Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

State of Virginia
2026 Individual Rate Filing
Rates Effective January 1, 2026

Part III – Actuarial Memorandum and Certification

1. Purpose

This document contains the Part III Actuarial Memorandum for Kaiser Foundation Health Plan ("KFHP") of the Mid-Atlantic States' Individual business segment rates in the State of Virginia, with an effective date on or after January 1, 2026. These Individual rates are guaranteed through December 31, 2026. These products may be offered both on and off the Insurance Exchange. This rate filing applies to new and renewal business on a guaranteed issue basis with no age limitations. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template ("URRT") and is in compliance with 45 CFR § 156.215. The purpose of the actuarial memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT. This memorandum may not be appropriate for other purposes.

The products within scope of this filing are listed in the Virginia Rate Template with their HIOS Plan and Product IDs, and metal levels. Form numbers are shown in the Health Insurance Rate Increase Summary Part I. All products are comprehensive medical plans and range from no-deductible HMO style plans and high-deductible Health Savings Account ("HSA") qualified plans. All products cover all required Essential Health Benefits ("EHBs") including pediatric dental benefits.

2. General Information Section

Company Identifying Information

Company Legal Name:	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
State:	Virginia
HIOS Issuer ID:	95185
Market:	Individual Market On and Off Exchange
Effective Date:	January 1, 2026

Company Contact Information

Primary Contact Name:	Stephen Chuang
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3. Proposed Rate Changes

28 renewing plans and 6 new plans are represented by this filing. For the renewing plans, primary factors that affect the rate change for these plans are:

- Claims experience of the single risk pool different than projected in the previous year.
- Medical inflation including increases in unit cost per service and utilization of services.
- Changes in population morbidity and demographic make-up of the pool.
- Risk adjustment transfer payments into the statewide risk adjustment pool.
- Benefit plan design adjustments, including those made to comply with Actuarial Value ("AV") requirements. This results in varying rate changes by plan.
- Changes in CSR defunding loads related to changes in the distribution of subsidy eligible members across plans. The CSR defunding load results in varying rate changes between on exchange Silver plans and other plans.
- Federal and state taxes and fees.

The average rate change is 11.60% and the number of current members to which the proposed rate revision applies is 36,390 (14VAC5-130-70.) and assumes the state-based reinsurance program is active for 2026.

The average rate change does not indicate that every member's rate will change by this amount as rates are affected by the ages of those covered and benefits chosen.

Proposed rate change by plan can be found in the Virginia Rate Template, Schedule V Plan Rates.

4. Callouts Related to 2026 Rate Filing

4.1 **Enhanced ARPA subsidies –** The version of rates filed assumes that the enhanced subsidies introduced by ARPA will expire at the end of 2025. This impacts the enrollment and morbidity assumptions used in rate development. The estimated rate impact from this change is around 4.8%. Assumptions that would change if enhanced federal subsidies are continued would be:

- Morbidity **–** Morbidity factor would decrease from 1.04 to 1.00
- Enrollment **–** Projected 2026 enrollment would increase by around 20.7%
- Risk Adjustment **–** Projected 2026 Risk Adjustment transfer would decrease by around $4.00 PMPM

4.2 **HIOS ID Alignment –** The HIOS IDs for plans that are on both On and Off Exchange have been aligned to have the same 14 digit HIOS IDs, with the Off Exchange variant updated to match the On Exchange.

4.3 **Non-EHBs – list of all non-EHBs and associated cost.** Please see Exhibit 6a for the list of covered non-EHB and associated cost.

4.4 **Additional notes –**

- Acupuncture is not covered and do not expect any associated costs
- Regarding CSR paid for enrollees in 2024, we are not able to provide the actual amount. Calculating the actual CSR would require readjudicating every member's claims using the base silver benefits, which is not a capability that Kaiser has internally. When we have had to calculate the actual CSR in the past for CSR reconciliation, we needed to work with an external vendor to undergo the complex readjudication process. In addition, there is insufficient time to complete this process by the rate filing deadline. In lieu of actual CSR, we can provide an estimate of the CSR paid for enrollees in 2024, which is $10.7 million.
- Non-EHB has been updated to reflect the change for transgender care.

5. Market Experience

5.1. Experience and Current Period Premium, Claims and Enrollment

Premium

Data for experience period and current period premiums through February 2025 is pulled from KFHPs data base which reflects premiums paid by policy holders. No MLR rebates were required for the experience period.

Claims

The experience period claims for the single risk pool are shown in Exhibit 1.

The claims data is for the incurred period January 2024 through December 2024 and paid through February 2025, including estimates for incurred but not reported claims for the Individual line of business. Net cost data from internal cost systems (i.e., the cost for medical services delivered within our integrated delivery system), fee for service claims, capitations and prescription drug claims net of drug rebates are aggregated to determine annual claims. Allowed claims are calculated based on system paid claims divided by the experience period paid benefit to allowed ratio expected for the plans offered in the experience period plus capitation.

Incurred but not reported estimates for non-capitated services are developed using the completion factor method consistent with KFHPs monthly reserve estimate process. The completion factors are based on all commercial claims which includes Individual, Small Group and Large Group business segments. Except for capitated expenses, all claims are processed by KFHPs internal systems. Capitated expenses are based on a monthly contractual PMPM amount paid to the vendor. Capitated and non-capitated expenses are shown separately in Exhibit 1.

Enrollment

Experience period and current period enrollment as of February 2025 is pulled from KFHPs data base at the plan level and by member age.

5.2. Benefit Categories

Claims are assigned to one of the following benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, and Prescription Drugs. The categorization is derived from each claim's specific information on services rendered, the location of service, and the type of provider. The categorization is an automated process within KFHP's data warehouse. Examples of services by benefit category include:

Benefit Category	Services
Inpatient Hospital	Inpatient Facility, Inpatient Visits, Inpatient Surgery, Maternity
Outpatient Hospital	Outpatient Facility, Emergency/Urgent Care, Outpatient Surgery
Professional	Diagnostic Services, Office Visits, Cardiovascular, Dialysis, PT/OT/ST
Other Medical	Other Services
Capitation	Dental
Prescription Drug	Pharmacy

5.3. Projection Factors

4.3.1 Trend Factors

Projected trend factors are based on a mixture of expected industry trends, future fixed costs, and expected internalization of services (i.e., movement of medical care delivery between contracted external providers and our integrated delivery system.) As an integrated health care provider, a large portion of KFHP's expenses are the fixed costs associated with providing medical care through Kaiser owned facilities. Therefore, the projected cost that is included in our total revenue requirement is largely based on budgeting.

For traditional carriers, projected cost per service and utilization per member trends are developed to project expected future costs. However, given KFHP's fixed cost structure, KFHP's projected claims trends largely stem from the development of budgeted costs for the rating year. For the period from 2024 to 2026, our projected total annualized medical expense trend for the ACA market can be found in Exhibit 3.

Exhibit 3 includes an allocation of trend into cost and utilization service categories which is derived for use in the URRT.

4.3.2 Adjustments to Trended EHB Allowed Claims PMPM

Demographic Shift

Base period claims experience is adjusted for the average mix of population by age in the experience period membership. The average age factor is developed by applying the CMS standard age curve to experience period member months. The same calculation is performed for projected rating period membership, which is based on actual KFHP enrolled members for the current period adjusted for expected distribution changes in the rating period. The projected age factor used is the closest rounded-age factor from the CMS standard age curve. The projected allowed claims are then multiplied by the change in the average age factor from the experience to the rating period. The development of the average age factor is shown in Exhibit 4.

Utilization Adjustment Changes

All plans have cost sharing in the rating period that generates different levels of utilization adjustments when compared with the experience period plans. The net impact is reflected as the change in average utilization for the pool in Exhibit 5. This is calculated by dividing the average utilization adjustment in the projection period by the base period average utilization. Changes from the experience period to the projection period may include, but is not limited to, member mix changes across plans in the projection period compared to the experience period.

Other Adjustments

No adjustments or factors, other than those previously discussed in this section, have been used to project the experience period allowed claims to the projection period.

4.3.3 Manual Rate Adjustments

KFHP considers the experience period data to be fully credible, and has not employed the use of additional, external claims data to develop a manual rate.

4.3.4 Credibility of Experience

KFHP VA had roughly 37,000 covered lives in the Individual pool for the experience period, which we consider fully credible. Actuarial Standard of Practice #25 was considered when making this determination

4.3.5 Establishing the Index Rate

The experience period data includes claims for non-EHBs. Claims for non-EHBs were removed from the allowed charge by applying the experience period ratio of EHB claims to total claims to the experience period allowed charges. The non-EHB removal ratio is shown in Exhibit 6.

4.3.6 Development of the Market-wide Adjusted Index Rate ("MAIR")

Paid to Allowed Ratio

The projected 2026 paid to allowed ratio is calculated as the average effective plan design factor. The average plan design accounts for the projected member distribution across the available plans.

Reinsurance

We estimated the rate impact of the reinsurance program in the 1332 waiver application, which is based on a 65% coinsurance rate for claims between $45,000 and $170,000. We estimate that this program will reduce rates by approximately 10% (ignoring the impact on risk adjustment).

Risk Adjustment

The risk adjustment transfer is based on expected experience period results by metal tier projected to the rating year. Exhibit 7 shows KFHP's projection of risk adjustment transfers which includes the impact of CMS changes to the risk adjustment transfer formula. The projected transfer PMPMs by metal level are adjusted for assumed risk scores for continuing and future new members entering the pool vs experience period risk scores. Anticipated market average premium increases and projected KFHP enrollment mix between metal levels also impacts the overall average transfer PMPM.

Exchange User Fees

Exchange user fees are applied as an adjustment to the Index Rate at the market level. Fees are applied across all plans, both On- and Off-Exchange, and are calculated by applying the percentage of enrollment On- Exchange to the 2.5% Exchange User Fee. The specific Exchange User Fee for the experience and rating period is shown in Exhibit 8.

5.4. Plan Adjusted Index Rate ("PAIR")

Allowable plan level modifiers are applied to the MAIR to develop PAIRs. Allowable adjustments, which can be found on the Virginia Rate Template Schedule V Plan Rates, include:

Plan Level Adjustments

Plan level adjustments accounting for differences in cost sharing between plans have been developed using Milliman's Managed Care Rating model calibrated with Kaiser-specific experience. Factors are shown in V Plan Rates of the Virginia Rate Template.

Plan level benefit richness factors are applied based on the metal level of the specific plan. Factors indicate the level of induced demand expected at the different metal levels. The induced demand factors are published by CMS and are shown on V Plan Rates.

In 2017, the Federal Administration decided against funding the Cost Share Reduction ("CSR") provision of the ACA. The impact of the elimination of CSR subsidies affects on-Exchange Silver plans and is shown in V Plan Rates and development of the impact factor is shown in Exhibit 9. The application to apply the impact to on-Exchange Silver plans was communicated to filers by the Virginia Bureau of Insurance on June 15, 2018.

Catastrophic Plan Adjustment

A catastrophic specific plan adjustment accounts for the specific eligibility requirements for consumers eligible to purchase the catastrophic plan. The adjustment factor is shown on Exhibit 4.

Non-EHB Adjustment

Rating period non-EHB covered benefits are added back to plan rates as a multiplier when calculating the Plan Adjusted Index Rate for each plan.

Administrative Expenses

Administrative expenses for the experience period and rating period are shown on Exhibit 8. Projected administrative expenses are added uniformly across all plans.

Taxes and Fees

Taxes and Fees for the experience period and rating period are shown on Exhibit 8. Projected taxes and fees are added uniformly across all plans. Note that the Exchange User Fee is included in the MAIR while all other taxes and fees are added in the determination of the PAIR.

Profit and Risk Load

The profit and risk load for the rating period, shown on Exhibit 8, is loaded uniformly across all plans.

5.5. Calibration

Calibration of the Plan Adjusted Index Rates is necessary in order to calculate Consumer Adjusted Premium Rates. The Plan Adjusted Index Rates are developed for the average individual within the Single Risk Pool. Based upon the allowable rating parameters, factors are developed to calibrate the Plan Adjusted Index Rates to generate Consumer Adjusted Premium Rates. The calibrated Plan Adjusted Index Rates have been defined as Base Rates, and the calibration factors are applied uniformly to all plans in the single risk pool.

Age Curve Calibration

The determination of the calibration factor is based upon the CMS Standard Age Curve and KFHP internal current year enrollment data. A weighted average age factor is calculated as the product of the enrollment by age and the unadjusted CMS age factors. The projected age factor used is the closest rounded-age factor from the CMS standard age curve. The Plan Adjusted Index Rates are then divided by this factor to adjust to an Individual aged 21, for which the age factor is 1.00. The development of the average age factor is shown in Exhibit 5.

Geographic Factor Calibration

KFHP does not vary rates by rating area, therefore the area calibration factor is 1.00.

Tobacco Use Rating Factor Calibration

KFHP does not charge a tobacco load.

5.6. Consumer Adjusted Premium Rate Development

IV Rate Development shows the development of the Index Rate and Market Adjusted Index Rate. The Plan Adjusted Index Rates are calculated in V Plan Rates by applying calibration factors and other allowable rating factors. The resulting base rates are then multiplied by the age slope to generate age specific rates. The age slope factor applied is based on the member's age as of the effective date of coverage and remains unchanged for the remainder of the policy period (15VAC5-130-70 B 1). Note that only the three oldest children under the age of 21 on a family policy are rated.

6. Projected Loss Ratio

Exhibit 10 provides a demonstration of the Minimum Loss Ratio (MLR) calculation based upon assumptions in this rate filing for the projection year.

State Anticipated Loss Ratio

Based on the traditional MLR methodology, with claims and risk adjustment included in the numerator and premium in the denominator, KFHP's projected loss ratio is greater than the 75% minimum required (15VAC5-130-65).

Federal Medical Loss Ratio

Using the federally prescribed methodology, we project the medical loss ratio shown in Exhibit 10, which is greater than the three-year average minimum threshold of 80%.

7. Plan Product Information

7.1. Actuarial Value ("AV") Metal Values

The AV Metal Values were developed based on the CMS Actuarial Value calculator, as all plans' designs were compatible with the calculator. The Federal AVs are shown in V Plan Rates.

AV Pricing Values/Allowable Plan Level Adjustments

Per the URRT Instructions, the Allowable Plan Level Adjustments include plan specific adjustment factors for the Cost-Sharing Design of each plan in addition to the EHBs, and administrative costs. The effective plan design adjustment components of the plan level adjustments are calculated using a proprietary pricing model, which reflects a standard population and KFHP specific data. Induced demand adjustments are based on CMS determined factors. The pricing method is consistent among all plans in that it does not include any differences in utilization due to differing health status of people with different cost-sharing designs.

The AV pricing values have changed for 2026 plans due to routine updates to the pricing model and changes to benefit plans. These changes can have different effects on each plan design, which leads to non-uniform rate changes between the plans.

7.2. Membership Projections

Current year member projections are based on current year open enrollment results and expected adds and cancellations occurring throughout the remainder of the year. Projection year member projections take into account the impact of enhanced federal subsidies ending.

7.3. Plan Type

There are no plan types that are not listed in the Worksheet 2 drop-down box.

8. Miscellaneous

8.1. Reliance

All data and assumptions contained in this filing were prepared by a team of KFHP employees.

8.2. Historical Rate Revisions Effective January 1 (14VAC5-130-70 B 7)

2015	1.0%
2016	5.6%
2017	25.0%
2018	34.5%
2019	33.8%
2020	-5.5%
2021	-13.0%
2022	-13.0%

2023	-13.1%
2024	4.8%
2025	8.0%

8.3. Estimated Average Premium (14VACS-130-70 B 5)

Estimated average premiums per member and per policy for the current year and projection year are shown below. The projected premium includes the requested rate increase as well as the impact of expected membership changes between products.

	Per Member Per Year	Per Policy Per Year
Current Year	$6,046	$9,554
Projection Year	$7,110	$11,237

8.4. Other

The rate for Adult Dental Buy-up Benefits is shown in Exhibit 11. These benefits are limited excepted benefits.

Actuarial Certification

I, Stephen Chuang, Senior Actuarial Associate, for Kaiser Foundation Health Plan (KFHP), am a member in good standing of the American Academy of Actuaries. I meet the qualification standards for certifying Regulatory Filings for Rates and Financial Projections for Health Plans.

This Actuarial Certification applies to the attached filing for an approval of premium rates for Individual plans sold on and off the Exchange. This actuarial memorandum documents the assumptions and sources of data pertaining to the development of KFHP premium rates effective January 2026.

- To the best of my knowledge and judgment, this rate filing is compliant with all applicable Virginia State and Federal Statutes and Regulations, including 45 CFR §156.80 and §147.102, and the premiums are reasonable in relation to the benefits provided.
- Rates are developed in accordance with 45 CFR part 147.102 and only the allowable modifiers as described in 45 CFR §156.80(d)(1) and §156.80(d)(2) were used to generate plan level rates.
- KFHP does not vary rates by geographic area, therefore all area factors, which are all equal to 1.00, do not include differences for population morbidity by geographic area.
- The federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.
- This filing is consistent with KFHP's internal business plans.
- The adjusted community rate charged can be reasonably expected to result in a medical loss ratio that, under ACA definitions, meets or exceeds the standard of eighty percent and, under

traditional definitions, meets or exceeds the standard of seventy five percent per 15VAC5-130-65.

Rates, calculations and values were developed accordance with generally accepted actuarial principles and methodologies for rating blocks of business and in accordance with the Code of Professional Conduct and the following Actuarial Standards of Practice:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans (Small Group Filings only)
- ASOP No. 41, Actuarial Communications
- 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

Qualifications:

1. The URRT does not demonstrate the process used by KFHP to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

2. The information contained within this filing reflects the Virginia State and Federal statutes, rules, regulations and guidance as of July 24, 2025. Changes to the applicable regulations, including but not limited to Risk Stabilization programs could have a significant impact on rate development. Subsequent changes to these statutes, rules and regulations may make these rates unacceptably deficient and would necessitate revisions to this filing.

3. While the filed rates are neither excessive nor unfairly discriminatory, KFHP leadership has targeted increased affordability resulting in rates that have a negative expected margin. However, KFHP's business plan calls for positive overall margin which would support the expected results on this line of business and provide a buffer for adverse deviation.

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Kaiser Foundation Health Plan
7/24/2025