redacted]

7. Adjustments to Trended EHB Allowed Claims PMPM

This section describes and supports the adjustments other than trend used to project the 2024 experience period Essential Health Benefit (EHB) allowed claims to the 2026 projection period as shown in Worksheet 1, Section II of the URRT. Each factor represents the change between the experience period and projection period. The factors, therefore, are not annualized values.

[redacted]

Appendix 7.2 decomposes the demographic changes factor into its components.

[redacted]

Appendix 7.3 decomposes the plan design changes factor into its components.

[redacted]

- [redacted]
- [redacted]

- [redacted]
- [redacted]
- [redacted]

Appendix 7.4 decomposes the other changes factor into its components. Adjustment for CSR payback to reflect payment of non-loaded premiums for the ARHOME products.

8. Manual Rate Adjustments

This filing is [redacted] experience rated. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

9. Credibility of Experience

[redacted]

- Total 2024 Member Months: [redacted]
- Credibility Level Assigned to Base Period Experience: [redacted]

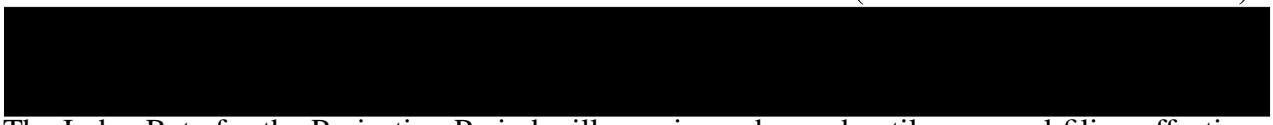
Note that credibility is calculated based on 2024 experience data that are suitable for pricing and may not exactly match the total 2024 member months shown above.

Actuarial Standard of Practice #25 “Credibility Procedures” was considered when determining the credibility level.

10. Establishing the Index Rate

The Index Rate for the Experience Period (calendar year 2024) is a measurement of the average allowed claims PMPM for EHB benefits. This value is located on Worksheet 1, Section I of the URRT. The Index Rate for the Experience Period reflects the actual mixture of smoker/non-smoker population, area factors, plan enrollment, and the actual mixture of risk morbidity in the single risk pool during the experience period. The Index Rate for the experience period has not been adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. We have adjusted the Index Rate for the Experience Period to remove any non-EHBs. The claim system does not currently distinguish between EHB and non-EHB claims, so this adjustment was made based on the expected percentage of non-EHB claims for the experience period. The experience period did not contain non-single risk pool claims, so no adjustment was made for this.

The Index Rate for the Projection Period (calendar year 2026) 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 Essential Health Benefits (EHB) for calendar year 2026 only and has not been adjusted for payments and charges under the risk adjustment program or for Exchange user fees. The index rate differs from the total allowed claims in that the total allowed claims include benefits in excess of EHBs (adult vision and adult dental).



The Index Rate for the Projection Period will remain unchanged until a renewal filing effective January 1, 2027.

The development of the Index Rate for the Projection Period is shown in Worksheet 1, Section II. This reflects:

- The 12-month projection period shown in Worksheet 1, Section II
- The anticipated claim level of the projection period with respect to trend, benefits, and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix 10.1 demonstrates the calculation of the Projected Index Rate by blending the Experience Period Index Rate with the Credibility Manual Index Rate, as applicable. The next two sections further describe the steps taken to develop the Market Adjusted Index Rate and Plan Adjusted Index Rate.

11. Development of the Market-Wide Adjusted Index Rate

The Index Rate for the projection period is adjusted to arrive at the Market Adjusted Index Rate (MAIR) based on the following, as outlined in 45 CFR 156.80(d):

- Adjustment for the Risk Adjustment Program
- Exchange user fee adjustment

The risk adjustment payment/charge is described below. Since the Index Rate is on an allowed claims basis, the market-level adjustments are also performed on an allowed basis.

[redacted]

For further detail on the development of the MAIR, please refer to Appendix 11.1.

Reinsurance:

[redacted]

Risk Adjustment Payment/Charge:

[redacted]

The Risk Transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below:

$$T_i = \left[\frac{(PLRS_i \times IDF_i \times GCF_i)}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{(AV_i \times ARF_i \times IDF_i \times GCF_i)}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)}\right] \times \overline{P}_s$$

Where:

$\overline{P}_s =$ statewide average premium $\times$ 0.86 (to reflect the admin reduction adjustment);

$PLRS_i =$ plan i's plan liability risk score;

$AV_i =$ plan i's metal level AV;

$ARF_i =$ plan i's allowable rating factor;

$IDF_i =$ plan i's induced demand factor;

$GCF_i =$ plan i's geographic cost factor;

S_i = plan i's share of state enrollment as measured in member months

The denominator is summed across all plans in the risk pool in the market in the state.

We project the portfolio average for each factor in the risk adjustment transfer formula using a combination of (i) actual historical risk adjustment factors adjusted to the projected population and (ii) adjustments for market and risk adjustment program changes. The resulting aggregate payment or receivable is then proportionally allocated to all plans in the portfolio.

For the purposes of stable modeling, each factor was approximated as follows:

[redacted]

[redacted]

[redacted]

Based on the Final Rule for the 2026 Annual Notice of Benefit and Payment Parameters, HHS's proposed 2024 and 2026 HCC model and coefficient changes for 2026 (including partial year adjustment factors, prescription drug condition categories, and model recalibration) were considered in the development of the projected risk adjustment transfer. The demographic, plan mix, and morbidity assumptions were used to project claims costs.

IDF: The statewide average IDF is projected based on the average IDF of the single risk pool in 2026. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Arkansas.

The average IDF for QCA Health Plan, Inc. is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to QCA Health Plan, Inc.'s projected population. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver, 1.03, Gold 1.08, and Platinum 1.15.

AV: The statewide average actuarial value (AV) is projected based on the average metal level AV of the single risk pool in 2024. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Arkansas. The average AV for QCA Health Plan, Inc. is calculated by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to QCA Health Plan, Inc.'s projected population. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor (ARF) adjustment accounts only for age rating.

The statewide average ARF was set equal to the average ARF of the single risk pool in 2024. For historical risk transfer data, we rely on a combination of the latest available HHS Summary Report on Permanent Risk Adjustment Transfers and when available, Wakely's National Risk Adjustment Reporting Project (WNRAR) for the state of Arkansas.

The average ARF for QCA Health Plan, Inc. is projected by applying the proposed 2026 HHS age rating factors to QCA Health Plan, Inc.'s projected population. An equal distribution across ages within each age band was assumed.

GCF: The average Geographic Cost Factors for QCA Health Plan, Inc.'s membership is projected based on the 2023 GCFs, as reported by HHS, adjusted for projected changes caused by carrier rate actions from 2023 to 2026.

Outliers were reflected in our calculations to the extent that outliers are reflected in historical risk scores used as the starting point of the 2026 risk transfer projection and via the calculation of the net High Risk Pool receivable or payment. Otherwise, there were no "potential outlier assumptions" that would have an impact on transfers.

[redacted]

The risk adjustment transfer amounts shown on Worksheet 1 of the URRT are the actual PMPM amounts expected in the projection period. The risk adjustment transfer amount applied to the Index Rate in the development of the Market Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and the morbidity assumptions used to project claims costs.

Exchange User Fees:

[redacted]

12. Plan Adjusted Index Rate

The Plan Adjusted Index Rate (PAIR) is included in Worksheet 2, Section III of the URRT. The PAIR is the MAIR adjusted for only the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- Actuarial value and cost-sharing design of the plan.
  - [redacted]
  - [redacted]
    - [redacted]
    - [redacted]
    - [redacted]
  - [redacted]
- The plan's provider network, delivery system characteristics, and utilization management adjustment practices
  - [redacted]
- Benefits provided under the plan that are in addition to the EHBs.
  - [redacted]
- Administrative costs, excluding the Exchange user fees (which are already accounted for in the Market Adjusted Index Rate).
  - [redacted]

There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

Administrative costs and non-EHB benefits common to all plans are added to the Market Adjusted Index Rate. Then, factors for actuarial value and cost-sharing and non-EHBs by plan are applied to reach the Plan Adjusted Index Rate for each plan.

The development and values of the Plan Adjusted Index Rates are shown in Appendix 12.1 and are not calibrated.

On Worksheet 2, Section II, the Plan Adjusted Index Rate of the Experience Period is reported.

Administrative Expense Load:

[redacted]

[redacted]

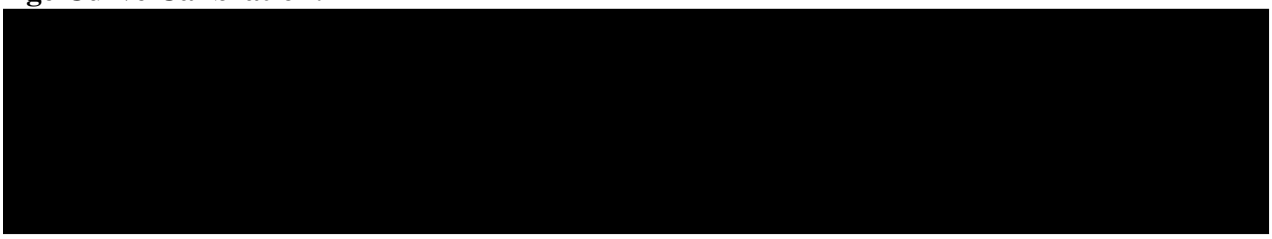
The administrative expenses are allocated proportionally by plan on a constant percentage of premium basis.

Profit (or Contribution to Surplus) & Risk Margin:
This load was applied proportionally to all products and plans and can be found in Appendix 12.2.

Taxes and Fees:
The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in Appendix 12.2. The Risk Adjustment User Fee has been included as part of this adjustment. See Section 11, "Development of the Market-Wide Adjusted Index Rate", for a discussion on how the Exchange user fee was calculated and applied to the Market Adjusted Index Rate.

13. Calibration

Age Curve Calibration:



Appendix 13.1 of the Actuarial Memorandum demonstrates the calibration of the Plan Adjusted Index Rate for age. The distribution of members by age is in Appendix 1.2 and the corresponding age factors are included in Appendix 1.3.

Geographic Factor Calibration:

Tobacco Use Rating Factor Calibration:

Calibration adjustments are applied uniformly to all plans:
The calibration adjustment does not vary by plan and this is demonstrated in Appendix 13.1. Member-level adjustments as described in 45 CFR 147.102 are applied uniformly to all plans in the single risk pool, and these adjustments do not vary by plan.

The distribution of members by rating area is included in Appendix 1.2. Furthermore, Appendix 1.4 provides a sample calculation of premium rates.

CSR Loaded Premium Development

See Appendix 13.5 for the development of the Silver and non-Silver rates inclusive of the 46% mandated load for cost sharing reduction load.

See Appendix 13.6 for the base rate and allowable rating factors for the CSR loaded and unloaded ARHOME rates. This exhibit illustrates how the rating factor will be applied.

14. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Calibrated Plan Adjusted Index Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Calibrated Plan Adjusted Index Rate to determine the rate that is charged to the health insurance subscriber:

- Rating Area
  - The area factors are listed in Appendix 1.3. The methodology for developing geographic factors is included in Section 13, "Calibration".
- Age
  - The prescribed standard age factors were used.
- Tobacco Status
  - 
- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21.

Appendix 1.3 lists the allowable rating factors and Appendix 1.4 contains an example walking through the calculation of a theoretical family's rates.

15. Projected Loss Ratio

The projected medical loss ratio (MLR) for QCA Health Plan, Inc. in 2026 in Arkansas is [redacted], which satisfies the state of Arkansas's minimum MLR requirement of 80%. This projected MLR is calculated according to 45 CFR 158. The projected MLR is the projected 2026 calendar year single risk pool experience rather than the three-year period used for determining rebates. No credibility adjustment based on projected enrollment and average deductible was estimated. See Appendix 15.1 for the detail underlying the calculation.

16. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were calculated using the Final 2026 Federal AV Calculator for the plan provisions that fit within the calculator parameters and making appropriate adjustments to the AV identified by the calculator for plan design features that are not compatible with the parameters of the AV Calculator. Consistent with CMS' Marketplace Integrity and Affordability rule, the plan designs in this filing have been developed in compliance with these proposed expanded AV parameters.

17. Membership Projections

18. Terminated Plans and Products

A list of the plans being terminated and the plans to which these are being mapped is included in the appendices as Appendix 18.1.

19. Plan Type

[redacted]

20. Effective Rate Review Information

See Appendix 20.1 for documents summarizing the capital and surplus position of QCA Health Plan, Inc.

21. Reliance

See Appendix 21.1 for a detailed listing of items received and relied upon for rate development.

22. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries in good standing and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work.

I certify the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis was placed on the following:

- 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. 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 50, Determining minimum value and Actuarial Value under the Affordable Care Act
- ASOP No. 56, Modeling

I certify that to the best of my knowledge and judgement:

1. The Index Rate for the Projection Period 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 based on my best estimate of the 2026 individual market
2. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.

3. The geographic rating factors reflect only difference in the cost of delivery and do not include differences for population morbidity by geographic area.
4. The CMS Actuarial Value Calculator, with appropriate adjustments, was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans. This rate filing was prepared in compliance with all applicable state and federal statutes and regulations.

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 2026 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, such as CMS' Marketplace Integrity and Affordability Rule, court decisions, or otherwise. Changes have the potential to greatly impact the 2026 plan year premium rates provided in this Actuarial Memorandum and the alignment of these premium rates with incurred costs. Changes include, but are not limited to, any legislative or regulatory amendment, court decision, 1332 waivers bringing reinsurance or other such programs to a state; or a decision by Congress, the Health and Human Services Secretary, or the Centers for Medicare and Medicaid Services director to fund cost-sharing reduction subsidies, alter Advance Premium Tax Credits (APTCs), or further modify the individual mandate requirement and penalty. In the event that a material provision is enacted renewing eAPTCs at current or partially funded levels, a revision to the rates will be needed. In particular, rates were developed assuming no funding of federal cost-sharing reduction (CSR) subsidy payments for members enrolling through the exchange and full funding for ARHOME members.

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.

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.

It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

Signed: [redacted]

Name: [redacted]

Date: 6/5/2025

All Appendices have been redacted.