August 13, 2026

Part II Written Explanation for the Rate Increase
Avera Health Plans, Inc.
Iowa Individual ACA Rate Filing
Effective January 1, 2027

1. SCOPE AND RANGE OF RATE INCREASE

Avera Health Plans, Inc. (Avera) is requesting a rate increase for the Avera MyPlan individual products for Iowa with an effective date of January 1, 2027.

The requested overall rate increase impacts approximately 393 members. The rate increase being requested for the Avera MyPlan products is 14.4% averaged across all members. Rate changes vary by plan due to changes in cost sharing parameters (e.g., deductible, coinsurance, copays) relative to 2026 cost sharing parameters, ranging from 12.4% to 18.0% by plan.

2. FINANCIAL EXPERIENCE

There is no historical financial experience to report as Avera entered the Iowa individual market on January 1, 2026. The financial experience for Avera's South Dakota individual ACA-compliant experience, which supports manual rate projections in Iowa, was unfavorable in 2025 relative to the 2024 experience used to develop 2026 rates.

3. CHANGES IN MEDICAL SERVICE COSTS AND TREND ASSUMPTIONS

To capture the increasing cost and utilization of medical services, projections from manual rate experience assume 6.7% annual trend. This assumption is based on analysis of regional and national trends and actuarial judgment.

4. CHANGES IN BENEFITS

Avera will make cost sharing modifications by plan to comply with the final 2027 Actuarial Value Calculator and based on 2027 strategic considerations. To the extent the plan changes lead to a higher or lower level of benefit richness, the premium rates would increase or decrease, respectively.

5. ADMINISTRATIVE COSTS AND ANTICIPATED PROFITS

Avera is targeting a loss ratio of 86.9% for its individual block of business in January 2027. This loss ratio allows 13.1% for total health plan administrative costs, taxes, fees, and anticipated profits.

6. EXPIRATION OF EXPANDED ADVANCE PREMIUM TAX CREDIT SUBSIDIES

Avera expects the expiration of expanded Advance Premium Tax Credit subsidies will result in higher market morbidity due to the anticipated mix of enrollees remaining in the market.

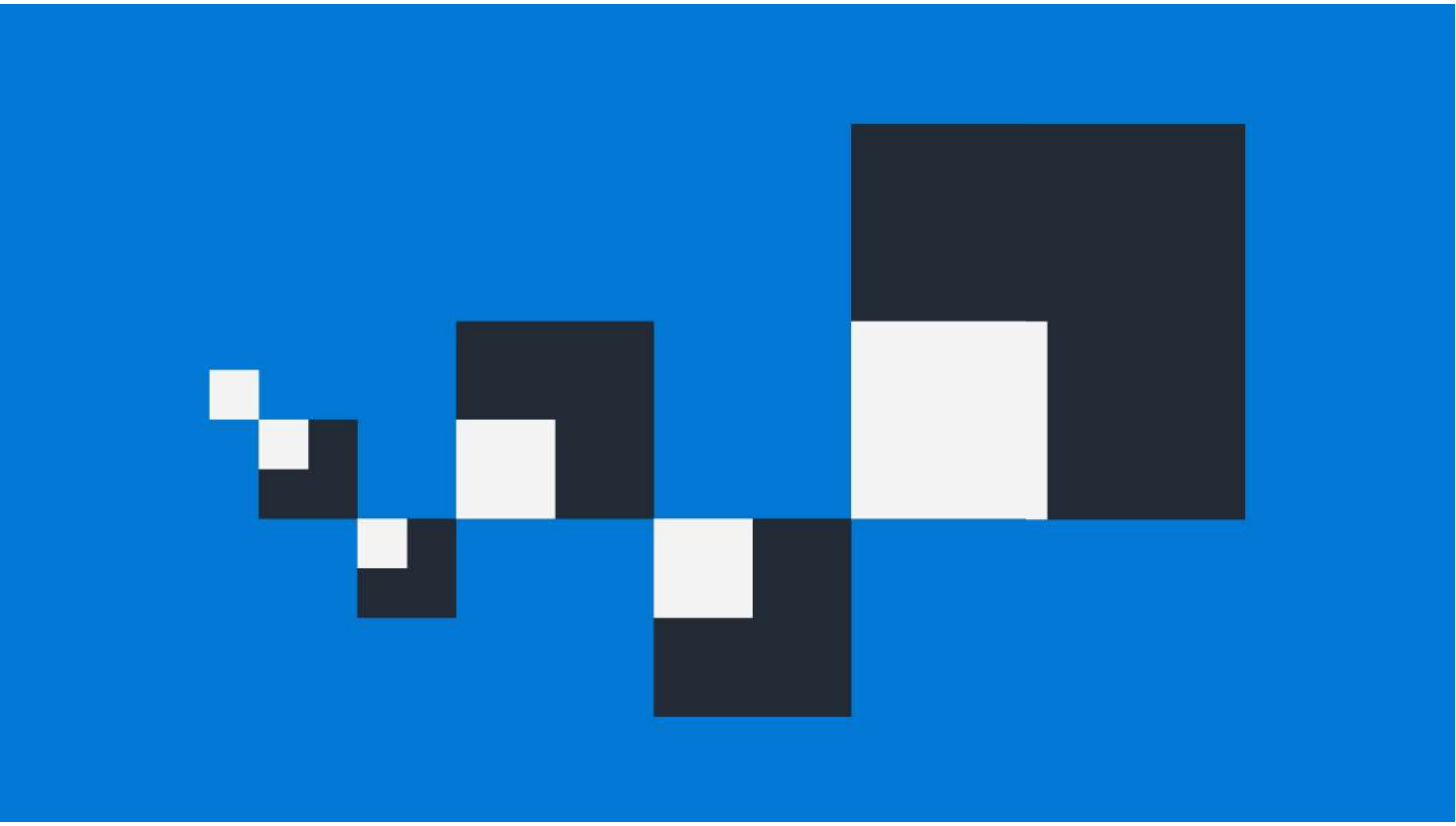
MILLIMAN ACTUARIAL MEMORANDUM

Avera Health Plans, Inc.

Iowa Individual Rate Filing
Effective January 1, 2027

August 10, 2026

[redacted]



[redacted]

Milliman

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I. General Information

This document contains the Part III Actuarial Memorandum for Avera Health Plans, Inc.'s (AHP) individual 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 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 Iowa's Insurance Division, 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. [redacted]

COMPANY IDENTIFYING INFORMATION

Company Legal Name:	Avera Health Plans, Inc.
State:	Iowa
HIOS Issuer ID:	74980
Market:	Individual
Effective Date:	January 1, 2027

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

II. Proposed Rate Changes

[redacted]

REASONS FOR RATE CHANGE

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

[redacted]

TABLE 1
AVERA HEALTH PLANS, INC.
EXPLANATION OF COMPOSITE RATE INCREASE

AGGREGATE CHANGE	RATE IMPACT	ANNOTATION
[redacted]		(1)
		(2)
		(3)
		(4)
		(5)
		(6) = (1) x (2) x … x (5)
		(7) = (6) - 1

Note: Factors are rounded.

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]

PAID THROUGH DATE

Not applicable.

CURRENT DATE

The reported date for current enrollment and premium in URRT Worksheet 2, Section II is March 31, 2026.

ALLOWED AND INCURRED CLAIMS INCURRED DURING THE EXPERIENCE PERIOD

Not applicable.

IV. Benefit Categories

We assigned the manual data utilization and cost information to benefit categories consistent with those 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, Durable Medical Equipment (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."

V. Projection Factors

Not applicable [redacted]

MORBIDITY ADJUSTMENT

Not applicable.

CHANGES IN DEMOGRAPHICS

Not applicable.

PLAN DESIGN CHANGES

Not applicable.

OTHER ADJUSTMENTS

Not applicable.

TREND FACTORS (COST / UTILIZATION)

[redacted]

The projected index rate for January 1, 2027 through December 31, 2027 is in Worksheet 1, Section II of the URRT and in Table 1.

VI. Manual Rate Adjustments

[redacted]

SOURCE AND APPROPRIATENESS OF EXPERIENCE DATA USED

[redacted]

ADJUSTMENTS MADE TO THE DATA

The following sections include a description of each factor used to adjust the experience of the manual rates and supporting information related to those factors.

MORBIDITY ADJUSTMENT

[redacted]

CHANGES IN DEMOGRAPHICS

We adjust the projection to reflect the age, gender, and tobacco differences between the population underlying AHP's manual rate and AHP's projected 2027 individual ACA enrollment in Iowa, [redacted]

PLAN DESIGN CHANGES

[redacted]

[redacted]

[redacted]

OTHER ADJUSTMENTS

[redacted]

TREND FACTORS (COST / UTILIZATION)

The manual rate experience was trended forward to benefit year 2027 [redacted]

The projected index rate for January 1, 2027 through December 31, 2027 is in Worksheet 1, Section II of the URRT and in Table 1.

INCLUSION OF CAPITATION PAYMENTS

[redacted]

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, 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 2027 mixture of smoker / non-smoker population, area factors, 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.

The projected Index Rate is equal to the projected total allowed claims PMPM, since there are no benefits offered beyond the EHBs. The development of the projected index rate is illustrated in Worksheet 1, Section II of the URRT and in Table 2 below. Amounts shown in Table 2 may not match the URRT exactly due to URRT rounding conventions.

TABLE 2
AVERA HEALTH PLANS, INC.
PROJECTED INDEX RATE DEVELOPMENT

	MANUAL
Experience Member Months	[redacted]
Experience EHB Allowed Claims	
Experience EHB Allowed Claims PMPM	
Experience EHB Allowed Claims PMPM [redacted]	
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	

[redacted]

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		
		ANNOTATION
2027 Index Rate PMPM	[redacted]	*(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 ended December 31, 2016 and is no longer applicable.

RISK ADJUSTMENT PAYMENT / CHARGE

Experience Period Risk Adjustment

[redacted]

Projected Risk Adjustment

[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 URRT Worksheet 2, Section III.

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]

CSR Load Development

[redacted]

Issuer CSR Payments

[redacted]

Recoveries from CSR Load

[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 4
AVERA HEALTH PLANS, INC.
PROJECTED 2027 ADMINISTRATIVE EXPENSES

	ADMINISTRATIVE EXPENSE	
	PMPM	% OF PREMIUM
General Admin	[redacted]	
Commission		
Commercial Reinsurance Recoveries		
Commercial Reinsurance Premiums		
Quality Improvement		
Total Administrative Expense Load		

Note: Values are rounded.

TAXES AND FEES

Table 5 displays the projected taxes and fees applicable in 2027. [redacted]

TABLE 5
AVERA HEALTH PLANS, INC.
SUMMARY OF TAXES AND FEES

	TAXES AND FEES	
DESCRIPTION	PMPM	% OF PREMIUM
Risk Adjustment Admin Fee	[redacted]	
Premium Tax		
Comparative Effectiveness Research Fee		
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

[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 weighted average age curve calibration factor 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 Milliman developed *HCGs* factors and expectations for provider reimbursement in 2027. 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 [redacted]

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 2, Section III of the URRT.

AHP's 2027 age and tobacco rating factors are shown below. The age rating factors used by AHP are identical to those prescribed by CMS.

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 2027 geographic rating factors are shown below. These geographic rating factors are based on based on Milliman developed *HCGs* factors and expectations for provider reimbursement. 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 3	[redacted]
Rating Area 7	

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 2027 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

	INDIVIDUAL 2027
Member Months	[redacted]
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 and 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 [redacted]

TABLE 9
AVERA HEALTH PLANS, INC.
ASSUMED MEMBERSHIP DISTRIBUTION WITHIN SILVER TIER

SILVER PLAN	ASSUMED MEMBERSHIP DISTRIBUTION
Silver 94%	[redacted]
Silver 87%	
Silver 73%	
Silver 70%	

XVI. Terminated Plans and Products

[redacted]

TABLE 10
AVERA HEALTH PLANS, INC.
PLANS TERMINATED AS OF JANUARY 1, 2027

PRODUCT NAME	PLAN NAME	2026 HIOS ID	2027 MAPPED HIOS ID
[redacted]			

[redacted]

XVII. Plan Type

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

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(d)(1)).
   - Developed in compliance with the applicable Actuarial Standards of Practice.
   - Reasonable in relation to the benefits provided and the population anticipated to be covered.
   - Neither excessive nor deficient based on my best estimates of the 2027 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 Iowa, 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 2027 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2027 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendments, court decisions, or decisions by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director.

The information provided in this Actuarial Memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop 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]