MILLIMAN ACTUARIAL MEMORANDUM

Avera Health Plans, Inc.

South Dakota Individual Rate Filing Effective January 1, 2026

May 28, 2025

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I. GENERAL INFORMATION

This document contains the Part III Actuarial Memorandum for Avera Health Plans, Inc.'s (AHP's) individual medical block of business, effective January 1, 2026. 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 of the premium rate filing, including support for the values entered in the Part I URRT (which supports compliance with the market rating rules and reasonableness of applicable rate increases). This memorandum may not be appropriate for other purposes.

This information is intended for use by the State of South Dakota Division of Insurance (DOI), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of AHP's individual rate filing. However, we recognize this certification may become a public document.

Future modifications in legislation, regulation, and / or court decisions regarding the funding of CSR subsidies may affect the extent to which the premium rates are neither excessive nor deficient.

COMPANY IDENTIFYING INFORMATION

Company Legal Name:	Avera Health Plans, Inc.
State:	South Dakota
HIOS Issuer ID:	60536
Market:	Individual
Effective Date:	January 1, 2026

COMPANY CONTACT INFORMATION

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

DESCRIPTION OF BENEFITS

These products provide comprehensive medical benefits for services received within the provider network. These products have various cost sharing designs, which are a combination of deductibles, coinsurance, and copayments that vary for in-network services.

Pharmacy cost sharing for some plans reflects a six-tier (preventive, preferred generic, non-preferred generic, preferred brand, non-preferred brand, and specialty) copay or coinsurance structure. For other plans, the deductible and coinsurance apply to pharmacy costs instead of the six-tier copay structure.

Avera ConnectPlus is a PPO product with Gold, Silver, Bronze, and Catastrophic benefit plan options that provide coverage for inpatient, outpatient, prescription drugs, and miscellaneous services subject to deductible, coinsurance, and copays.

Avera DirectConnect is an HMO product with Gold, Silver, and Bronze benefit options that provide coverage for inpatient, outpatient, prescription drugs, and miscellaneous services subject to deductible, coinsurance, and copays. [redacted]

II. PROPOSED RATE CHANGES

[redacted]

[redacted]

Appendix A included with each filing scenario summarizes proposed rate increases for renewing plans by rating region and plan effective January 1, 2026.

[redacted]

[redacted]

[redacted]

[redacted]

REASON FOR RATE INCREASE

A rate change is needed to account for medical trend, as well as revisions to the following pricing assumptions:

[redacted]

III. EXPERIENCE AND CURRENT PERIOD PREMIUM, CLAIMS, AND ENROLLMENT

AHP is a provider-owned health plan. AHP contracts with providers on a non-capitated basis.

[redacted]

[redacted]

PAID THROUGH DATE

The claims incurred in the experience for non-capitated services reflect payments through March 31, 2025.

CURRENT DATE

The reported date for current enrollment and premium in URRT Worksheet 2, Section II is March 31, 2025.

ALLOWED AND INCURRED CLAIMS INCURRED DURING THE EXPERIENCE PERIOD

AHP's incurred claims during the experience period include fee-for-service claims and prescription drug claims. [redacted]

We add an estimate of incurred but not paid (IBNP) claims to the processed amount to arrive at a final estimate of total claims. [redacted] Consideration is given for liabilities calculated using a claim cost or loss ratio method for recent incurral months prior to the valuation date that have less data available (e.g., one to three months). We use the same IBNP as a percentage of claims for allowed and incurred claims. No estimate of incurred but not paid claims was added to the prescription drug claims.

Table 1 summarizes the allowed claims, incurred claims, and earned premium for AHP's [redacted] experience.

Table 1
Avera Health Plans, Inc.
[redacted]

	Allowed	Paid	Premium
Claims Paid through March 2025	[redacted]	[redacted]	[redacted]
Incurred But Not Paid (IBNP)			
Earned Premium			
Total			

IV. BENEFIT CATEGORIES

We categorized the experience to benefit categories, as shown in Worksheet 1, Section II of the Part 1 URRT, based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- 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: 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: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.

AHP's projected prescription drug claims are included in the "Prescription Drug" line in the URRT with a benefit category of "Prescription Drugs."

[redacted]

V. PROJECTION FACTORS

We made the following adjustments to project the experience period index rate to the projection period.

MORBIDITY ADJUSTMENT

[redacted]

CHANGES IN DEMOGRAPHICS

We adjust AHP's 2024 ACA experience period allowed PMPM to reflect the age and gender differences between AHP's 2024 enrollment and AHP's projected 2026 enrollment. [redacted]

We also include an adjustment to reflect the changing mix of membership distribution by rating region. [redacted]

PLAN DESIGN CHANGES

[redacted]

OTHER ADJUSTMENTS

[redacted]

TREND FACTORS (COST / UTILIZATION)

The [redacted] experience was trended forward to 2026 [redacted]

INCLUSION OF CAPITATION PAYMENTS

[redacted]

VI. MANUAL RATE ADJUSTMENTS

[redacted] Therefore, no manual rate was developed.

VII. CREDIBILITY OF EXPERIENCE

[redacted]

VIII. ESTABLISHING THE INDEX RATE

The index rate for the experience period is a measurement of the average allowed claims PMPM for EHBs. The experience period index rate reflects the actual mixture of smoker / non-smoker population, area factors, catastrophic / non-catastrophic enrollment, and the actual mixture of risk morbidity that AHP received in the Single Risk Pool during the experience period.

[redacted] The experience Index Rate has not been adjusted for payments and charges under the risk adjustment and reinsurance programs or for Marketplace user fees.

[redacted]

The index rate for the projection period is a measurement of the average allowed claims PMPM for EHBs. The projected index rate reflects the projected CY 2026 mixture of smoker / non-smoker population, area factors, catastrophic / non-catastrophic enrollment, and the projected mixture of risk morbidity that AHP expects to receive in the Single Risk Pool.

[redacted] The projected Index Rate has not been adjusted for payments and charges projected under the risk adjustment program or for Marketplace user fees.

[redacted]

Table 2
Avera Health Plans, Inc.
Projected Index Rate Development

	[redacted]	[redacted]
2024 Experience Member Months		
2024 Experience EHB Allowed Claims		
2024 Experience EHB Allowed Claims PMPM		
Year 1 Trend		
Year 2 Trend		
Morbidity Adjustment		
Demographic Shift		
Plan Design Changes		
Other Adjustments		
Adjusted Trended EHB Allowed Claims PMPM		
Credibility %		
Projected Index Rate		

Note: Values are rounded.

IX. DEVELOPMENT OF THE MARKET-WIDE ADJUSTED INDEX RATE

The market-wide adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 CFR Part 156, §156.80(d)(1). [redacted]

Table 3
Avera Health Plans, Inc.
Market Adjusted Index Rate Development

	[redacted]	[redacted]	*Annotation*
2026 Index Rate PMPM			*(1)*
Market Adjustments (paid basis)			
Gross Risk Adjustment			*(2)*
Net Federal Transitional Reinsurance			*(3)*
Exchange User Fees			*(4)*
Paid-to-Allowed Ratio			*(5)*
Market Adjustments (allowed basis)			
Gross Risk Adjustment			*(6) = (2) / (5)*
Net Federal Transitional Reinsurance			*(7) = (3) / (5)*
Exchange User Fees			*(8) = (4) / (5)*
Market Adjusted Index Rate PMPM			***(9) = (1) + ((6) + (7) + (8))***

REINSURANCE

The federal transitional reinsurance program is a temporary program that ended December 31, 2016. Since the program is not expected to continue in 2026, we assume reinsurance contributions and reinsurance recoveries will be zero. As a result, we did not project any federal transitional reinsurance contributions or recoveries for 2026.

RISK ADJUSTMENT PAYMENT / CHARGE

Experience Period Risk Adjustment

[redacted]

Projected Risk Adjustment

[redacted]

[redacted]

[redacted]

EXCHANGE USER FEES

The exchange user fee was applied as an adjustment to the index rate at the market level. [redacted]

X. PLAN-ADJUSTED INDEX RATE

The development of the plan-adjusted index rates is shown in Appendix B and URRT Worksheet 2, Section III. Note, the plan-adjusted index rate shown in Appendix B may not exactly match the URRT due to URRT rounding conventions. The market-wide adjusted index rate is adjusted to compute the plan-adjusted index rates using the following allowable adjustments.

ACTUARIAL VALUE AND COST SHARING DESIGN OF THE PLAN

[redacted]

Experience Period Cost Sharing Reduction Amounts

[redacted]

Projected Cost Sharing Reduction Amounts

[redacted]

PROVIDER NETWORK, DELIVERY SYSTEM CHARACTERISTICS AND UTILIZATION MANAGEMENT PRACTICES

[redacted]

BENEFITS IN ADDITION TO EHBS

[redacted]

ADMINISTRATIVE COSTS, EXCLUDING EXCHANGE USER FEES AND REINSURANCE FEES

Administrative expenses were provided by AHP [redacted]

Table 4A
Avera Health Plans, Inc.
Projected 2026 Administrative Expenses [redacted]

	Administrative Expense PMPM	Administrative Expense % of Premium
General Admin	[redacted]	[redacted]
Commission		
Commercial Reinsurance Recoveries		
Commercial Reinsurance Premiums		
Quality Improvement		
Total Administrative Expense Load		

Note: Values are rounded.

Table 4B
Avera Health Plans, Inc.
Projected 2026 Administrative Expenses [redacted]

	Administrative Expense PMPM	Administrative Expense % of Premium
General Admin	[redacted]	[redacted]
Commission		
Commercial Reinsurance Recoveries		
Commercial Reinsurance Premiums		
Quality Improvement		
Total Administrative Expense Load		

Note: Values are rounded.

TAXES AND FEES

[redacted]

Table 5A
Avera Health Plans, Inc.
Summary of Taxes and Fees [redacted]

Description	Taxes and Fees PMPM	Taxes and Fees % of Premium
Risk Adjustment Admin Fee	[redacted]	[redacted]
Premium Tax		
Comparative Effectiveness Research Fee (PCORI)		
Total Taxes and Fees		

Note: Values are rounded.

Table 5B
Avera Health Plans, Inc.
Summary of Taxes and Fees [redacted]

Description	Taxes and Fees PMPM	Taxes and Fees % of Premium
Risk Adjustment Admin Fee	[redacted]	[redacted]
Premium Tax		
Comparative Effectiveness Research Fee (PCORI)		
Total Taxes and Fees		

Note: Values are rounded.

PROFIT AND RISK LOAD

The profit and risk load is determined as an aggregate value for the single-risk pool [redacted]

CATASTROPHIC ADJUSTMENT

The catastrophic adjustment factor reflects the projected average demographics of individuals enrolled in a catastrophic plan relative to the other metal tiers. [redacted]

XI. CALIBRATION

A single calibration factor is applied to the Plan Adjusted Index Rates 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

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 CMS federal 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 multiplied by the age curve calibration factor.

The approximate weighted average age, rounded to a whole number, for the single risk pool is [redacted] The calibration to the age curve complies with the rating rules specified in 45 CFR Part 147, §147.102.

GEOGRAPHIC FACTOR CALIBRATION

AHP applies geographic rating area factors to its plans as shown in Worksheet 3 of the URRT. The geographic rating factors were developed based on AHP's historical experience net of risk adjustment and expectations for provider reimbursement in 2026. The relativities 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. The relativities are normalized to a geographic calibration factor of 1.0000.

TOBACCO USE RATING FACTOR CALIBRATION

[redacted] In order to determine the calibration factor for tobacco use rating, the projected percentage of members using tobacco by age was determined. The weighted average of the non-tobacco use and tobacco use factors in the age curve was then calculated using this percentage.

The weighted average of the composite non-tobacco / tobacco use factors (i.e., age / tobacco premium relativity) was then determined by using the projected distribution of members by age. The tobacco use rating calibration factor was then calculated as the age / tobacco premium relativity factor divided by the age curve calibration. Prior to applying the allowed rating factors for age, geography, and tobacco, the Plan Adjusted Index Rates need to be multiplied by the tobacco use [redacted]

Appendix C demonstrates the calibration performed for each plan in the projection period. Note, the calibrated plan-adjusted index rate shown in Appendix C may not exactly match URRT Worksheet 2 due to URRT rounding conventions.

XII. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for a plan charged to an individual 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 age calibration factor, the geographic calibration factor, and the tobacco calibration factor.

The applicable adjustment factors for each plan are illustrated in Worksheet II, Section III of the URRT.

AHP's 2026 age and tobacco rating factors are shown below. The age rating factors used by AHP are identical to those prescribed by CMS. Industry research regarding tobacco use and differences in health costs for smokers by age was used as the basis of our adjustment factors.

Table 6
Avera Health Plans, Inc.
Age and Tobacco Factors

Age Band	Age Rating Factor	Tobacco Factor	Age Band	Age Rating Factor	Tobacco Factor
0 to 14	0.765	[redacted]	40	1.278	[redacted]
15	0.833		41	1.302	
16	0.859		42	1.325	
17	0.885		43	1.357	
18	0.913		44	1.397	
19	0.941		45	1.444	
20	0.970		46	1.500	
21	1.000		47	1.563	
22	1.000		48	1.635	
23	1.000		49	1.706	
24	1.000		50	1.786	
25	1.004		51	1.865	
26	1.024		52	1.952	
27	1.048		53	2.040	
28	1.087		54	2.135	
29	1.119		55	2.230	
30	1.135		56	2.333	
31	1.159		57	2.437	
32	1.183		58	2.548	
33	1.198		59	2.603	
34	1.214		60	2.714	
35	1.222		61	2.810	
36	1.230		62	2.873	
37	1.238		63	2.952	
38	1.246		64+	3.000	
39	1.262				

AHP's 2026 geographic rating factors are shown below. These geographic rating factors are based on AHP experience. The geographic factors used reflect only differences in expected cost of delivery, and do not include differences for population morbidity by geographic area.

Table 7
Avera Health Plans, Inc.
Geographic Rating Factors

Region	Area Rating Factor
Rating Area 1	[redacted]
Rating Area 2	
Rating Area 3	
Rating Area 4	

XIII. PROJECTED LOSS RATIO

The projected loss ratio is [redacted] This loss ratio is calculated consistently with the MLR methodology, according to the National Association of Insurance Commissioners, as prescribed by 45 CFR 158.221. The following table demonstrates AHP's premium development and projected 2026 MLR calculation using rounded values.

The following table summarizes the calculation for the projected federal medical loss ratio.

Table 8
Avera Health Plans, Inc.
Projected Federal Medical Loss Ratio

	[redacted]	[redacted]
Member Months		
MLR Numerator Calculations		
Paid Claims PMPM		
Claim-Related Retention (QI / Health IT) PMPM		
Risk Adjustment Paid (Received) PMPM		
MLR Numerator		
MLR Denominator Calculations		
Premium PMPM		
Premium-Related Retention (Taxes & Fees) PMPM		
MLR Denominator		
Medical Loss Ratio		

XIV. AV METAL LEVELS

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed based on the CMS Actuarial Value Calculator (AVC).

XV. MEMBERSHIP PROJECTIONS

The projected membership (as displayed in Worksheet 2, Section IV of the URRT) was determined by considering [redacted]

[redacted]

Projected membership by plan and subsidy level is summarized in the tables below for silver plans. [redacted]

Table 9A
Avera Health Plans, Inc.
Projected 2026 Membership by Subsidy Level (Silver Plans) [redacted]

HIOS ID	70%	73%	87%	94%	Total
60536SD0020031	[redacted]				
60536SD0020052					
60536SD0020058					
60536SD0020060					
60536SD0020062					
60536SD0020063					
60536SD0020070					
60536SD0020071					
60536SD0020074					
60536SD0020075					
60536SD0020076					
60536SD0020077					
60536SD0020078					
60536SD0020079					
60536SD0020080					
60536SD0020081					
60536SD0020082					
60536SD0020083					
60536SD0020084					
60536SD0020085					
60536SD0060018					
60536SD0060025					
60536SD0060028					
60536SD0060029					
60536SD0060031					
60536SD0060032					
60536SD0060033					
60536SD0060034					

Table 9B
Avera Health Plans, Inc.
Projected 2026 Membership by Subsidy Level (Silver Plans) [redacted]

HIOS ID	70%	73%	87%	94%	Total
60536SD0020031	[redacted]				
60536SD0020052					
60536SD0020058					
60536SD0020060					
60536SD0020062					
60536SD0020063					
60536SD0020070					
60536SD0020071					
60536SD0020074					
60536SD0020075					
60536SD0020076					
60536SD0020077					
60536SD0020078					
60536SD0020079					
60536SD0020080					
60536SD0020081					
60536SD0020082					
60536SD0020083					
60536SD0020084					
60536SD0020085					
60536SD0060018					
60536SD0060025					
60536SD0060028					
60536SD0060029					
60536SD0060031					
60536SD0060032					
60536SD0060033					
60536SD0060034					

XVI. TERMINATED PLANS AND PRODUCTS

The following plans sold in 2025 will be terminated as of January 1, 2026. Rate increase calculations in Appendix A include the impact of crosswalking the membership on terminating HIOS IDs to new plans in 2026.

Table 10
Avera Health Plans, Inc.
Plans Terminated as of January 1, 2026

Product Name	Plan Name	2025 HIOS ID	2026 Mapped HIOS ID
Avera ConnectPlus	[redacted]	[redacted]	[redacted]
Avera ConnectPlus			
Avera DirectConnect			
Avera DirectConnect			
Avera DirectConnect			
Avera DirectConnect			
Avera DirectConnect			

[1] *Rating Area 1 plan.*
[2] *Rating Areas 2 to 4 plan.*

XVIII. RELIANCE

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, we relied on information provided by AHP. To the extent it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum, along with many of the conclusions, may be materially affected.

We 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 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.

[redacted]

XIX. ACTUARIAL CERTIFICATION

[redacted] am a member of the American Academy of Actuaries, and I meet its Qualification Standards to render the actuarial opinion contained herein. Avera Health Plans, Inc. engaged me to provide the opinion herein.

The rates accompanying this Actuarial Memorandum reflect current law and regulations effective at the time of this rate filing submission. Future regulatory changes may affect the extent to which the rates are neither excessive nor deficient.

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 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 differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
4. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.
5. The proposed premium rates in this filing are actuarially sound in aggregate.
6. The entire rate filing is in compliance with all the applicable laws and rules of South Dakota and the benefits are reasonable in relation to premium.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

The information provided in this Actuarial Memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop propose premium rates. It does certify 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 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.

[redacted]