

**BridgeSpan Health Company – Individual  
Actuarial Memorandum and Certification – Part III  
Rates Effective January 1, 2027**

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**4.1: Redacted Actuarial Memorandum**

This document is intended to serve as both the “CMS Version” and the “public version” of the Part III Actuarial Memorandum; no items are redacted.

**4.2: General Information**

**Company Identifying Information**

- Company Legal Name: BridgeSpan Health Company
- State: Oregon
- HIOS Issuer ID: 63474
- Market: Individual
- Effective Date: January 1, 2027

**Company Contact Information**

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**Purpose**

This Actuarial Memorandum is prepared to provide transparency regarding the assumptions and methods used to calculate the rates proposed in the BridgeSpan Health Company (hereafter referred to as BridgeSpan) January 2027 Individual Filing. Information is also included, where applicable, to support the information shown in the Part I Unified Rate Review template (URRT). The intended purpose of this document is to demonstrate the proposed rates included in this filing and the template are reasonable in relationship to the benefits provided and meet all rating requirements in the applicable laws and regulations in the state of Oregon. The intended audience for this document is the Oregon Division of Financial Regulation.

Two Appendix exhibits show the key framework supporting the rate filing. The process to develop the rate change for this filing is shown in “Exhibit 1: Development of Rate Change.” Development of the URRT projection period index rate is shown in “Exhibit E1: Development of 2027 Index Rate.”

Please note in reviewing this memorandum and its accompanying exhibits that BridgeSpan developed rates directly from incurred claims experience. The URRT requires issuers to include an index rate calculation based on allowed claims experience following a prescribed calculation methodology. Because BridgeSpan does not develop rates on an allowed claims basis, the URRT was populated indirectly such that the resulting projected average premium was consistent with the underlying rate development. Explanations regarding how the URRT was populated are included throughout this memorandum and explained relative to the actual rate development.

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Per the 2027 Unified Rate Review Instructions, the actuary may state: *“The URRT does not demonstrate the insurer’s process for developing the rates. Instead, it represents 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 that the Index Rate is developed in accordance with Federal regulation, used consistently, and adjusted only by the allowable modifiers.”*

**4.3: Proposed Rate Changes**

This filing proposes an average annual rate change of 11.7% at January 1, 2027, for the Individual line of business, as shown in “Exhibit 1: Development of Rate Change.” The 2027 projected average premium is \$951.33 per member per month (PMPM).

The average annual rate change is calculated based on Individual enrollment data as of March 2026 and includes the mapped rate impact for membership enrolled in plans terminating in 2027. A summary of the rate changes by plan is shown in “Exhibit D1: 2027 Average Change in Plan Base Rates.”

The estimated distribution of member-level rate changes due to changes in base rates, plan relativities, rating factors, and plan mappings is as follows:

Rate Change	Distribution
8.0% to 11.0%	34.6%
11.0% to 14.0%	57.7%
14.0% to 17.0%	7.7%

The benefit plans impacted by the rate change request are shown in “Exhibit 6: Plan Relativities.”

This filing assumes Cost Sharing Reduction (CSR) payments will not be paid in 2027. If changes are made to the premium subsidies, risk adjustment, or reinsurance, the proposed rates in this filing may need to change materially to ensure adequacy with expected market costs.

**Factor Changes**

This filing includes updates to the plan and area factors. Rating factor tables and changes since the last filing are shown in the “Rate Tables and Factors” document. The average annual rate change impact of 11.7% includes the impact of these factor changes and is on a member-weighted basis.

Plan pricing factors are updated using the most recent data and factors from the BridgeSpan pricing relativity model, with benefit design changes incorporated. Rate differences between plans reflect objective plan design differences and not differences in population morbidity.

Area factors reflect relative cost differences between rating areas and, as required, do not include differences for population morbidity by geographic area. Area factors were updated to reflect relative cost differences between rating areas based on changes in unit cost and normalized PMPM claims cost.

**Pool Base Rate Change**

The pool base rate is \$1070.96 as of January 1, 2027, compared to \$923.46 as of January 1, 2026, which is an increase of 16.0%. The pool base rate is the starting amount such that multiplying the base rate by

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the member’s rating factors (plan, age, area, and tobacco) and adjusting for family composition results in the member’s premium.

**Reasons for Proposed Rate Change**

The following components are significant factors contributing to the proposed rate change: medical trend and utilization, financial experience, and increasing market morbidity.

*Medical Trend and Utilization:* These adjustments refer to what is commonly known as healthcare trend. They reflect contractual changes in the carrier’s payments to healthcare providers and expected changes in the volume and types of services utilized by carrier’s members.

*Financial Experience:* Each year BridgeSpan evaluates the most recent financial results in the Oregon Individual market and incorporates that information into pricing.

*Market Morbidity:* The rate of incidence of disease varies from year-to-year with the Oregon Individual market and within BridgeSpan. The adjustment is to account for projected change to market morbidity and BridgeSpan morbidity relative to market.

The above descriptions are intended to provide an overall understanding of the significant factors contributing to the rate change, and each item is described in detail later in this memorandum.

The rating assumptions template required by the state, “Summary of Filed Rating Assumptions”, is included in the “Actuarial Memorandum Supplemental Exhibits” document.

**4.4: Market Experience**

This filing demonstrates that BridgeSpan followed federal guidance and market reform rating requirements in establishing a single risk pool in the Oregon Individual market. The experience data includes all of the BridgeSpan non-grandfathered covered lives in the Oregon Individual market.

**4.4.1: Experience Period Premium and Claims**

The premium and claims used to develop this filing were incurred during calendar year 2025 and includes payments and adjustments paid through March 2026. They are shown in “Exhibit E1: Development of 2027 Index Rate.” Current enrollment and premium are reported as of March 2026.

For rate development purposes, all available Oregon Individual ACA experience was used. This includes experience from BridgeSpan and affiliated company Regence BlueCross BlueShield of Oregon (RBCBSO).

In completing the Experience Period Data section of the URRT, Worksheet 1, only BridgeSpan information is reflected, as required by the instructions. Affiliated company experience projected to 2027 appears in the Credibility Manual section of the URRT, Worksheet 1, as described in the Credibility Manual Rate Development section of this memorandum.

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Allowed claims and incurred claims were extracted directly from company claim records. Unpaid claims liability (UCL) for incurred claims was developed using the following methodology, which is consistent with the corporate reserve development methodology. Unpaid claims liability for allowed claims was estimated using the same factors that were developed for incurred claims.

*Review and Analyze Data*

- Check data for inconsistencies and anomalies
- Reconcile paid claims data against the general ledger
- Monitor unpaid claims inventory
- Assess impact of large claims (claims over \$100,000)
- Review claims on a per exposure basis for reasonableness (PMPM)
- Compare past UCL estimates to actual claims run-out on an ongoing basis to assess the reasonability of past calculations

*Develop UCL Estimates Using Multiple Methods*

- Basic Claims Development Method
- Paid PMPM Method

*Determine UCL for Recent Incurred Months*

The UCL was selected using judgment and considered factors such as recent observed and expected claims trends, seasonality, product design, and changes in membership and claims inventory.

For rate development purposes, pharmaceutical manufacturer rebates were not subtracted from experience period claims because an overall adjustment occurs in a later step of the claims projection process. In contrast, in the URRT, Worksheet 1, pharmacy rebates are subtracted from experience period claims. The Pharmacy Rebates section of this memorandum contains additional information about the adjustments.

**4.4.2: Benefit Categories**

Each allowed claim is 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 type of service, provider type, and place of service and is an automated process within the BridgeSpan data warehouse. This categorization is consistent with the definitions described in the URR Instructions, section 2.1.3.1 "Benefit Category and Manual Rate."

**4.4.3: Projection Factors**

Following is a description of the projection factors used in the filing. As described in the Purpose section of this memorandum, rate development is performed on an incurred claims basis (Exhibit 1) while development of the URRT projection period index rate is performed on an allowed claims basis (Exhibit E1).

Each projection factor's description addresses first how the adjustment is developed for rate development purposes (incurred claims basis). Then, any modifications needed to use the adjustment for developing the URRT projection period index rate (allowed claims basis) are described. Fixed dollar cost sharing measures such as deductibles and copays amplify the impact of cost changes on an incurred

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claims basis, so generally, a dampening adjustment is necessary to convert a factor on an incurred claims basis to an allowed claims basis.

**4.4.3.1: Trend Factors**

Following is a summary of trend information. Detailed information regarding trend is included in “Exhibit 4: Trend Information and Projection.”

*Projected Rating Trend*

The trend factor used in rate development is shown on the “Trend Factor to Rating Period” line in “Exhibit 1: Development of Rate Change”, reflecting twenty-four months of trend at an annual rate of 9.5%. The table below shows the expected components of the annual trend used to project incurred claims costs to the rating period. Note that the leverage component does not impact allowed claims; this trend applies to incurred, paid claims.

Reimbursement	5.4%
Utilization	1.5%
Mix/Intensity	0.7%
Leverage	1.9%

For reporting purposes, trend and its respective components are reported throughout the filing on a medical and prescription drug combined basis.

To determine projected trend for the rating period, BridgeSpan analyzed the individual components of trend, change in reimbursement, utilization, mix/intensity, and leverage, to determine the aggregate expected trend.

The reimbursement component captures unit cost changes, including negotiated rate changes with providers. The utilization component measures the difference in number of services per 1,000 members. The mix/intensity component measures the shift within service categories (e.g., using more MRIs versus X-Rays or more specialty drug prescriptions as a percentage of total prescriptions) and between service categories (utilizing outpatient services instead of inpatient services). Fixed dollar cost sharing measures, such as deductibles and copays, serve to amplify trend since the member portion of total costs remains fixed while the insurer portion increases over time. This effect is captured in the leveraging component of trend.

BridgeSpan considers historical experience, state and federal mandates, new technologies, cost shifting, drug patents, and anticipated economic conditions in determining the utilization and mix/intensity components of projected trend.

Additionally, BridgeSpan actively reviews and implements opportunities to improve the quality of health care delivery and achieve sustainable costs. This filing reflects an explicit reduction to overall projected trend of 0.5% due to expected incremental impacts of program changes from the base period to projection period. These initiatives are focused on lowering the utilization, mix/intensity, and reimbursement components of trend.

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A few examples of new or expanded initiatives include:

- Launching a new provider rating methodology to identify and surface for our members providers with proven track records of using evidence-based practices, adhering to best practices for patient care and delivering cost-efficiencies.
- Expanding inpatient short stay program to enable real-time admission reviews, optimizing care settings and maintaining quality of care.
- Enhancing post-discharge support for complex cases to promote successful transitions home and reduce readmission risk.
- Expanding utilization management to ensure medical appropriateness and manage outcomes.
- Reducing overpayments through data mining as well as pre-pay and post-pay edits and audits.
- Ensuring visit level coding aligns with Centers for Medicare & Medicaid Services (CMS) Guidelines.
- Engaging with network providers to align financial incentives and support better outcomes for episodes of care.

The following trend variables are not considered when calculating trend: margin, fluctuation, anti-selection, or underwriting wear-off.

The selected projected rating trend assumption and the resulting rate change consider but do not rely on differences in projected and observed trend levels in prior periods.

In the URRT, Worksheet 1, Section II, the annualized “Cost” trend factor is populated with the Reimbursement component shown above. The “Util” trend factor is populated with a blend of the Utilization and Mix/Intensity components in the projected trend. Trend is developed for a 24 month projection, so Years 1 and 2 are populated with identical annualized values. Additionally, please note the URRT trend is on an allowed basis and thus excludes the leverage trend component while remaining an actuarially equivalent claims projection.

*Normalized Experience Trend*

BridgeSpan reviews experience trend by calculating rolling twelve-month historical claims trend on both an observed and underlying basis. In order to differentiate between the observed trend and the underlying trend, claims are normalized for differences in benefits, demographics, health risk, and large claims. Demographic adjustments are developed using the current filed factors for age and area, benefit adjustments are developed using a benefit relativity model, and health risk adjustments are developed using risk score data.

A summary of the underlying experience is included in “Exhibit 4: Trend Information and Projection.” The analysis shows an underlying average claim trend of 15.5% when comparing calendar year 2025 to calendar year 2024. This estimate of recent underlying trend experience is a single point of reference and is not the sole predictor of future trends.

#### **4.4.3.2: Adjustments to Trended EHB Allowed Claims PMPM**

##### **4.4.3.2(a): Morbidity Adjustment**

This assumption reflects the anticipated change in morbidity from calendar year 2025 (“base period”) to calendar year 2027 (“projection period”) for BridgeSpan Individual ACA plans. The morbidity adjustment reflects a change in the expected health risk of the pool regardless of the underlying demographics.

The morbidity adjustment used for rate development is shown on the “Changes in Morbidity” line in “Exhibit 1: Development of Rate Change.” Development of the claims adjustment for morbidity is shown in “Exhibit B1: Morbidity and Risk Adjustment.” This exhibit also shows the projected risk adjustment transfer, which is closely related to the assumed projection period morbidity. An explanation of the risk adjustment transfer and its relation to company and market morbidity assumptions is provided in the “Risk Adjustment Payment/Charge” section of this memorandum.

The claims adjustment for morbidity was developed using the following process:

- Estimate morbidity level of base period company experience
- Estimate BridgeSpan Individual morbidity change from base period to projection period
- Adjust base period experience to projection period BridgeSpan Individual morbidity level

##### *Morbidity Level of Base Period Company Experience*

Morbidity for each base period experience pool was estimated using risk score data normalized for demographic and benefit differences. Because the risk scores were calculated on a consistent basis for each pool, the relativities between the risk scores represent the relative morbidities.

##### *BridgeSpan Individual Morbidity Change from Base Period to Projection Period*

A wide range of outcomes is possible for the average morbidity change between the base period and projection period for the population insured on BridgeSpan Individual plans. Population enrollment change is the biggest driver of morbidity change. Similar to claims variability, the average morbidity of an insured population will vary from one year to the next, even with no change in covered members.

Some drivers of insured population changes include macroeconomic conditions, market competitiveness, and consumer behavior changes; however, none of these factors or their resulting impacts can be forecasted with certainty.

An estimate for the projected morbidity change between the base period and projection period is shown in “Exhibit B1: Morbidity and Risk Adjustment.” Changes to each of the risk adjustment transfer components between 2025 and 2027 are shown in the exhibit. The projection of 2027 risk adjustment transfers is developed using the risk adjustment parameters and coefficients in effect for the 2025 benefit year. This is done to provide transparency in the reconciliation of experience period risk adjustment transfers as well as the assumptions used to project into the rating period. This implicitly assumes that the impact from model recalibrations will not materially skew the results in a known manner at the issuer level. No explicit adjustments have been made to account for model recalibration impacts. The calculation of the 2027 transfer payments reflects the 14 percent administrative cost reduction to state average premium.

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*Adjust Base Period Experience to Projection Period BridgeSpan Individual Morbidity Level*

The final factor used to adjust company base period morbidity to the projection period BridgeSpan Individual morbidity is derived by taking the ratio of the projection period BridgeSpan Individual morbidity to the base period company morbidity.

For purposes of incorporating the morbidity adjustment into the “Morbidity Adjustment” projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor for the URRT for each experience pool is shown in “Exhibit E1: Development of 2027 Index Rate.”

**4.4.3.2(b): Demographic Shift**

A demographic adjustment is reflected to account for population demographic differences between the experience period and the projection period. Adjustments are developed consistent with current filed factors for age and area.

The demographic adjustment used for rate development is shown on the “Changes in Demographics” line in “Exhibit 1: Development of Rate Change.”

For purposes of incorporating this adjustment into the “Demographic Shift” projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment was applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool can be found in “Exhibit E1: Development of 2027 Index Rate.”

**4.4.3.2(c): Plan Design Changes**

Company experience period claim costs are adjusted to reflect anticipated changes in covered benefits (Essential Health Benefits, Mandated Benefits, and Other Benefits) and changes in cost sharing.

The overall benefit design adjustment used for rate development is shown on the “Changes in Benefits” line in “Exhibit 1: Development of Rate Change.”

*Essential Health Benefits*

Plans offered in 2027 must include covered benefits following Oregon’s essential health benefits (EHB) benchmark package for Individual plans. Covered benefits included in the base period plans were reviewed against the 2027 EHB benchmark plan.

*Mandated Benefits*

There are no significant pricing adjustments for mandated benefits included in this filing.

*Other Benefits*

This adjustment reflects anticipated differences in non-EHB benefits between the experience period and projection period. There are no material differences that require an adjustment.

*Changes in Cost Sharing*

This adjustment reflects anticipated changes in the average cost sharing requirements between the base period and projection period, which was derived by comparing the base period average benefit design to the projection period average benefit design, independent of changes in covered benefits and population health status. It includes anticipated changes in the average utilization and cost of services due to differences in average cost sharing requirements.

The “Plan Design Changes” projection factor in the URRT, Worksheet 1, Section II, includes corresponding adjustments to the changes in covered benefits and changes in cost sharing described above. The changes in cost sharing component only includes the portion of the adjustment attributable to anticipated changes in the average utilization of services due to differences in average cost sharing requirements. Anticipated changes in the average cost sharing requirements were excluded because they do not affect allowed claims.

*Summary of Benefit Changes*

A summary of benefit plan changes is included in “Exhibit 2: Covered Benefit or Plan Design Changes.” This exhibit also includes benefit change impacts for continuing plans and plan factor changes from realignment within the new portfolio of plan offerings.

**4.4.3.2(d): Other Adjustments**

This section describes cost adjustments other than changes in morbidity, demographic shift, and plan design changes.

*Changes in Network*

A network adjustment is reflected to account for expected network differences between the experience period and the projection period. The network adjustment used for rate development is shown on the “Changes in Network” line in “Exhibit 1: Development of Rate Change.”

A proprietary network model is used to determine the projected cost relativities between different networks, based on historical experience projected to the rating period. The model allows the inclusion or exclusion of providers on a group by group basis. As a provider group is excluded from the network, the services that were delivered by that group are redistributed to other providers within the same specialty. As care is shifted among providers, adjustments are made to reflect utilization efficiency and unit cost differences between the providers.

If the network also has a risk sharing arrangement with the provider with an incentive component, a second model is used to calculate the cost impact of this arrangement. An additional reduction in cost is assumed due to improvements in care management for these members and a simulation model is used to estimate the value of the shared savings and/or deficit repayment. The value of these arrangements is included in the network factors.

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In 2027, network offerings include the Individual Value network (a statewide network).

For purposes of incorporating this adjustment into the “Other” projection factor in the URRT, Worksheet 1, Section II, a dampening adjustment is applied to convert the factor to an allowed claims basis. The projection factor used in the URRT for each experience pool is shown in “Exhibit E1: Development of 2027 Index Rate.”

*Pharmacy Rebates*

Incurred claims in the experience period are not reduced by estimated pharmaceutical manufacturer rebates, so a pharmacy rebates adjustment is reflected to account for estimated rebates in the projection period. The pharmacy rebates adjustment for rate development is shown on the “Pharmacy Rebates” line in “Exhibit 1: Development of Rate Change.” Pharmacy rebates are estimated by projecting 2027 aggregate rebate-eligible script counts companywide from base period experience, adjusting for expected changes in average per script rebate guarantees, and then allocating the projected rebates to each line of business using base period pharmacy experience.

Because experience period allowed claims used in the URRT are net of pharmacy rebates, for purposes of incorporating this adjustment into the “Other” projection factor in the URRT, Worksheet 1, Section II, only the estimated difference in pharmacy rebates between the experience period and the projection period is reflected. The projection factor used in the URRT for each experience pool is shown in “Exhibit E1: Development of 2027 Index Rate.”

Overall, the “Other” projection factor in the URRT, Worksheet 1, Section II, includes adjustments for network and pharmacy rebates.

**4.4.3.3: Manual Rate Adjustments**

**Source and Appropriateness of Experience Data Used**

As described previously in the Experience Period Premium and Claims section, 2025 calendar year data for BridgeSpan and RBCBSO Individual ACA plans are used to develop 2027 rates. Given the choice of available options, affiliated company Individual experience was deemed best to develop the framework for a state-wide single risk pool.

For purposes of completing the URRT, Worksheet 1, all BridgeSpan non-grandfathered Individual experience was included to develop the Adjusted Trended EHB Allowed Claims PMPM. All other experience used to develop rates was reflected in the Manual EHB Allowed Claims PMPM item in the URRT, Worksheet 1. A detailed summary is included in “Exhibit E1: Development of 2027 Index Rate.”

**Adjustments Made to the Data**

Adjustments made to the data underlying the Credibility Manual section of the URRT are similar to the adjustments made to the data included in the URRT, Worksheet 1, Section II. A detailed summary of the adjustments is included in “Exhibit E1: Development of 2027 Index Rate.” Descriptions of the adjustments are included in the corresponding sections of this memorandum.

#### **Inclusion of Capitation Payments**

No services are provided under a capitation arrangement.

#### **4.4.3.4: Credibility of Experience**

To develop 2027 rates, the overall projected claims cost was derived by taking a weighted average from each experience pool.

The claims cost weight assigned to each experience pool is shown in “Exhibit 1: Development of Rate Change.” The resulting overall projected incurred claims cost is \$1078.09 PMPM.

For purposes of completing the URRT, the credibility percentage applied to the experience included in the Credibility Manual section is consistent with the weights for rate development. The resulting projected allowed claims cost is \$1372.11 PMPM.

#### **4.4.3.5: Establishing the Index Rate**

The index rate is \$839.55 PMPM. Non-EHB benefit categories are excluded from the calculation based upon the benefit category code assigned automatically within the BridgeSpan data warehouse. Benefits excluded include termination of pregnancy and gene therapy. Please note the index rate does not demonstrate the process used to develop the rates; it was prepared for reporting purposes and is calculated consistently with the results of the underlying rate development process.

For purposes of determining non-EHB benefits, only material benefit categories not covered in the EHB benchmark plan are identified. In cases where the company provided offering is richer than the EHB benchmark plan, the benefits are not considered non-EHB. For instance, if 15 service visits are covered compared to 10 visits in the benchmark plan, then the additional 5 visits would be considered non-EHB.

Development of the index rate is shown in “Exhibit E1: Development of 2027 Index Rate.”

#### **4.4.3.6: Development of the Market-wide Adjusted Index Rate**

The market adjusted index rate is \$921.55 PMPM. It is calculated as the projection period index rate adjusted for the following allowable market-wide modifiers:

- Reinsurance Program Adjustment
- Impact of the risk adjustment program
- Exchange user fees

Development of the market adjusted index rate is shown in “Exhibit E1: Development of 2027 Index Rate.”

#### **4.4.3.6(a): Reinsurance**

Oregon has a state reinsurance program for the Individual line of business. BridgeSpan anticipates an average recovery from the state reinsurance program of 10.0% of claims in 2027. This amount is shown in “Exhibit 1: Development of Rate Change” under “Reinsurance Receipts.” The expected recovery from the state reinsurance program was determined by analyzing the impact of the 2026 proposed reinsurance parameters on claims experience from 2022-2025 for the individual line of business and actuarial judgment.

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The reinsurance amount entered into the URRT, Worksheet 1 is \$100.42.

Cambia, the parent company to BridgeSpan, was engaged in a private reinsurance arrangement for all its insured business during the experience period. This arrangement partially reimbursed a portion of claims incurred above \$4.0 million for any one member in a year in the experience period, and a similar arrangement is expected for claims in excess of \$4.0 million in the projection period in exchange for a small premium. The net impact of this arrangement is expected to be negligible, so the amounts are excluded from this filing.

**4.4.3.6(b): Risk Adjustment Payment/Charge**

Risk adjustment transfers are populated in the “Risk Adjustment Transfer Amount” line of the URRT, Worksheet 2, Section II. The risk adjustment user fee for 2025 was \$0.18 PMPM. The experience period risk adjustment transfer PMPM, before reduction for the risk adjustment user fee, is shown in “Exhibit B1: Morbidity and Risk Adjustment.”

The projected risk adjustment PMPM reflects the difference in projection period expected relative risk between the BridgeSpan block of business and the overall market. The estimated risk adjustment transfer used for rate development is shown on the “Risk Adjustment Transfer” line in “Exhibit 1: Development of Rate Change.” Information regarding the transfer estimate is shown in “Exhibit B1: Morbidity and Risk Adjustment.” A positive amount represents an anticipated risk adjustment payment receipt, and a negative amount represents an anticipated risk adjustment charge.

The federal risk adjustment program transfers funds from carriers with relatively lower risk enrollees to carriers with relatively higher risk enrollees, which mitigates the potential concern of adverse selection in a guaranteed issue market. The transfer formula operates such that, in general, changes in a carrier’s enrolled risk profile results in corresponding changes to the transfer amount. That is, a carrier enrolling relatively higher risk members would expect to receive a higher transfer payment (or pay a lower transfer charge). Similarly, a carrier whose enrolled risk profile stayed the same while the market-wide average risk improved would also expect a higher transfer payment (or lower transfer charge).

A carrier’s risk transfer results from HHS’s risk transfer formula will inherently vary from year-to-year even with no significant carrier or market morbidity changes. For example, periodic updates to the transfer formula methodology and carrier differences in diagnosis coding practices and data submission capabilities will introduce additional variation. For carriers whose enrollees have a significantly different average risk profile than market average, the variability in risk adjustment results may be even higher.

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The 2027 projected risk adjustment PMPM is developed considering expected changes in market-wide morbidity and company enrollment profile changes, combined with risk adjustment transfer formula relationships and reasonable judgment. Considerations included 2024 actual risk adjustment results, 2025 estimated risk adjustment results, projected changes in the market-wide morbidity level between 2025 and 2027, and projected changes in company morbidity of the population insured between 2025 and 2027. In order to enhance transfer credibility and to have rate consistency and stability, the morbidity and risk relationships between Cambia companies in the Oregon Individual market were considered together.

Continuing in 2027, a federal high-cost risk pooling program (HCRP) is expected to partially reimburse carriers for claims over one million dollars, with a fee assessed to the pool to cover the cost of the claims. For rate development purposes, both claim and premium adjustments are made to account for the impact of this program. For claims projection, expected reimbursement amounts from HCRP are removed from the experience period before trending to the projection period. For the anticipated HCRP program assessment, an estimated value of 0.6% of premium is added to the non-benefit expenses.

The projected risk adjustment transfer was populated in the “Risk Adjustment Payment/Charge” item in the URRT, Worksheet 1, Section II.

The “Risk Adjustment Transfer Amount” item in the URRT, Worksheet 2, Section IV is the plan allocation of the aggregate risk adjustment transfer amount from the URRT, Worksheet 1, Section II. Single risk pool pricing requirements require anticipated risk adjustment transfers to be allocated proportionally as a market level adjustment, so the risk adjustment transfer amounts were similarly allocated.

**4.4.3.6(c): Exchange User Fees**

This filing reflects exchange user fees of \$25.48 PMPM. This is based on a \$5.50 PMPM proposed administrative assessment from Oregon’s exchange marketplace and a 1.50% of premium assessment for state-based exchanges utilizing the federal platform (SBE-FP).

**4.4.4: Plan Adjusted Index Rate**

The plan adjusted index rates are calculated as the market adjusted index rate adjusted for allowable plan-level modifiers. The following adjustments are made:

- AV and cost-sharing design
- Network, delivery system characteristics, and utilization management practices
- Non-EHB benefits
- Administrative costs, excluding exchange user fees and reinsurance fees

Development of the plan adjusted index rates from the market adjusted index rate and allowable plan-level modifiers is shown in “Exhibit E2: Plan Adjusted Index Rate Development.” Included in the exhibit are explanations of how the modifiers are developed.

#### **4.4.5: Calibration**

The URRT and actuarial memorandum instructions require the plan adjusted index rates to be calibrated for age, area, and tobacco use factors. Calibration adjustments for these factors were applied uniformly to all plans.

The plan adjusted index rates calibrated for age, tobacco, and area factors are expected to approximate plan starting costs for premium determination, before applying the allowable consumer-specific rating factors for age, area, and tobacco, as well as family composition adjustments. Reconciliation of the plan adjusted index rates and the 2027 plan base rates is shown in “Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping.”

Exhibit E3 displays the actual 2027 Plan Base Rates and may not exactly match the URRT, Worksheet 2, Section III Calibrated Plan Adjusted Index Rates. As noted in the URR Instructions, section 2.2.3, “It is understood [the Calibrated Plan Adjusted Index Rate] may not match exactly to rates submitted in the Rates Table Template document due to rounding and truncation of variables in the URRT; however it is expected the rates will be reasonably close to each other.”

#### **Age Curve Calibration**

The age factor calibration adjustment was calculated by applying the age curve premium factors to the projection period population. An age factor of 0 was used for the projected population under age 21 subject to the three child family rating limitation. Development of the calibration adjustment is shown in “Exhibit C1: Age Curve and Tobacco Calibration Factors.”

#### **Geographic Factor Calibration**

The geographic factor calibration adjustment is calculated by applying the 2027 area factors to the projection period population. This adjustment is shown in “Exhibit C2: Geographic Calibration Factor.”

#### **Tobacco Use Rating Factor Calibration**

The tobacco use rating factor calibration adjustment is calculated by applying the 2027 tobacco use factors to the projection period population. Development of the calibration adjustment is shown in “Exhibit C1: Age Curve and Tobacco Calibration Factors.”

#### **4.4.6: Consumer Adjusted Premium Rate Development**

The consumer adjusted premium rate is the final premium rate charged to an individual or family. Premiums are determined starting from each plan’s base rate. Premium rates may vary due to the following factors, as permitted by 45 CFR 147.102 and 45 CFR 146.121(f):

- Plan
- Age
- Area
- Tobacco
- Family status

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To distribute the projected average premium across the projected population, BridgeSpan determined an overall pool base rate using a normalization calculation. The pool base rate represents the starting amount for premium determination purposes before applying consumer-specific premium factors.

The 2027 pool base rate of \$1070.96 and the average factors for normalization are shown in “Exhibit 1: Development of Rate Change.”

The pool base rate is determined by dividing the projected average premium by the projected population’s average factors. The average age factor is adjusted to reflect the three child dependent premium limit. Area factors reflect geographical delivery cost differences with respect to unit cost and provider practice pattern differences; as required, they do not include differences for population morbidity. Tobacco use status is also used as a rating factor.

A plan base rate is calculated for each plan by multiplying the pool base rate with the plan’s corresponding plan factor.

Each member’s premium is developed by multiplying the plan base rate for the member’s selected plan with the member’s applicable age, area and tobacco factors. The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children are considered in determining the total family premium.

**4.4.7: Non-Benefit Expenses and Profit & Risk**

The “Retention Development” section of “Exhibit 1: Development of Rate Change” and the “Premium Retention” section of “Exhibit 5: Statement of Administrative Expenses” show non-benefit expenses included in the premium development.

**4.4.7(a): Administrative Expense Load**

The BridgeSpan administrative expense load is comprised of expected plan operating expenses and commissions paid to agents and brokers.

Operating expenses for 2027 are projected at \$79.15 PMPM or 8.3% of premium. Operating expenses are developed by the cost accounting department consistent with company policy and were reviewed for reasonability compared to prior results. When possible, operating expenses are assigned directly as a claim or non-claim related expense to the appropriate line of business. When costs cannot be assigned directly to a specific line of business, the expenses are allocated based upon appropriate objective statistical measures. As such, reliance is placed on the internal cost accounting department’s expertise in developing these estimates. Operating expense detail is included in the “Expenses” section of “Exhibit 5: Statement of Administrative Expenses.”

Commission expenses for 2027 are projected at \$2.23 PMPM or 0.2% of premium. Historical utilization of distribution channels was analyzed against the 2027 commission schedule.

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The following table shows the components of “Administrative Expense” in the URRT Worksheet 2 Section III.

<b>Administrative Expense Components</b>		
<b>Component</b>	<b>Percent of Premium</b>	<b>PMPM</b>
Administrative Expenses	8.3%	\$79.15
Commissions	0.2%	\$2.23
Total Administrative Expense Load	8.5%	\$81.38

2027 Projected Average Premium PMPM: \$951.33

PMPM values shown here match the rate development and may differ from the URRT due to rounding.

**4.4.7(b): Contribution to Surplus & Risk Margin**

Rate setting for ACA plans includes many pricing risks. Claims experience continues to be more volatile and less predictable relative to recent years because the covered population may change materially from year-to-year. These changes increase uncertainty with how closely morbidity adjustments align to final risk adjustment transfer amounts. There is further underlying variability with risk adjustment transfers due to differences between carriers in diagnosis coding practices and data submission capabilities, which are factors that cannot be predicted. Also, while the risk adjustment program is intended to compensate for morbidity differences between carriers, it does not protect against the risk of market morbidity being less favorable than projected across all carriers.

A value of 4.0% is included in this filing for risk and contingency margin. The assumption included in the 2026 rate filing was 4.0%.

A value of 0.0% is included in this filing for contribution to surplus.

This information is included in “Profit & Risk Load” in the URRT Worksheet 2 Section III.

**4.4.7(c): Taxes and Fees**

The BridgeSpan taxes and fees for the Individual line of business are comprised of state premium taxes, exchange user fees, PCORI fees, and HCRP fees. These are in addition to the risk adjustment user fee previously described.

- State premium tax is set at 2.0% by the state of Oregon
- This filing reflects exchange user fees of \$25.48 PMPM
- This filing assumes a PCORI fee of \$0.32 PMPM
- This filing assumes an HCRP assessment of 0.5% of premium

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The following table summarizes the components of “Taxes & Fees” in the URRT Worksheet 2 Section III.

<b>Taxes &amp; Fees Components</b>		
<b>Component</b>	<b>Percent of Premium</b>	<b>PMPM</b>
Premium Tax	2.0%	\$19.03
PCORI Fee	0.0%	\$0.36
HCRP Fee	0.6%	\$5.71
Exchange User Fee	2.7%	\$25.48
Total Taxes & Fees	5.3%	\$50.58

2027 Projected Average Premium PMPM: \$951.33

PMPM values shown here match the rate development and may differ from the URRT due to rounding.

**4.5: Projected Loss Ratio**

The projected loss ratio for this line of business is 82.1%. The numerator for this ratio is projected incurred claims net of projected risk adjustment transfers, \$781.15 PMPM, and the denominator is projected average premium, \$951.33 PMPM.

The projected federal loss ratio calculated using federally-prescribed methodology for medical loss ratio (MLR) rebates calculations is 86.7%, which is greater than the federally prescribed MLR requirement of 80.0%. Due to the complexity of the federal MLR rebate methodology, which is beyond the scope of this filing, the only adjustment reflected is subtracting projected taxes and fees from the premium denominator. This simplified MLR calculation is strictly less than or equal to the federal MLR methodology, so the federal MLR must also be greater than 80.0%. The denominator of this simplified calculation is equal to projected average premium, less the Total Taxes & Fees PMPM described in the preceding Taxes & Fees section and \$0.18 PMPM for the risk adjustment user fee: \$900.58.

Both the projected loss ratio and the projected federal loss ratios are shown in “Exhibit 1: Development of Rate Change.”

**4.6: Plan Product Information**

**4.6.1: AV Metal Values**

BridgeSpan followed applicable guidance in determining AV Metal Values using the prescribed AV Calculator methodology, including guidance issued by CMS on May 16, 2014, titled “Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards.” This CMS guidance states, “A plan design is incompatible when the use of the AV Calculator yields a materially different AV result from using the other approved methodologies.” A materially different AV result is interpreted as one that changes a plan’s metal tier.

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As required, BridgeSpan used an actuarially justifiable process for inputting plan designs into the AV Calculator. For non-standard cost shares, AV Metal Values were tested using an alternate methodology under 45 CFR 156.135(b), and all plan designs were determined to be compatible with the AV Calculator, as the alternate methodologies did not produce materially different results.

Please note that AV Metal Value determinations follow the AV Calculator methodology prescribed by HHS, and these actuarial values are only to be used to determine a plan's metal tier. They do not reflect the BridgeSpan best estimate of the portion of allowed costs covered by the health plan.

**4.6.2: Membership Projections**

Projected member months by plan for the URRT, Worksheet 2, are estimated based on data through March 2026, assuming minimal changes in the enrollment distribution by plan to ensure non-zero enrollment in each 2027 plan. 2027 product selections are assumed to be similar to 2026 product selections. Although no explicit projection is made for additional 2027 enrollment or disenrollment, BridgeSpan implicitly assumes that there will be enrollment changes that are immaterial to rate development.

Projected member months by CSR subsidy levels for 2027 silver on-exchange plans can be found on "Exhibit F1: Silver Plan Projected Enrollment by Subsidy Level."

**4.6.3: Plan Type**

BridgeSpan does not offer any plans that do not meet the plan type definitions in the URRT, Worksheet 2.

**4.6.4: CSR Funding**

This filing assumes CSR payments will not be funded in 2027. The additional rate load for Silver plans on the exchange included in this filing is 0.5%. The CSR load was determined by calculating the weighted average of the actuarial value (AV) difference between all CSR variations and the base silver (rounded to the nearest 0.5%). An 87% was chosen as a more reasonable estimate of the expected relative cost increase for the 94% CSR plan. Estimated 2027 company's silver enrollment by CSR level was used for the weighting. Development of the rate load is also discussed in Appendix III, Question 5.

#### **4.7 Miscellaneous Instructions**

##### **4.7.1: Effective Rate Review Information and Additional Memorandum Requirements**

This rate filing includes information meeting Oregon’s rate filing requirements:

The following exhibits are included in the rate filing to comply with OAR 836-010-0011(2):

- Filing Description
- Exhibit 1: Development of Rate Change
- Exhibit 2: Covered Benefit or Plan Design Changes
- Exhibit 3: Summary of Rate Increases
- Exhibit 4: Trend Information and Projection
- Exhibit 5: Statement of Administrative Expenses
- Exhibit 6: Plan Relativities
- Actuarial Memorandum Supplemental Exhibits, including:
  - Summary of Filed Rating Assumptions
  - Exhibit B1: Morbidity and Risk Adjustment
  - Exhibit B2: Normalized Claims Trend
  - Exhibit C1: Age Curve and Tobacco Calibration Factors
  - Exhibit C2: Geographic Calibration Factor
  - Exhibit D1: 2027 Average Change in Plan Base Rates
  - Exhibit D2: Terminated Plan Mapping
  - Exhibit D3: Paid to Allowed Ratio and AV Metal Value
  - Exhibit E1: Development of 2027 Index Rate
  - Exhibit E2: Plan Adjusted Index Rate Development
  - Exhibit E3: Plan Adjusted Index Rate to Base Rate Mapping
  - Exhibit E4: Plan Variation from Market Adjusted Index Rate for Renewal Plans
  - Exhibit F1: Silver Plan Projected Enrollment by Subsidy Level
- Consumer Friendly Rate Summary
- Appendix I: Insurers Financial Position
- Appendix II: Cost Containment and Quality Improvement Efforts
- Appendix III: Standard Review Questions
- Rate Tables and Factors
- 2027 Proposed Individual Standard Plan Rates
- 2027 Service Area
- Certificate of Compliance
- Cost and Quality Metrics
- Unified Rate Review Template

**4.7.2: Reliance**

In preparing this filing, other internal experts were relied upon to produce information contained in the following documents:

- Exhibit 5: Statement of Administrative Expenses
- Appendix I: Insurers Financial Position
- Appendix II: Cost Containment and Quality Improvement Efforts
- Appendix III: Standard Review Questions
- 2027 Service Area
- Cost and Quality Metrics

Other than as previously identified, I did not rely on any other information or underlying assumptions provided by another individual in preparing the Part I Unified Rate Review Template.

*Caveats and Limitations*

The index rate and premium projections contained in this filing reflect best estimates of future costs that were developed based on available data, review of the literature, applicable rules and regulations, best thinking regarding the market population, and actuarial judgment. Actual experience and financial results will likely differ from these estimates for many reasons, including material differences in the population that enrolls, demographic mix, new treatments and technologies, economic conditions, catastrophic claims, and random claim fluctuations. Changes in rules and regulations may require revisions to the premium rates included in this filing.

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**4.7.3: Actuarial Certification**

I, Daniel Boeder, am an actuary employed by Cambia Health Solutions, the parent company of BridgeSpan. I am a member of the American Academy of Actuaries (AAA), in good standing, and meet the education and experience standards necessary to complete this actuarial certification.

On behalf of BridgeSpan, I have reviewed this rate filing for a January 1, 2027 effective date for the Individual block of business. I hereby certify that, in my opinion:

- The monthly premium rates are actuarially sound; aggregate expected premium is adequate to cover expected claims costs and the filed rates are reasonable in relation to the benefits offered
- The projected index rate is:
  - In compliance with all applicable State and Federal Statutes and Regulations
  - Developed in compliance with applicable Actuarial Standards of Practice (ASOPs) and professional standards
  - Reasonable in relation to the benefits provided and the population anticipated to be covered
  - Neither excessive nor deficient
- 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
- The factors representing benefits in addition to EHB (essential health benefits) included in the Part I URRT, Worksheet 2, Section III, were calculated in accordance with actuarial standards of practice
- 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
- The AV Calculator was used to determine the AV Metal Values shown in the Part I URRT, Worksheet 2
- This rate filing is consistent with the BridgeSpan internal business plans

Relevant AAA documents reviewed in preparation for this filing include:

- 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. 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*
- Professional Code of Conduct

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Daniel Boeder, FSA, MAAA  
Assistant Director, Actuarial Pricing  
Cambia Health Solutions, on behalf of BridgeSpan Health Company