Filing at a Glance

Company:	MVP Health Plan, Inc.
Product Name:	VT 2015 Exchange Filing Rates
State:	VermontGMCB
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.002C Any Size Group - HMO
Filing Type:	GMCB Rate
Date Submitted:	06/02/2014
SERFF Tr Num:	MVPH-129560321
SERFF Status:	Pending State Action
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2015
Author(s):	Kristen Marsh, Matt Lombardo, Evan Steinhart, Eric Bachner
Reviewer(s):	Thomas Crompton (primary), Kelly Macnee, David Dillon, Judith Henkin, Jacqueline Lee
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 07/02/2014
State Status Changed:
Created By: Matt Lombardo
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact: 14.4%

Deemer Date:
Submitted By: Eric Bachner

PPACA: Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

The proposed rates included within this exchange filing are available to small groups and individuals with effective dates of coverage beginning between January 1, 2015 and December 31, 2015.

Company and Contact

Filing Contact Information

Matt Lombardo,
625 State Street
Schenectady, NY 12305

mlombardo@mvphealthcare.com
518-388-2483 [Phone]

Filing Company Information

MVP Health Plan, Inc.
625 State Street
Schenectady, NY 12305
(518) 388-2469 ext. [Phone]

CoCode: 95521
Group Code: 1198
Group Name:
FEIN Number: 14-1640868

State of Domicile: New York
Company Type: Health Maintenance Organization
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $150.00
Retaliatory? No
Fee Explanation:

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Response	Thomas Crompton	07/02/2014	07/02/2014
Pending Response	Jacqueline Lee	06/25/2014	06/25/2014
Pending Response	Jacqueline Lee	06/10/2014	06/10/2014

Response Letters

Responded By	Created On	Date Submitted
Matt Lombardo	07/02/2014	07/02/2014
Matt Lombardo	06/27/2014	06/27/2014
Matt Lombardo	06/17/2014	06/17/2014

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request for Confidentiality - Response to Objection Letter #2	Note To Reviewer	Matt Lombardo	07/02/2014	07/02/2014
Request for Confidentiality v2	Note To Reviewer	Matt Lombardo	06/20/2014	06/20/2014
Request for Confidentiality	Note To Reviewer	Matt Lombardo	06/17/2014	06/17/2014
Filing submitted	Note To Reviewer	Eric Bachner	06/02/2014	06/02/2014

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	07/02/2014
Submitted Date	07/02/2014
Respond By Date	07/02/2014

Dear Matt Lombardo,

Introduction:

Please send corrected versions with redactions in response to L&E's 06/25/2014 objection letter. Do not mark confidential.

Conclusion:

Sincerely,
Thomas Crompton

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/25/2014
Submitted Date	06/25/2014
Respond By Date	06/27/2014

Dear Matt Lombardo,

Introduction:

Please see attached inquiry letter.

Conclusion:

Sincerely,

Rita Tansen
Consulting Actuary

Sincerely,

Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Wesley R. Campbell, F.C.A.S., F.S.A.
Jacqueline B. Lee, F.S.A.
Brian C. Stentz, A.S.A.
Robert E. Gove, A.S.A.
J. Finn Knox-Seith, A.S.A.
Jennifer M. Allen, A.S.A.
Josh A. Hammerquist, A.S.A.
Xiaoxiao (Lisa) Jiang, A.S.A.
Sujaritha Tansen, A.S.A.
Jay W. Fuller, A.S.A.
Sergei V. Mordovin, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

L&E Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
Leon L. Langlitz, F.S.A.
Anthony G. Proulx, F.S.A.
Thomas L. Handley, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.
Christopher J. Merkel, F.S.A.
Kimberly S. Shores, F.S.A.
Jan E. DeClue, A.S.A.
Patricia A. Peebles, A.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

Baltimore
David A. Palmer, C.F.E.

June 25, 2014

Matt Lombardo
MVP Health Insurance Company
625 State Street
Schenectady, NY 12305

Re: MVP Health Plan, Inc.
2015 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-129560321

Dear Mr. Lombardo:

Thank you for your response on June 17, 2014. The following additional information is required for this filing.

Contract Type

1. Upon review of "Exh 4. Tier Ratios and Conv Fxs" worksheet in "VT 2015 Exchange Rate Filing – SERFF.xlsx", explain the source of the assumed tier distribution (subscriber months and member months) by contract type (Single, Double, etc.) used in conversion factor derivation. If actual 2014 enrollment data was not used, please justify how the other source is more appropriate.

2. For the standard HDHP plans, please describe what adjustments were made to account for the aggregate family deductible.

Rx Trend

3. In the response, it was indicated that the trend forecasts provided by your pharmacy vendor were not adjusted for MVP's Vermont specific book of business. A review of 12-month rolling trends during the experience period (January 1 – December 3, 2013) shows mostly negative trends, as evidenced by "Question #9" worksheet. We note that

"Question #9" worksheet also includes members that did not have Rx coverage in the last 36 months.

a. Please provide a revised exhibit that only includes members with Rx coverage.
b. We recognize that historically MVP has used pharmacy vendor recommended trends in pricing. Please explain at what point MVP will start accounting for Rx trend experience from its book of business while incorporating vendor recommended trends.
c. With historical experience and prospective trends that are not Vermont-specific, please provide further justification for the proposed Rx trend.

4. We note that your Rx vendor has changed since the earlier filing and the assumed Rx rebates as % of Rx claim has reduced from what was evidenced historically. Provide quantitative support for the contract change factor of 0.867 (illustrated in "Question #15 worksheet).

Admin Expense

5. Please explain the "National Network Fee" illustrated in "Question #26". In doing so, please indicate why this fee is new in 2015.

Pediatric Dental

6. Provide quantitative support for the Pediatric Dental PMPM seen in Exhibit 3 of $5.61. How is this figure derived from Exh 3a?

7. Provide quantitative support for the Pediatric Dental PMPMs and Adjustments seen in Exh 3a. This would include a report from Milliman regarding the methodology used to determine the pricing.

8. What were the Pediatric Dental PMPM assumptions by plan from the 2014 Exchange filing?

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible, but no later than June 27, 2014.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Rita Tansen A.S.A., M.A.A.A.
Consulting Actuary
Lewis & Ellis, Inc.
rtansen@lewisellis.com
(972)850-0850

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/10/2014
Submitted Date	06/10/2014
Respond By Date	06/17/2014

Dear Matt Lombardo,

Introduction:

Please see attached inquiry letter.

Conclusion:

Sincerely,
Jacqueline Lee

State:	*VermontGMCB*	**Filing Company:**	*MVP Health Plan, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*VT 2015 Exchange Filing Rates*		
Project Name/Number:	*/*		

Attachment Rate Increase Exhibit.xlsx is not a PDF document and cannot be reproduced here.

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
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D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher H. Davis, F.S.A.
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Jill J. Humes, F.S.A.
Christopher J. Merkel, F.S.A.
Kimberly S. Shores, F.S.A.
Jan E. DeClue, A.S.A.
Patricia A. Peebles, A.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

Baltimore
David A. Palmer, C.F.E.

June 10, 2014

Matt Lombardo
MVP Health Insurance Company
625 State Street
Schenectady, NY 12305

Re: MVP Health Plan, Inc.
2015 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-129560321

Dear Mr. Lombardo:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced filing submitted on 6/2/2014. The following additional information is required for this filing.

Rate Increase

1. Provide a breakdown of the main drivers (similar to the current rate scale in the actuarial dataset) of the 15.4% rate increase stated in the Actuarial Memorandum.

2. Please populate the attached "Rate Increase Exhibit.xlsx" to show derivation of proposed rate increase.

Membership Projections

3. Please update 2014 enrollment in "HHS Age Summary Table and Current Exchange Membership Snapshot.xlsx" to include tier-wise enrollment and provide breakdown of silver CSR plan enrollment (by subsidy level) as well.

4. Provide the April 2014 snapshot by age, and provide quantitative support for the current exchange snapshot age factor of 1.61.

5. Provide the distribution of the projected 2015 membership by age. Describe any differences between the distribution of the 2014 actual membership and 2015 projected membership by plan, age, and tier. If 2014 enrollment was not considered, please provide rationale and support for the 2015 projected membership.

6. What was the methodology used to estimate the portion of projected enrollment eligible for CSR subsidies at each subsidy level?

Medical/Rx Trend

7. We recognize that facility unit cost trends reflect GMCB's approved budget increases as well as contract changes signed between MVP and hospitals. Given that the approved 3Q14-4Q14 MVP Large group HMO plans (SERFF # MVPH-129391759) and 3G14-4Q14 SG PPO plans (MVPH-129389265) used lower 2014 facility trends, please provide quantitative support for the assumed higher inpatient facility trend of 6.0% by illustrating GMCB's approved 2014 hospital budget increases weighted on MVP's utilization by facility. In doing so, please describe what has transpired between these two filings in causing an increase in inpatient trend, as illustrated below:

	2014 Annual Trend (MVPH-129389265)	2014 Annual Trend (Current)
Inpatient	5.4%	6.0%
Outpatient & Other Medical	5.4%	5.4%
Physician	16.6%	15.3%
Total Medical Trend	8.9%	8.6%

8. We have reviewed the aggregate medical and Rx claim experience illustrated in the actuarial dataset. In an excel format, please provide medical only monthly claim experience for this 36 month period showing rolling 12 month trends.

9. In an excel format, please provide historical incurred Rx claims, membership for the base experience period used in rate development and for at least two preceding 12-month periods showing rolling 12 month trends.

10. We recognize that annual Rx trend factors split by generic, brand and specialty drugs, as illustrated in "Exh 2a. Trend Projection" are best estimates of utilization trends and cost trend from your pharmacy vendor. We note that the overall annual Rx trend factor of 9.0% assumed in this filing is a material increase from the 7.5% for non-HDHP and 7.8% for HDHP products in earlier approved 3Q14/4Q14 small group filings.
    i. Please describe all considerations (such as Vermont specific cost and utilization trend) that were made in supplement to vendor-recommended trends in setting the Rx pricing trends. If no other considerations were made, provide rationale for why it is appropriate.

ii. How were the drug patent expirations in 2014 considered in setting the trends for brand and specialty drugs?

iii. If analysis was done using MVP specific Rx trends by drug category, please detail what the unit cost/utilization trends by drug category would be. Please share results of regression analysis, if any, performed on historical Rx claims experience. If no analysis was performed, please explain why.

URRT and Rate Development

11. We note that calendar year 2013 data for small group EPO/PPO/HMO plans, small group HDHPs, and individual indemnity products (with an aggregate $76 million in earned premium) was used in rate development for this filing. Please provide a breakdown of incurred claims, earned premium, and membership by product and market.

12. How were the differences in contracts and reimbursement schedules (PPO vs. HMO plans etc.) accounted for in adjusting the experience period claims for projection to the rating period? Please show all network adjustment factors applied.

13. We note that base experience period used in development of 2014 Exchange rates included claims experience from Catamount and AgriServices populations as well. Were these groups included in the experience period used in 2015 rate development? If not, please explain why. Explain any other differences in markets/groups used in 2014 exchange rate development versus 2015 exchange rate development.

14. Show numeric development of "Paid to Allowed Average Factor in Projection Period" used in WS 1.

15. The Rx rebate as % of Rx claim expense, as illustrated in "Exh 3. Index Rate Dev" is 12%. The memorandum states that adjustments were made to reflect any contract changes occurring between the experience period and projection period. Please provide the actual historical rebate as % of Rx claim experience for the merged market at least for the preceding two years and the adjustment factors applied to actual experience.

16. Please provide quantitative support (including historical claim distribution) for the derivation of transitional reinsurance recovery adjustment of 7.6% illustrated in "Exh 3. Index Rate Dev".
    a. Also, show how this figure relates to the $12.84 seen on WS 1 of the URRT.
    b. In the reinsurance calculations, what groups were included in the claims experience (small group and/or individual markets)? If small groups were included, please explain why.

17. Provide quantitative support for the development of 10.4% pooling charge in the rate development.

18. Provide quantitative support for the Capitations and Non-FRDM Claim Expenses of $6.78 used in rate development.

Metal AV/Pricing AV

19. For the non-standard silver plan (FRVT-HMO-S-001-N), provide quantitative support showing the derivation of the Outpatient Surgery copay to coinsurance equivalent used in the AV Calculator.

20. For the non-standard silver plan (FRVT-HMO-S-001-N), the "Summary of Plans Offered" shows a Medical OOP Max of $5,350, while the AV Calculator Screen Shot shows a Medical OOP Max of $5,300. Please explain this discrepancy.

21. For the non-standard bronze plan (FRVT-HMO-B-001-N), the "Summary of Plans Offered" shows an Rx Generic Copay of $20, while the AV Calculator Screen Shot shows an Rx Generic Copay of $16. Provide a quantitative derivation of the copay used in the AV Calculator.

22. For the non-standard bronze plan (FRVT-HMO-B-001-N), the "Summary of Plans Offered" shows an Rx OOP Max of $1,300, while the AV Calculator Screen Shot shows an integrated OOP Max of $6,600. Please explain the discrepancy.

23. We note that pricing AV for each plan was determined using MVP's in-house benefit pricing tools. Describe in detail how this methodology ensures that induced utilization is not in-built into the pricing model.

24. Do the "Pricing Actuarial Values" illustrated in "Exh 6. 2015 Premium Rates" account only for cost sharing differences? Were other considerations made for induced utilization, network differences, plan benefits in addition to EHBs, etc that are accounted for in the Pricing AV?

    a. Please explain why the AV Pricing Values in WS 2 of the URRT do not include these other adjustments. Note that the URRT instructions state that the impact of induced utilization is included in the development of pricing AV.
    b. Demonstrate how the induced utilization slope adopted by MVP reconciles with the recommendations in HHS Notice of Benefit and Payment.

Profit Margin/Contribution to Surplus

25. The actuarial dataset shows a profit margin of -7.11% during the experience period. Do you anticipate 2014 approved Exchange rates to produce negative profit margin similar to what is seen in the actuarial dataset for the experience period?

Admin Expenses

26. Please update Exhibit 5 showing a comparison of retention components between the current filing and approved 2014 Exchange filing.

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible, but no later than June 17, 2014.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Rita Tansen A.S.A., M.A.A.A.
Consulting Actuary
Lewis & Ellis, Inc.
rtansen@lewisellis.com
(972)850-0850

State: VermontGMCB **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: VT 2015 Exchange Filing Rates
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/02/2014
Submitted Date	07/02/2014

Dear Thomas Crompton,

Introduction:

Response 1

Comments:

Please see the attached documents which contain a redacted version of MVP's Pediatric Dental Memorandum received from consultants.

Regards,
Matt Lombardo

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Objection Letter #2 - REDACTED VERSION
Comments:	
Attachment(s):	MVP Vermont Ped Dental 20130627 REDACTED.pdf Response to Objection #2 - Quantitative Responses SERFF.pdf Response to Objection #2.pdf Response to Objection #2 - Quantitative Responses SERFF.xlsx

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Matt Lombardo

State: VermontGMCB **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: VT 2015 Exchange Filing Rates
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/17/2014
Submitted Date	06/17/2014

Dear Thomas Crompton,

Introduction:

Response 1

Comments:

Please see the attached supporting documentation items below.

Regards,
Matt Lombardo

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Objection Letter #1
Comments:	Please see the attachments below which contain MVP's response to L&E's Objection Letter dated June 10, 2014. Regards, Matt Lombardo
Attachment(s):	Response to Objection #1 - Quantitative Responses SERFF.pdf Response to Objection #1 - Quantitative Responses SERFF.xlsx Response to Objection #1 - SERFF.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Matt Lombardo

State:	*VermontGMCB*	**Filing Company:**	*MVP Health Plan, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*VT 2015 Exchange Filing Rates*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Matt Lombardo on 07/02/2014 11:16 AM

Last Edited By:

Matt Lombardo

Submitted On:

07/02/2014 02:12 PM

Subject:

Request for Confidentiality - Response to Objection Letter #2

Comments:

On June 30, 2014 MVP filed its responses to the Lewis Ellis Second Objection letter in SERFF. We inadvertently failed to identify confidential information and request that it be designated confidential. The information in question is contained in an exhibit to that filing, a June 27, 2013 Milliman Memo on Pediatric Dental Pricing. We make this request for confidentiality pursuant to 1 V.S.A. § 317 (c)(9), and ask that the designated language remain confidential and not subject to disclosure under Vermont's public records law. The disclosure of this information, which is partly based upon and/or derived from MVP's contractual agreements with providers and facilities would put our organization at a competitive disadvantage. The public disclosure of this information will undermine MVP's private negotiations, advantage our competitors, and potentially result in increased premiums for Vermonters.

The following portions of Milliman's June 27, 2013 Memo on Pediatric Dental Pricing have been redacted in the attached file:

REDACTIONS
Page 1Contents of Table after heading through end of page 1
Page 2Remaining Contents of Table after heading through end of page 2
Page 3Entire page
Page 4Entire page up to Howard Kahn signature block

Regards,
Matt Lombardo

Milliman

MEMO

One Pennsylvania Plaza,
38th Floor
New York, NY 10119
Tel +1 646 473.3000
Fax +1 646 473.3199
www.milliman.com

June 27, 2013

To Kathleen Fish, Matt Lombardo (MVP)
From Howard Kahn (Milliman)
Subject Vermont Pediatric Dental Pricing

As requested, we have estimated the incremental cost of adding pediatric dental in the individual and small group plans MVP Health Care (MVP) intends to offer in Vermont during 2014.

Results

Below are our estimates for the incremental 2014 allowed and paid Per Member Per Month (PMPM) costs for embedding pediatric dental into each plan MVP will be offering in Vermont.

MVP Health Plan - Vermont Pediatric Dental Costs - Individual			
Plan Description	Form Number	Estimated 2014 Allowed Cost PMPM	Estimated 2014 Net Claims Cost PMPM
[redacted]			

Milliman

MVP Health Plan - Vermont
Pediatric Dental Costs – Small Group

Plan Description	Form Number	Estimated 2014 Allowed Cost PMPM	Estimated 2014 Net Claims Cost PMPM
[redacted]			

[redacted]

Milliman

[redacted]

Milliman

[redacted]

Howard Kahn, FSA, MAAA
Consulting Actuary
June 27, 2013

State:	*VermontGMCB*	**Filing Company:**	*MVP Health Plan, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*VT 2015 Exchange Filing Rates*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Matt Lombardo on 06/20/2014 07:56 AM

Last Edited By:

Matt Lombardo

Submitted On:

07/02/2014 10:57 AM

Subject:

Request for Confidentiality v2

Comments:

To Whom It May Concern:

Pursuant to 1 V.S.A. § 317 (c)(9), MVP requests that the designated portions of our Objection Letter response, dated June 17, 2014, remain confidential and not subject to disclosure under Vermont’s public records law. The disclosure of this information, which is partly based upon and/or derived from MVP's contractual agreements with providers and facilities would put our organization at a competitive disadvantage. In part, the information reflects reimbursement rates that were the subject of MVP’s negotiation with an entity that also negotiates with MVP competitors. The public disclosure of this information will undermine MVP’s private negotiations, advantage our competitors, and potentially result in increased premiums for Vermonters.

Sincerely,
Matt Lombardo

State:	*VermontGMCB*	**Filing Company:**	*MVP Health Plan, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*VT 2015 Exchange Filing Rates*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Matt Lombardo on 06/17/2014 04:07 PM

Last Edited By:

Matt Lombardo

Submitted On:

07/02/2014 10:57 AM

Subject:

Request for Confidentiality

Comments:

Pursuant to 1 V.S.A. § 317 (c)(9), MVP requests that the designated portions of our Objection Letter response, dated June 17, 2014, remain confidential and not subject to disclosure under Vermont’s public records law. The disclosure of this information, which is partly based upon and/or derived from MVP's contractual agreements with providers and facilities would put our organization at a competitive disadvantage.

Sincerely,
Matt Lombardo

State:	*VermontGMCB*	**Filing Company:**	*MVP Health Plan, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*VT 2015 Exchange Filing Rates*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Eric Bachner on 06/02/2014 03:58 PM

Last Edited By:

Matt Lombardo

Submitted On:

07/02/2014 10:57 AM

Subject:

Filing submitted

Comments:

Tom,

We believe that we have attached all necessary documents for the rate filing and submitting it now. If you have any questions, please refer to the email addresses provided to you by Matt Lombardo.

Thanks,
Eric Bachner

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision: 01/01/2014
Filing Method of Last Filing: SERFF

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
MVP Health Plan, Inc.	Increase	14.400%	14.400%	$2,942,940	2,371	$20,404,146	10.700%	18.300%

Rate Review Detail

COMPANY:

Company Name: MVP Health Plan, Inc.
HHS Issuer Id: 77566

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Vermont HMO Contract Grp	77566VT005	77566VT005	1857
Vermont HMO Contract Ind	77566VT004	77566VT004	2941

Trend Factors:

FORMS:

New Policy Forms:
Affected Forms:
Other Affected Forms: VT Exchange COC

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 57,576
Benefit Change: Increase
Percent Change Requested: Min: 10.7 Max: 18.3 Avg: 15.4

PRIOR RATE:

Total Earned Premium: 20,404,146.00
Total Incurred Claims: 18,423,370.00
Annual $: Min: 168.92 Max: 513.21 Avg: 354.86

REQUESTED RATE:

Projected Earned Premium: 23,347,087.00
Projected Incurred Claims: 19,995,518.00
Annual $: Min: 186.40 Max: 577.30 Avg: 405.50

State: VermontGMCB **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: VT 2015 Exchange Filing Rates
Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Federal AVC Screenshots for All Plans.pdf MVP Vermont Essential Health Benefits.pdf VT 2015 Exchange Rate Filing - SERFF.pdf VT 2015 Exchange Rate Filing - SERFF.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	Please see attached files.
Attachment(s):	VT 2015 Exchange Actuarial Memorandum.pdf VT 2015 Federal Actuarial Memorandum.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Civil Union Rating Requirements
Comments:	MVP's benefits being offered comply with the Civil Union rating requirements outlined in 8 V.S.A. § 4724.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Consumer Disclosure Form
Comments:	
Attachment(s):	Consumer Disclosure Form about Rate Increases - VT Exchange 2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Filing Compliance Certification
Comments:	
Attachment(s):	Certification of Compliance - VT.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Filing Authorization
Bypass Reason:	N/A

State: VermontGMCB **Filing Company:** MVP Health Plan, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: VT 2015 Exchange Filing Rates
Project Name/Number: /

Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	URRT VT 2015 - SERFF.xlsm UnifiedRateReviewSubmission_VT_Exchange_2015_20140529164040.xml URRT VT 2015 - SERFF.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum Dataset
Comments:	
Attachment(s):	Actuarial Memo Dataset SERFF.xlsx Actuarial Memo Dataset SERFF.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Plan Management Rates Template
Comments:	
Attachment(s):	Rate Data Template_VT_SMAL_ON_20140528.xlsm Rate Data Template_VT_SMAL_ON_20140528.pdf Rate Data Template_VT_SMAL_ON_20140528.xml
Item Status:	
Status Date:	

Satisfied - Item:	Response to Objection Letter #1
Comments:	Please see the attachments below which contain MVP's response to L&E's Objection Letter dated June 10, 2014. Regards, Matt Lombardo
Attachment(s):	Response to Objection #1 - Quantitative Responses SERFF.pdf Response to Objection #1 - Quantitative Responses SERFF.xlsx Response to Objection #1 - SERFF.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response to Objection Letter #2 - REDACTED VERSION
Comments:	

State: *VermontGMCB* **Filing Company:** *MVP Health Plan, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *VT 2015 Exchange Filing Rates*
Project Name/Number: */*

Attachment(s):	MVP Vermont Ped Dental 20130627 REDACTED.pdf Response to Objection #2 - Quantitative Responses SERFF.pdf Response to Objection #2.pdf Response to Objection #2 - Quantitative Responses SERFF.xlsx
Item Status:	
Status Date:	

Attachment VT 2015 Exchange Rate Filing - SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment URRT VT 2015 - SERFF.xlsm is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission_VT_Exchange_2015_20140529164040.xml is not a PDF document and cannot be reproduced here.

Attachment Actuarial Memo Dataset SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment Rate Data Template_VT_SMAL_ON_20140528.xlsm is not a PDF document and cannot be reproduced here.

Attachment Rate Data Template_VT_SMAL_ON_20140528.xml is not a PDF document and cannot be reproduced here.

Attachment Response to Objection #1 - Quantitative Responses SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment Response to Objection #2 - Quantitative Responses SERFF.xlsx is not a PDF document and cannot be reproduced here.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,000.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
OOP Maximum ($)	$6,600.00					
OOP Maximum if Separate ($)			$0.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑		
Specialist Visit	☑	☐		$100.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☐		$90.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	Generic	$20.00
Specialty Rx Coinsurance Maximum:		VBID	$3.00
Set a Maximum Number of Days for Charging an IP Copay?	☐		
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	
# Visits (1-10):		Surgery	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	59.9%	**Bronze Non-Standard**
Metal Tier:	Bronze	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,400.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$6,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐			☑	☑		
Specialist Visit	☑	☐			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐			☑	☑		
Rehabilitative Speech Therapy	☑	☐			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐			☑	☑		
X-rays and Diagnostic Imaging	☑	☐			☑	☑		
Skilled Nursing Facility	☑	☐			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐			☑	☑		
Preferred Brand Drugs	☑	☐			☑	☑		
Non-Preferred Brand Drugs	☑	☐			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	60.4%	
Metal Tier:	Bronze	**Catastrophic**

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,800.00	$250.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$5,300.00	$1,300.00	$6,600.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$650.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$100.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	37.98%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	54.04%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐		
Specialty Rx Coinsurance Maximum:		Generic	$12.00
Set a Maximum Number of Days for Charging an IP Copay?	☐	VBID	$3.00
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	$1,400.00
# Visits (1-10):		Surgery	$600.00
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	68.14%	**Silver Non-Standard**
Metal Tier:	Silver	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$700.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	50.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$4,000.00	$1,200.00	$5,200.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$10.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$400.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$100.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	64.56%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	69.36%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐		
Specialty Rx Coinsurance Maximum:		Generic	$12.00
Set a Maximum Number of Days for Charging an IP Copay?	☐	VBID	$3.00
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	$800.00
# Visits (1-10):		Surgery	$400.00
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.	
Actuarial Value:	73.9%	
Metal Tier:	Silver	**Silver 73 Non-Standard**

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$300.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	60.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$4,000.00	$1,200.00	$5,200.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$200.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$100.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	82.28%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	84.68%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐		
Specialty Rx Coinsurance Maximum:		Generic	$12.00
Set a Maximum Number of Days for Charging an IP Copay?	☐	VBID	$3.00
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	$400.00
# Visits (1-10):		Surgery	$200.00
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	77.97%
Metal Tier:	**Silver 77 Non-Standard**

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$60.00	$50.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	60.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$1,800.00	$450.00	$2,250.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☑	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$30.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	95.77%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	94.60%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$8.00	☑	☑		
Preferred Brand Drugs	☑	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐		
Specialty Rx Coinsurance Maximum:		Generic	$10.00
Set a Maximum Number of Days for Charging an IP Copay?	☐	VBID	$3.00
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	$100.00
# Visits (1-10):		Surgery	$75.00
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.94%
Metal Tier:	Gold

Silver 87 Non-Standard

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	95.00%	95.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$1,800.00	$450.00	$2,250.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$50.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$10.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$50.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$10.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$10.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$10.00	☑	☑		
Skilled Nursing Facility	☐	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	96.96%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	97.76%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☑	☑		
Preferred Brand Drugs	☐	☐		$10.00	☑	☑		
Non-Preferred Brand Drugs	☐	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐		
Specialty Rx Coinsurance Maximum:		Generic	$5.00
Set a Maximum Number of Days for Charging an IP Copay?	☐	VBID	$1.00
# Days (1-10):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	facility	$50.00
# Visits (1-10):		Surgery	$25.00
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐		
# Copays (1-10):			

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.	
Actuarial Value:	94.9%	
Metal Tier:	Platinum	**Silver 94 Non-Standard**

APPENDIX B

Standard Plan Designs

	Deductible Plans				HDHPs	
Deductible/OOP Max	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
Type of Plan	Deductible	Deductible	Deductible	Deductible	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$100	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	$1,250	$1,250
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,250	$1,250
Integrated OOPM	No	No	No	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb	Preventive	Preventive	Preventive
Drug Deductible waived for:	N/A	Generic scripts	Generic scripts	Applies to all scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	10%	20%	40%	50%	20%	50%
Outpatient [2]	10%	20%	40%	50%	20%	50%
ER [3]	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$20	$35	10%	50%
MH/SA Office Visit	$10	$15	$20	$35	10%	50%
Specialist Office Visit [4]	$20	$25	$40	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%
Actuarial Value						
Federal AVC, Adjusted if Necessary	88.0%	79.5%	71.2%	61.5%	69.2%	60.6%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Plan Designs – Cost Sharing Reduction Plans (Deductibles)

	Cost Sharing Reduction Plan Designs - Deductible Plans				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	Deductible	Deductible	Deductible	Deductible	Deductible
Medical Ded	$1,900	$1,900	$1,500	$600	$100
Rx Ded	$100	$100	$100	$100	$0
Integrated Ded	No	No	No	No	No
Medical OOPM	$5,100	$4,000	$3,000	$1,250	$500
Rx OOPM	$1,250	$1,200	$1,000	$400	$200
Integrated OOPM	No	No	No	No	No
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb
Drug Deductible waived for:	Generic scripts	Generic scripts	Generic scripts	Generic scripts	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	40%	40%	40%	40%	10%
Outpatient [2]	40%	40%	40%	40%	10%
ER [3]	$250	$250	$250	$250	$75
Radiology (MRI, CT, PET)	40%	40%	40%	40%	10%
Preventive	$0	$0	$0	$0	$0
PCP Office Visit	$20	$20	$20	$10	$5
MH/SA Office Visit	$20	$20	$20	$10	$5
Specialist Office Visit [4]	$40	$40	$40	$30	$15
Urgent Care	$60	$60	$60	$50	$35
Ambulance	$100	$100	$100	$100	$50
Rx Generic	$12	$12	$12	$10	$5
Rx Preferred Brand	$50	$50	$50	$50	$20
Rx Non-Preferred Brand	50%	50%	50%	50%	30%
Actuarial Value					
Federal AVC, Adjusted if Necessary	71.2%	73.3%	76.2%	86.0%	93.4%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Plan Designs – Cost Sharing Reduction Plans (HDHPs)

	Cost Sharing Reduction Plan Designs - HDHPs				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,550	$1,400	$1,250	$1,000	$450
Rx Ded	$1,250	$1,250	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$5,750	$3,400	$2,500	$1,000	$450
Rx OOPM	$1,250	$1,250	$1,250	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**				
Inpatient [1]	20%	20%	20%	0%	0%
Outpatient [2]	20%	20%	20%	0%	0%
ER [3]	20%	20%	20%	0%	0%
Radiology (MRI, CT, PET)	20%	20%	20%	0%	0%
Preventive	0%	0%	0%	0%	0%
PCP Office Visit	10%	10%	10%	0%	0%
MH/SA Office Visit	10%	10%	10%	0%	0%
Specialist Office Visit [4]	20%	20%	20%	0%	0%
Urgent Care	20%	20%	20%	0%	0%
Ambulance	20%	20%	20%	0%	0%
Rx Generic	$10	$10	$5	$0	$0
Rx Preferred Brand	$40	$40	$30	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	0%	0%
Actuarial Value					
Federal AVC, Adjusted if Necessary	69.2%	73.3%	76.8%	87.2%	93.8%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$400.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
OOP Maximum ($)						
OOP Maximum if Separate ($)	$5,300.00	$1,300.00	$6,600.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$5.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$400.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	84.48%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	86.44%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Generic	$5.00
VBID	$1.00
facility	$400.00
Surgery	$200.00

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.02%
Metal Tier:	Gold

Gold Non-Standard

Appendix D

Screen shots and AV Development

1. Silver HDHP
2. Bronze HDHP
3. Bronze Deductible Plan
4. Silver HDHP CSR – 73%
5. Silver HDHP CSR – 77%
6. Silver HDHP CSR – 87%
7. Silver HDHP CSR – 94%

1. Silver HDHP

AV from AVC = 70.8%
Adjusted AV = 69.2%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$10.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$40.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.84%
Metal Tier:	Silver

1. Silver HDHP, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	5,750	5,750
Family Out-of-Pocket	11,500	11,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$210.01	$52.50	$262.51
Plan PMPM	$155.85	$30.09	$185.94
Actuarial Value	74.2%	57.3%	70.8%

1. **Silver HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	5,750	1,250
Family Out-of-Pocket	11,500	2,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$210.01	$52.50	$262.51
Plan PMPM	$147.42	$34.27	$181.69
Actuarial Value	70.2%	65.3%	69.2%

2. Bronze HDHP

AV from AVC = 63.3%
Adjusted AV = 60.6%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$12.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	40%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 63.32%
Metal Tier:

2. Bronze HDHP, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	2,000
Family Deductible	4,000	4,000
Individual Out-of-Pocket	6,250	6,250
Family Out-of-Pocket	12,500	12,500
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$233.41	$58.35	$291.76
Plan PMPM	$153.54	$31.16	$184.70
Actuarial Value	65.8%	53.4%	63.3%

2. **Bronze HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	1,250
Family Deductible	4,000	2,500
Individual Out-of-Pocket	6,250	1,250
Family Out-of-Pocket	12,500	2,500
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$233.41	$58.35	$291.76
Plan PMPM	$138.77	$38.17	$176.95
Actuarial Value	59.5%	65.4%	60.6%

3. Bronze Deductible

AV from AVC = 60.0%
Adjustments = Wakely pricing model at $300 Deductible / Wakely pricing model at $200 Deductible x HDHP Model with drug adjustments / HDHP Model without drug adjustments = 59.5%/60.0% x 61.5%/59.5% = 1.025
Adjusted AV = 60.0% x 1.025 = 61.5%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options		Narrow Network Options
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:		1st Tier Utilization:
		2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$35.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$80.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☐		$80.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$80.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$20.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$80.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.01%
Metal Tier:	Bronze

3. Bronze Deductible, Continued

HDHP Model – Without Prescription Drug Adjustments:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	3,500	300
Family Deductible	7,000	600
Individual Out-of-Pocket	6,350	6,350
Family Out-of-Pocket	12,700	12,700
Coinsurance (50% or Less)	48%	57%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$223.99	$56.00	$279.98
Plan PMPM	$135.07	$31.41	$166.48
Actuarial Value	60.3%	56.1%	59.46%

3. **Bronze Deductible, Continued**

HDHP Model – With Prescription Drug Adjustments:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	3,500	300
Family Deductible	7,000	600
Individual Out-of-Pocket	6,350	1,250
Family Out-of-Pocket	12,700	2,500
Coinsurance (50% or Less)	48%	57%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$223.99	$56.00	$279.98
Plan PMPM	$132.72	$39.56	$172.29
Actuarial Value	59.3%	70.7%	61.53%

4. Silver HDHP CSR – 73%

AV from AVC = 74.9%
Adjusted AV = 73.3%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,400.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$3,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$10.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$40.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	74.93%
Metal Tier:	

4. Silver HDHP CSR – 73%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,400
Family Deductible	2,800	2,800
Individual Out-of-Pocket	3,400	3,400
Family Out-of-Pocket	6,800	6,800
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$227.17	$56.79	$283.96
Plan PMPM	$177.14	$35.65	$212.79
Actuarial Value	78.0%	62.8%	74.9%

4. **Silver HDHP CSR – 73%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,250
Family Deductible	2,800	2,500
Individual Out-of-Pocket	3,400	1,250
Family Out-of-Pocket	6,800	2,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$227.17	$56.79	$283.96
Plan PMPM	$169.81	$38.43	$208.25
Actuarial Value	74.8%	67.7%	73.3%

5. Silver HDHP CSR – 77%

AV from AVC = 78.7%
Adjusted AV = 76.8%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$2,500.00
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$30.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? ☐
Specialty Rx Coinsurance Maximum:
Set a Maximum Number of Days for Charging an IP Copay? ☐
Days (1-10):
Begin Primary Care Cost-Sharing After a Set Number of Visits? ☐
Visits (1-10):
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? ☐
Copays (1-10):

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.68%
Metal Tier: Gold

5. Silver HDHP CSR – 77%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	2,500	2,500
Family Out-of-Pocket	5,000	5,000
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$239.17	$59.79	$298.96
Plan PMPM	$193.63	$41.51	$235.14
Actuarial Value	81.0%	69.4%	78.7%

5. **Silver HDHP CSR – 77%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	2,500	1,250
Family Out-of-Pocket	5,000	2,500
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$239.17	$59.79	$298.96
Plan PMPM	$187.58	$42.10	$229.68
Actuarial Value	78.4%	70.4%	76.8%

6. Silver HDHP CSR – 87%

AV from AVC = 87.7%
Adjusted AV = 87.2%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.65%
Metal Tier:	Gold

6. Silver HDHP CSR – 87%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,000	1,000
Family Deductible	2,000	2,000
Individual Out-of-Pocket	1,000	1,000
Family Out-of-Pocket	2,000	2,000
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$255.61	$63.90	$319.51
Plan PMPM	$227.10	$53.02	$280.12
Actuarial Value	88.8%	83.0%	87.7%

6. **Silver HDHP CSR – 87%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,000	1,000
Family Deductible	2,000	2,000
Individual Out-of-Pocket	1,000	1,000
Family Out-of-Pocket	2,000	2,000
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$255.61	$63.90	$319.51
Plan PMPM	$225.73	$52.80	$278.52
Actuarial Value	88.3%	82.6%	87.2%

7. Silver HDHP CSR – 94%

AV from AVC = 93.9%
Adjusted AV = 93.8%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☑
Desired Metal Tier: Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$450.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$450.00
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑				
Drugs	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.88%
Metal Tier:	Platinum

7. Silver HDHP CSR – 94%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	450	450
Family Deductible	900	900
Individual Out-of-Pocket	450	450
Family Out-of-Pocket	900	900
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$264.01	$66.00	$330.01
Plan PMPM	$249.44	$60.28	$309.73
Actuarial Value	94.5%	91.3%	93.9%

7. **Silver HDHP CSR – 94%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	450	450
Family Deductible	900	900
Individual Out-of-Pocket	450	450
Family Out-of-Pocket	900	900
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$264.01	$66.00	$330.01
Plan PMPM	$249.35	$60.26	$309.61
Actuarial Value	94.4%	91.3%	93.8%

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March 18, 2013

To Kathleen Fish, Matt Lombardo (MVP)
From Howard Kahn (Milliman)
Subject Vermont EHB Pricing

As requested, we have estimated the cost of the following benefits included by Vermont in its Essential Health Benefits (EHB) package:

- Private duty nursing
- Sterilization Reversal
- Couples therapy
- Wigs
- Pediatric vision

MVP Health Care's (MVP) does not currently offer these benefits in Vermont.

In addition, we have:

- Estimated the annual visit limit equivalent to an annual $2,000 limit for private duty nursing.
- Estimated the impact of removing contractual limits on days in a skilled nursing facility (SNF) and home health care visits.

Results

Our estimates for the incremental 2014 allowed Per Member Per Month (PMPM) cost, assuming a standard population, for each of the additional benefits are:

Benefit	Estimated 2014 Allowed PMPM
Private Duty Nursing	$0.31
Sterilization Reversal	$0.00
Couples Therapy	$0.60
Wigs	$0.02
Pediatric Vision	$1.46

In addition, we estimate:

- A 4 visit annual limit is equivalent to a $2,000 annual limit for private duty nursing in 2014.
- Increasing SNF day limits of 30, 45, 60, and 120 to unlimited results in an insignificant increase to the paid PMPM.
- Increasing home health visit limits of 40, 60, and 200 to unlimited results in an insignificant increase to the paid PMPM.

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Methodology

Private Duty Nursing

Using the 2010 Truven Health Analytics MarketScan Commercial database (MarketScan)[1] for the Northeast region we identified all claims for the following codes provided by MVP with a place of service equal to 12:

- HCPCS
  - S9123
  - S9124
  - T1000
  - T1002
  - T1003
  - T1030
  - T1031

We trended the resulting per member amount by the secular trend for professional service of 6% per year recommended by Milliman's Health Cost Guidelines (HCGs)[2] for 4 years.

Sterilization Reversal

Using the 2010 MarketScan Commercial database we identified all claims for the following codes provided by MVP:

- HCPCS
  - 55400
  - 58750
  - 58752
  - 58760
  - 58770
- ICD-9 Diagnosis Codes (primary position)
  - V26.0
  - V26.22

[1] This database contains all paid claims generated by approximately 35 million commercially insured lives. The MarketScan database represents the inpatient and outpatient healthcare service use of individuals nationwide who are covered by the benefit plans of large employers, health plans, government, and public organizations. The MarketScan database links paid claims and encounter data to detailed patient information across sites and types of providers, and over time. The annual medical database includes private sector health data from approximately 100 payers.

[2] The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually. The HCGs provide a flexible but consistent basis for the determination of health claim costs and premium rates for a wide variety of health plans. The HCGs are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources.

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- ICD-9 Procedure Codes
  - 63.82
  - 66.79

The total number of services for these codes in nationwide 2010 MarketScan was insignificant with a resulting allowed PMPM of almost $0.00. Therefore, we estimate that the addition of this benefit will not materially increase claims costs.

Couples Therapy

Using the 2010 MarketScan Commercial database we identified all claims for the following codes:

- HCPCS
  - 90847
  - 99510
- ICD-9 Diagnosis Code (primary position)
  - V61.10

We refined the list of codes provided by MVP to include only codes which we believe represent couple therapy services.

We trended the resulting per member amount by the secular trend for professional service of 6% per year recommended by Milliman's HCGs for 4 years and applied the psychiatric area factor of 1.04 recommended by Milliman's HCGs for Vermont.

Wigs

Vermont is including wigs in its EHB when hair loss is due to disease or chemotherapy. Since wigs are not a commonly offered benefit, we are unable to derive credible utilization rates from the MarketScan database. Instead, we refer to other published literature to estimate the incremental cost for wigs due to chemotherapy, assuming no additional cost for other diseases:

2014 Allowed Wig PMPM Development		**Source**
Cancer Incidence (Under 65)	0.22%	http://seer.cancer.gov/statfacts/html/all.html
Probability of Losing Hair Under Chemo	65%	http://www.derma-haarcenter.ch/files/Directory/Publikationen/Chemotherapy.pdf
Percent Female	48%	http://seer.cancer.gov/statfacts/html/all.html
2014 Unit Cost for Wigs	$379.31	2010 Nationwide MarketScan (HCPCS A9282, trended annually at 6%)
2014 PMPY	$0.26	
2014 PMPM	**$0.02**	

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Pediatric Vision

Vermont is including pediatric vision (to age 21) in its EHB:

- 1 vision exam per year
- $150 per year for vision hardware

We priced out the additional allowed PMPM cost for these benefits by calibrating our 2013 HCGs to Vermont and assuming 120% of Medicare reimbursement.

Annual visit limit for private duty nursing

To convert an annual dollar limit to an annual visit limit for private duty nursing services, we develop a claims probability distribution from 2010 MarketScan for Northeast states. We used the codes described above to identify private duty nursing procedures.

The probability distribution table shown in Exhibit 1 represents 2010 claims trended by the secular trend for professional service of 6% per year recommended by Milliman's HCGs for 4 years. The table estimates the probability that the allowed cost for a private duty nursing visit will fall within certain ranges.

Based on a simulation of 10,000 trials, we estimated that 4.20 visits on average will exceed $2,000.

Benefit Relativities for increased contractual limits on skilled nursing facility (SNF) and home care

MVP currently offers plans in Vermont that have:

- SNF day limits of 30, 45, 60 and 120
- Home health care visit limits of 40, 60 and 200

Using the 2013 SNF length of stay tables found in the HCGs, adjusted for Milliman's standard plan design (80/20 coinsurance with a $500 deductible) and Vermont's utilization and unit cost, we estimate an insignificant increase in total estimated paid PMPM amounts if the limit for day in SNF is removed.

Since the HCGs do not have home health care visit distributions, we developed a probability distribution for members utilizing home health care from 2010 MarketScan for Northeast states. Based on these results, we estimate an insignificant increase in total estimated paid PMPM amounts if the limit for home health care visits is removed.

Data Reliance

We relied on the following files provided by MVP:

- VermontNewBenefits.pdf
- Codes for VT Exchange Benefits.xlsx

Additional Notes and Caveats

Our models are based on the assumptions listed above and the data you have provided to us. If you believe any of our assumptions are incorrect, please let us know and we will amend our models accordingly. Actual experience will vary from expected.

This memo has been produced for the sole benefit of MVP and is not for distribution outside MVP.

Howard Kahn is employed by Milliman, Inc. and is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion in this report.

cc: Rob Parke (Milliman)

Exhibit 1
MVP Health Care
Private Duty Nursing Simulation
Converting $2,000 Annual Dollar Limit to Visit Limit

Private Duty Nursing Probability Distribution*

Lower Bound	Upper Bound	2014 Average Allowed Unit Cost per Visit	Visits	Probability
$0	$25	$16.64	30	0.1%
$26	$50	$39.34	139	0.4%
$51	$76	$68.21	696	2.2%
$77	$101	$91.10	823	2.6%
$102	$126	$115.51	3,362	10.6%
$127	$158	$142.00	2,809	8.9%
$159	$189	$176.64	737	2.3%
$190	$221	$208.01	772	2.4%
$222	$252	$233.14	1,061	3.3%
$253	$316	$282.19	1,855	5.8%
$317	$379	$353.86	1,445	4.6%
$380	$442	$410.23	1,577	5.0%
$443	$505	$477.77	1,766	5.6%
$506	$631	$574.33	3,214	10.1%
$632	$757	$708.05	1,809	5.7%
$758	$884	$826.84	1,201	3.8%
$885	$1,010	$955.95	1,791	5.6%
$1,011	$1,136	$1,060.72	1,698	5.4%
$1,137	$1,262	$1,190.31	1,021	3.2%
$1,263	$1,389	$1,324.64	820	2.6%
$1,390	$1,515	$1,484.55	727	2.3%
$1,516	$1,641	$1,577.93	878	2.8%
$1,642	$1,767	$1,700.09	489	1.5%
$1,768	$1,894	$1,831.38	226	0.7%
$1,895	$2,020	$1,966.49	74	0.2%
$2,021	$2,146	$2,096.32	129	0.4%
$2,147	$2,272	$2,261.47	205	0.6%
$2,273	$2,399	$2,349.88	60	0.2%
$2,400	$2,525	$2,481.25	33	0.1%
$2,526		$4,954.81	267	0.8%

Number of Simulation Trials	**10,000**
Average Number of Visits to Meet $2,000 Threshold	**4.20**

*Data represents 2010 MarketScan trended at 6% annually to 2014

MVP Health Care -- 2015 Exchange Rate Filing

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

Exhibit 1 -- Summary of Medical Coplans Offered

Exhibit 2a -- Pricing Trend Assumptions

Exhibit 2b -- Support for Rx Trend Used in Development of Index Rate

Exhibit 3 -- Index Rate Development

Exhibit 3a -- Pediatric Dental

Exhibit 4 -- Conversion Factor and Tier Ratios

Exhibit 5 -- Retention Loads and Paid Claim Surcharges

Exhibit 6 -- 2015 Premium Rates

Exhibit 1 -- Summary of Medical Coplans Offered

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

				In-Network Benefits												
Coplan	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Ded	Deductible Type	Coins.	Med OOP Max	Rx OOP Max	OOP Max Type	Pharmacy
FRVT-HMO-P-001-S	HyHMO	Platinum	Standard	$10	$20	10%	$100	10%	$50	$150	Stacked	10%	$1,250	$1,250	Separate	$5 / $40 / 50%
FRVT-HMO-G-001-S	HyHMO	Gold	Standard	$15	$25	20%	$150	20%	$50	$750	Stacked	20%	$4,250	$1,250	Separate	$5 / $40 / 50% $50 Brand Ded
FRVT-HMO-G-002-N	HyHMO	Gold	Non-Standard	$5	$30	20%	$200*	$200	$50*	$400	Stacked	20%	$5,350	$1,300	Separate	$5 / $40 / 50%, $100 Brand Ded, VBID = $1 #
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	$25	$45	40%	$250*	40%	$100	$1,900	Stacked	40%	$5,100	$1,250	Separate	$12 / $50 / 50%, $100 Brand Ded
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	10%	20%	20%	20%	20%	20%	$1,550	Aggregate	20%	$5,750	$1,300	Integrated	$10 / $40 / 50%
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	$15	$50*	50%	$250*	$600	$100*	$1,800	Stacked	50%	$5,350	$1,300	Separate	$12 / $40 / 50%, $250 Brand Ded, VBID = $3 #
FRVT-HMO-B-001-S	HMO	Bronze	Standard	$35*	$80*	50%	50%	50%	$100*	$3,500	Stacked	50%	$6,350	$1,250	Integrated	$20 / $80 / 60%, $300 Brand Ded
FRVT-HMOH-B-001-S	HDHMO	Bronze	Standard	50%	50%	50%	50%	50%	50%	$2,000	Aggregate	50%	$6,250	$1,300	Integrated	$12 / 40% / 60%
FRVT-HMO-B-001-N	HMO	Bronze	Non-Standard	$30*	$100*	50%	50%	50%	$100*	$3,000	Stacked	50%	$6,600	$1,300	Integrated	$20 / $90 / 60%, $200 Ded, VBID = $3 #
FRVT-HMO-C-001-S	HMO	Catastrophic	Standard	$0**	$0	0%	$0	0%	$0	$6,400	Stacked	0%	$6,350	$1,250	Integrated	$0 / $0 / $0

Subsidized Cost-Sharing Benefits (Non AI/AN)					In-Network Benefits												
Subsidy Level	Coplan	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Ded	Deductible Type	Coins.	Med OOP Max	Rx OOP Max	OOP Max Type	Pharmacy
73%	FRVT-HMO-S1-001-S	HyHMO	Silver	Standard	$25	$45	40%	$250*	40%	$100	$1,900	Stacked	40%	$4,000	$1,200	Separate	$12/$50/50% ($100 Brand DED)
87%	FRVT-HMO-S1-002-S	HyHMO	Silver	Standard	$10	$30	40%	$250*	40%	$100	$600	Stacked	40%	$1,250	$400	Separate	$10/$50/50% ($100 Brand DED)
94%	FRVT-HMO-S1-003-S	HyHMO	Silver	Standard	$5	$15	10%	$75*	10%	$50	$100	Stacked	10%	$500	$200	Separate	$5/$20/30%
77%	FRVT-HMO-S1-004-S	HyHMO	Silver	Standard	$20	$40	40%	$250*	40%	$100	$1,500	Stacked	40%	$3,000	$1,000	Separate	$12/$50/50% ($100 Brand DED)
73%	FRVT-HMOH-S1-001-S	HDHMO	Silver	Standard	10%	20%	20%	20%	20%	20%	$1,400	Aggregate	20%	$3,400	$1,300	Integrated	$10/$40/50%
87%	FRVT-HMOH-S1-002-S	HDHMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$1,000	Aggregate	0%	$1,000	$1,000	Integrated	$0/$0/0%
94%	FRVT-HMOH-S1-003-S	HDHMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$450	Aggregate	0%	$450	$450	Integrated	$0/$0/0%
77%	FRVT-HMOH-S1-004-S	HDHMO	Silver	Standard	10%	20%	20%	20%	20%	20%	$1,250	Aggregate	20%	$2,500	$1,300	Integrated	$5/$30/50%
73%	FRVT-HMO-S1-001-N	HyHMO	Silver	Non-Standard	$10	$50*	30%	$150*	$400*	$100*	$700	Stacked	30%	$4,000	$1,200	Separate	$12/$40/50% ($200 DED), VBID = $3 #
87%	FRVT-HMO-S1-002-N	HyHMO	Silver	Non-Standard	$5	$30*	10%	$100*	$75*	$100*	$60	Stacked	10%	$1,800	$450	Separate	$10/$25/40% ($50 Brand DED), VBID = $3 #
94%	FRVT-HMO-S1-003-N	HyHMO	Silver	Non-Standard	$5	$10*	5%	$50*	$25*	$50*	$0	Stacked	5%	$1,800	$450	Separate	$5/$10/5%, VBID = $1 #
77%	FRVT-HMO-S1-004-N	HyHMO	Silver	Non-Standard	$5	$40*	20%	$100*	$200*	$100*	$300	Stacked	20%	$4,000	$1,200	Separate	$12/$40/40% ($100 DED), VBID = $3 #

American Indian and Alaskan Native (AI/AN) Benefits (Unsubsidized)^				In-Network Benefits												
Coplan	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Ded	Deductible Type	Coins.	Med OOP Max	Rx OOP Max	OOP Max Type	Pharmacy
FRVT-HMO-PA2-001-S	HyHMO	Platinum	Standard	$10	$20	10%	$100	10%	$50	$150	Stacked	10%	$1,250	$1,250	Separate	$5 / $40 / 50%
FRVT-HMO-GA2-001-S	HyHMO	Gold	Standard	$15	$25	20%	$150	20%	$50	$750	Stacked	20%	$4,250	$1,250	Separate	$5 / $40 / 50% $50 Brand Ded
FRVT-HMO-GA2-002-N	HyHMO	Gold	Non-Standard	$5	$30	20%	20%	20%	$50	$400	Stacked	20%	$5,350	$1,250	Separate	$5 / $40 / 50%, $100 Brand Ded, VBID = $1 #
FRVT-HMO-SA2-001-S	HyHMO	Silver	Standard	$25	$45	40%	$250*	40%	$100	$1,900	Stacked	40%	$5,100	$1,250	Separate	$12 / $50 / 50%, $100 Brand Ded
FRVT-HMOH-SA2-001-S	HDHMO	Silver	Standard	10%	20%	20%	20%	20%	20%	$1,550	Aggregate	20%	$5,750	$1,250	Integrated	$10 / $40 / 50%
FRVT-HMO-SA2-001-N	HyHMO	Silver	Non-Standard	$10	$40	50%	$400*	50%	$100	$1,700	Stacked	50%	$5,100	$1,250	Separate	$12 / $60 / 50%, $200 Brand Ded, VBID = $3 #
FRVT-HMO-BA2-001-S	HMO	Bronze	Standard	$35*	$80*	50%	50%	50%	$100*	$3,500	Stacked	50%	$6,350	$1,250	Integrated	$20 / $80 / 60%, $300 Ded
FRVT-HMOH-BA2-001-S	HDHMO	Bronze	Standard	50%	50%	50%	50%	50%	50%	$2,000	Aggregate	50%	$6,250	$1,250	Integrated	$12 / 40% / 60%
FRVT-HMO-BA2-001-N	HMO	Bronze	Non-Standard	$30*	$100*	50%	50%	50%	$100*	$3,000	Stacked	50%	$6,350	$1,250	Separate	$20 / $90 / 60%, $200 Brand Ded, VBID = $3 #

American Indian and Alaskan Native (AI/AN) Benefits (Subsidized)				In-Network Benefits												
Coplan	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Ded	Deductible Type	Coins.	Med OOP Max	Rx OOP Max	OOP Max Type	Pharmacy
FRVT-HMO-BA1-001-S	HMO	Bronze	Standard	$0	$0	0%	$0	0%	$0	$0	$0	0%	N/A	N/A	N/A	$0
FRVT-HMO-BA1-001-N	HMO	Bronze	Non-Standard	$0	$0	0%	$0	0%	$0	$0	$0	0%	N/A	N/A	N/A	$0

** Cost-sharing applies after deductible is met*
*** 3 PCP Office Visits are covered in full*
 # Generic Drugs are Covered in full up to age 10, after Pharmacy deductible is met
^ Services provided by a tribal facility are covered in full for non-HDHP plans. For HDHP plans, services are covered in full if provided by a tribal facility after the deductible is met.
Note: MVP's Non-Standard Plan Designs also have a Member Wellness Rider (Form: FRVT-301) attached which provides up to $50 per adult member (age >= 18) per year.

Exhibit 2 -- Pricing Trend Assumptions

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

		Midpoint
Experience Period:	January 1, 2013 - December 31, 2013	July 1, 2013
Rating Period:	January 1, 2015 - December 31, 2015	July 1, 2015

	2014	2015	Total
Months of Trend	12	12	**24**

Medical Trend Summary

2014 Annual Trend

	% of Allowed Claims	Allowed Cost	Utilization	Total
IP	20.9%	6.0%	0.0%	6.0%
OP and Other Med	47.9%	5.4%	0.0%	5.4%
PHY	31.3%	15.3%	0.0%	15.3%
Medical Total		8.6%	0.0%	**8.6%**

2015 Annual Trend

	% of Allowed Claims	Allowed Cost	Utilization	Total
IP	20.9%	6.0%	0.0%	6.0%
OP and Other Med	47.9%	5.4%	0.0%	5.4%
PHY	31.3%	3.5%	0.0%	3.5%
Medical Total		4.9%	0.0%	**4.9%**

Annual Allowed Medical Trend **6.8%**

Leveraging Impact - Fee-For-Service Medical Claims

	Allowed-COB	Coinsurance	Copay	Deductible	Paid
Rating Period:	$362.38	$3.96	$4.71	$68.35	$285.37
24 Months of Trend:	1.140	1.140	1.000	1.067	1.159
Projection Period:	$412.99	$4.52	$4.71	$72.96	$330.81
Allowed Trend (Annual)	6.8%				
Paid Trend (Annual)	7.7%				
Leveraging (Annual)	**0.9%**				

Rx Trend Summary

	2014 Trend		2015 Trend	
	Unit Cost	Utilization	Unit Cost	Utilization
Generic	-1.4%	3.8%	-1.8%	3.6%
Brand	12.5%	-7.0%	10.1%	-4.6%
Specialty	11.0%	4.0%	8.6%	3.0%

Exhibit 2b -- Support for Rx Trend Used in Development of Index Rate

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

Experience Period: Jan 2013 - Dec 2013
Paid Through: Mar 31, 2014
Member Months with Rx Benefit: 201,474

Rx Claim Information	**Generic**	**Brand**	**Specialty**	**Total**
	1	2	3	
Experience Period Scripts / 1000	8,468	1,209	51	9,728
Experience Period Allowed Cost per Script	$20.37	$186.61	$3,125.59	$57.38
Experience Period Deductible per Script	$7.47	$42.21	$153.00	$12.55
Experience Period Copay per Script	$2.40	$12.84	$20.87	$3.80
Experience Period Coinsurance per Script	$0.78	$11.04	$27.36	$2.19
Experience Paid Cost per Script	$9.72	$120.51	$2,924.37	$38.83
Experience Period Allowed PMPM	$14.37	$18.80	$13.34	$46.52
Experience Period Cost Sharing PMPM	$7.52	$6.66	$0.86	$15.03
Experience Period Paid PMPM	$6.86	$12.14	$12.48	$31.48
Annual Util Trend	1.037	0.942	1.035	1.026
Annual Unit Cost Trend	0.984	1.113	1.098	1.040
Annual Deductible Trend	1.019	1.018	1.019	0.992
Annual Paid Trend	0.974	1.098	1.141	1.090
Months of Trend to Q1 2015**	24.0	24.0	24.0	24.0
Projected Scripts / 1000 as of Q1 2015	9,103	1,073	55	10,231
Projected Allowed Cost per Script as of Q1 2015	$19.72	$231.14	$3,769.17	$62.00
Projected Deductible per Script	$7.76	$43.74	$159.02	$12.34
Projected Copay per Script	$2.58	$11.39	$22.35	$3.61
Projected Coinsurance per Script	$0.81	$12.14	$35.34	$2.18
Projected Paid Cost per Script as of Q1 2015	$8.57	$163.87	$3,552.46	$43.86
Projected Allowed PMPM as of Q1 2015	$14.96	$20.67	$17.23	$52.86
Projected Cost Sharing PMPM as of Q1 2015	$8.46	$6.01	$0.99	$15.47
Projected Paid PMPM as of Q1 2015	$6.50	$14.65	$16.24	$37.40

**Midpoint of Experience Period -- 07/01/2013, Midpoint of Q1 2015 Rating Period -- 07/01/2015

Exhibit 3 -- Development of Index Rate

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

Experience Period: Jan 2013 - Dec 2013
Completed Through: Mar 31, 2014

	Paid Claims PMPM
Member Months	204,962
FRDM Medical Claims and Capitation/Non-FRDM Information	
I) Total Experience Period Claims	$276.59
II) Claims in Excess of $100k in Exp. Period	$42.12
III) Pooling Charge	1.104
IV) IBNR Factor *Completed Through Mar-14*	1.032
Net Experience Period Claims Covered for Exchange Pricing *= [I) - II)] * III) * IV)*	$267.14
Elective Abortion Cost (not covered in Exchange)	$0.00
Vision (Only Pediatric Covered in Exchange)	($0.01)
Net Experience Period Claims After Removal of Non-Covered Benefits	$267.13
Annual Medical Trend	1.077
Months of Trend to Q1 2015**	24.0
Trended Net Experience Period Claims	$309.67
Expanded benefits due to EHB Requirements and Mandates	
Disposable Supplies	$0.11
Copay Adjustment for Mental Health/Substance Abuse	$0.09
Pediatric Vision	$1.08
Other Benefit Expansions*	$0.69
Capitations and Non-FRDM Claim Expenses	$6.78
Trended Incurred Medical Claims PMPM as of Q1 2015	$318.42
Rx Claim Information	
Experience Period Rx Claims	$31.48
Annual Rx Trend	1.090
Months of Rx Trend	24.0
Trended Gross Rx Claims PMPM for 2015	$37.40
Rx Rebates	($4.48)
Trended Bill H559 Impact	$2.28
Trended Net Rx Claims PMPM for 2015	$35.21
Index Rate Development for 2015	
A) Total Claim Cost for 2015 Excluding Taxes/Assessments/Pediatric Dental, Prior to Adjustments	$353.62
B) Projected Change in Risk Pool Due to Membership Changes (Morbidity Adjustment)	0.980
C) Pediatric Dental Paid Cost PMPM for 2015	$5.61
2015 Paid Index Rate *= [A) * B)] + C)*	**$352.16**
D) Removing Pediatric Dental Allowed Cost PMPM for 2014 from Adjusted Paid Cost	($5.61)
E) Impact of Temporary Reinsurance Pool on 2015 Adjusted Paid Cost	0.953
Support for Impact of Temporary Reinsurance Pool on Merged Market Adj. Paid Cost	
Avg Value of Temporary Reinsurance Pool from 2011 - 2013	7.6%
Projected % of Membership in Individual Market	61.3%
Adjustment to Merged Market Adjusted Paid Amount	-4.7%
F) Payment Transfer Impact	$0.00
G) 2015 Adjusted Paid Amount *= [2015 Paid Index Rate + D)] * E) + F) -- reflects a Benefit Relativity of 70.1%*	**$330.30**

*Other Benefit expansions include: Wigs, Sterilization Reversal, Couples Therapy, and Private Duty Nursing
**Midpoint of Experience Period -- 07/01/2013, Midpoint of 2015 Rating Period -- 07/01/2015

Exhibit 3a -- Pediatric Dental Net Claim Costs

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

Plan Description	Form Number	2014 Net Claims Cost	Increase Due to Type I Claims Covered 1st Dollar	2015 Blended Net Claims Cost
Platinum Standard	FRVT-HMO-P-001-S	$6.97	0.6%	$7.01
Gold Standard	FRVT-HMO-G-001-S	$5.91	2.2%	$6.04
Gold Non-Standard 2	FRVT-HMO-G-002-N	$5.97	1.0%	$6.03
Silver Standard	FRVT-HMO-S-001-S	$5.59	7.0%	$5.98
Silver Non-Standard	FRVT-HMO-S-001-N	$5.58	5.3%	$5.87
Bronze Standard	FRVT-HMO-B-001-S	$5.03	14.1%	$5.74
Bronze Non Standard	FRVT-HMO-B-001-N	$4.90	12.5%	$5.51
Silver HDHP Standard	FRVT-HMOH-S-001-S	$5.61	0.0%	$5.61
Bronze HDHP Standard	FRVT-HMOH-B-001-S	$5.42	0.0%	$5.42
Catastrophic	FRVT-HMO-C-001-S	$3.08	16.1%	$3.58

Exhibit 4 -- Conversion Factor and Tier Ratios

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

Tier	Contract Type	Subscriber Months	Member Months	Avg Contract Size	Load Factor
4	Single	71,027	71,027	1.000	1.000
4	Double	16,135	32,270	2.000	2.000
4	Parent/Child(ren)	4,914	12,402	2.524	1.930
4	Family	22,450	89,263	3.976	2.810

Proposed Conversion Factor **1.165**

Exhibit 5 -- Retention Loads, Taxes/Assessments, and Paid Claim Surcharges

MVP Health Plan, Inc. 2015 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2015 - December 31, 2015

% of Premium Retention Components	
General Administrative Load	9.50%
Broker Load	0.00%
Bad Debt	0.25%
Contribution to Reserves	1.50%
Total % of Premium Retention Components	11.25%

PMPM Retention Components	
National Network Fee	$1.50
Total % of Premium Retention Components	$1.50

% of Premium Taxes and Assessments	
Premium Tax	0.00%
VT Vaccine Pilot	0.60%
ACA Insurer Tax	2.00%
Total % of Premium Taxes/Assessments	2.60%

% of Paid Claim Taxes and Assessments	
Vermont Paid Claim Surcharge	0.999%
New York State HCRA Surcharge	0.250%
Total % of Paid Claim Taxes/Assessments	1.249%

PMPM Taxes and Assessments	
HHS Risk Adjustment User Fee	$0.08
Fed Reinsurance Assessment	$3.67
Comparative Eff Research Tax	$0.17
Total PMPM Taxes/Assessments	$3.92

Exhibit 6 -- 2015 Exchange Premium Rates

2015 Adjusted Paid Claim Cost (Exhibit 3, Item G)	$330.30
Benefit Relativity Reflected in Index Rate	0.701

Coplan	Product Type	Metal Level	Standard/Non-Standard	Federal and State Combined Subsidy	Pricing Actuarial Value	Induced Utilization Factor*	Net Claim Cost PMPM (excl Ped Dental)	Pediatric Dental Net Claims Cost (Exh 3a)	% of Premium Retention Components	PMPM Retention Components	% of Premium Taxes and Assessments	% of Paid Claim Taxes / Assessments	PMPM Taxes and Assessments	Benefits in Excess of EHB's**	Gross Claim Cost PMPM	Single***	Double	Parent/Child (ren)	Family	Annual Single Rate Change	Annual Double Rate Change	Annual P/C Rate Change	Annual Family Rate Change
FRVT-HMO-P-001-S	HyHMO	Platinum	Standard	Non-Subsidized	0.907	1.121	$478.84	$7.01	$64.95	$1.50	$15.01	$6.07	$3.92	$0.00	$577.30	$672.55	$1,345.10	$1,298.02	$1,889.87	13.2%	13.2%	13.2%	13.2%
FRVT-HMO-G-001-S	HyHMO	Gold	Standard	Non-Subsidized	0.836	1.076	$423.67	$6.04	$57.52	$1.50	$13.29	$5.37	$3.92	$0.00	$511.31	$595.68	$1,191.36	$1,149.66	$1,673.86	15.9%	15.9%	15.9%	15.9%
FRVT-HMO-G-002-N	HyHMO	Gold	Non-Standard	Non-Subsidized	0.839	1.078	$426.01	$6.03	$57.84	$1.50	$13.37	$5.40	$3.92	$0.09	$514.16	$599.00	$1,198.00	$1,156.07	$1,683.19	14.8%	14.8%	14.8%	14.8%
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	Non-Subsidized	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	Non-Subsidized	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	Non-Subsidized	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-B-001-S	HMO	Bronze	Standard	Non-Subsidized	0.609	0.973	$279.39	$5.74	$38.41	$1.50	$8.88	$3.56	$3.92	$0.00	$341.39	$397.72	$795.44	$767.60	$1,117.59	18.3%	18.3%	18.3%	18.3%
FRVT-HMOH-B-001-S	HDHMO	Bronze	Standard	Non-Subsidized	0.620	0.977	$285.53	$5.42	$39.18	$1.50	$9.05	$3.63	$3.92	$0.00	$348.23	$405.69	$811.38	$782.98	$1,139.99	10.8%	10.8%	10.8%	10.8%
FRVT-HMO-B-001-N	HMO	Bronze	Non-Standard	Non-Subsidized	0.617	0.976	$283.69	$5.51	$38.96	$1.50	$9.00	$3.61	$3.92	$0.09	$346.29	$403.43	$806.86	$778.62	$1,133.64	18.0%	18.0%	18.0%	18.0%
FRVT-HMO-C-001-S	HMO	Catastrophic	Standard	Non-Subsidized	0.596	0.533	$149.67	$3.58	$20.97	$1.50	$4.85	$1.91	$3.92	$0.00	$186.40	$217.16	$434.32	$419.12	$610.22	11.0%	11.0%	11.0%	11.0%
FRVT-HMO-S1-001-S	HyHMO	Silver	Standard	Subsidized (73%)	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMO-S1-002-S	HyHMO	Silver	Standard	Subsidized (87%)	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMO-S1-003-S	HyHMO	Silver	Standard	Subsidized (94%)	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMO-S1-004-S	HyHMO	Silver	Standard	Subsidized (77%)	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMOH-S1-001-S	HDHMO	Silver	Standard	Subsidized (73%)	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMOH-S1-002-S	HDHMO	Silver	Standard	Subsidized (87%)	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMOH-S1-003-S	HDHMO	Silver	Standard	Subsidized (94%)	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMOH-S1-004-S	HDHMO	Silver	Standard	Subsidized (77%)	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMO-S1-001-N	HyHMO	Silver	Non-Standard	Subsidized (73%)	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-S1-002-N	HyHMO	Silver	Non-Standard	Subsidized (87%)	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-S1-003-N	HyHMO	Silver	Non-Standard	Subsidized (94%)	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-S1-004-N	HyHMO	Silver	Non-Standard	Subsidized (77%)	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-PA2-001-S	HyHMO	Platinum	Standard	AI/AN	0.907	1.121	$478.84	$7.01	$64.95	$1.50	$15.01	$6.07	$3.92	$0.00	$577.30	$672.55	$1,345.10	$1,298.02	$1,889.87	13.2%	13.2%	13.2%	13.2%
FRVT-HMO-GA2-001-S	HyHMO	Gold	Standard	AI/AN	0.836	1.076	$423.67	$6.04	$57.52	$1.50	$13.29	$5.37	$3.92	$0.00	$511.31	$595.68	$1,191.36	$1,149.66	$1,673.86	15.9%	15.9%	15.9%	15.9%
FRVT-HMO-GA2-002-N	HyHMO	Gold	Non-Standard	AI/AN	0.839	1.078	$426.01	$6.03	$57.84	$1.50	$13.37	$5.40	$3.92	$0.09	$514.16	$599.00	$1,198.00	$1,156.07	$1,683.19	14.8%	14.8%	14.8%	14.8%
FRVT-HMO-SA2-001-S	HyHMO	Silver	Standard	AI/AN	0.741	1.022	$357.03	$5.98	$48.70	$1.50	$11.26	$4.53	$3.92	$0.00	$432.92	$504.35	$1,008.70	$973.40	$1,417.22	18.0%	18.0%	18.0%	18.0%
FRVT-HMOH-SA2-001-S	HDHMO	Silver	Standard	AI/AN	0.709	1.005	$335.55	$5.61	$45.81	$1.50	$10.59	$4.26	$3.92	$0.00	$407.24	$474.43	$948.86	$915.65	$1,333.15	10.7%	10.7%	10.7%	10.7%
FRVT-HMO-SA2-001-N	HyHMO	Silver	Non-Standard	AI/AN	0.713	1.007	$338.18	$5.87	$46.21	$1.50	$10.68	$4.30	$3.92	$0.09	$410.75	$478.52	$957.04	$923.54	$1,344.64	14.2%	14.2%	14.2%	14.2%
FRVT-HMO-BA2-001-S	HMO	Bronze	Standard	AI/AN	0.609	0.973	$279.39	$5.74	$38.41	$1.50	$8.88	$3.56	$3.92	$0.00	$341.39	$397.72	$795.44	$767.60	$1,117.59	18.3%	18.3%	18.3%	18.3%
FRVT-HMOH-BA2-001-S	HDHMO	Bronze	Standard	AI/AN	0.620	0.977	$285.53	$5.42	$39.18	$1.50	$9.05	$3.63	$3.92	$0.00	$348.23	$405.69	$811.38	$782.98	$1,139.99	10.8%	10.8%	10.8%	10.8%
FRVT-HMO-BA2-001-N	HMO	Bronze	Non-Standard	AI/AN	0.617	0.976	$283.69	$5.51	$38.96	$1.50	$9.00	$3.61	$3.92	$0.09	$346.29	$403.43	$806.86	$778.62	$1,133.64	18.0%	18.0%	18.0%	18.0%
FRVT-HMO-BA1-001-S	HMO	Bronze	Standard	AI/AN, Subsidized	0.609	0.973	$279.39	$5.74	$38.41	$1.50	$8.88	$3.56	$3.92	$0.00	$341.39	$397.72	$795.44	$767.60	$1,117.59	18.3%	18.3%	18.3%	18.3%
FRVT-HMO-BA1-001-N	HMO	Bronze	Non-Standard	AI/AN, Subsidized	0.617	0.976	$283.69	$5.51	$38.96	$1.50	$9.00	$3.61	$3.92	$0.09	$346.29	$403.43	$806.86	$778.62	$1,133.64	18.0%	18.0%	18.0%	18.0%

*The Induced Utilization Factor for the Catastrophic Plan includes an additional adjustment to reflect the population eligible to purchase the coplan. Support for this factor can be found in the Actuarial Memorandum.
**Reflects cost of Member Wellness Incentive Rider, Form FRVT-301
***Child Only Rate = Single Rate

Contact Information

Company Information

Company Legal Name:	MVP Health Plan, Inc.
HIOS Issuer ID:	77566
NAIC Number:	95521

Primary Contact Information

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ACTUARIAL MEMORANDUM
2015 Vermont Exchange Rate Filing

Scope and Purpose

This memorandum details the methods and assumptions underlying the proposed 2015 premium rates for the State of Vermont's Individual and SHOP Exchange. These products will be issued by MVP Health Plan, Inc., a non-profit subsidiary of MVP Health Care, Inc. The rate filing has been prepared to satisfy the requirements of 8 V.S.A §5104 as well as the requirements of the Federal ACA including 45 CFR Part 156, §156.80. The premium rates are effective between 1/1/2015 and 12/31/2015. These rates reflect an average rate adjustment to prior rates of 15.4%, ranging from 10.7% to 18.3%.

Market/Benefits

All products and rates included in this rate filing are available to both individuals and small employer groups. A description of benefits is included in Exhibit 1 of the rate filing. All Essential Health Benefits (EHBs) are covered. Only one EHB substitution was made as required by the Department of VHA, a substitution for the $2,000 annual Private Duty Nursing benefit limit in the benchmark plan. MVP contracted Milliman to determine an actuarially equivalent visit limit. The supporting memorandum is included with the documents supplementing this filing. The non-standard products proposed by MVP and included in this rate filing include a wellness benefit in excess of the EHBs. This wellness benefit is included in all non standard products and is filed as a mandatory rider, Form: FRVT-301.

To inform consumers of the availability and details of the products included in this filing, MVP will provide community outreach support as well as offer web and print product content and other printed product materials for VT plans. MVP will also have a mass media presence to further educate health care customers in Vermont.

The book of business affected by this rate filing reflects 2,371 policyholders, 3,134 subscribers and 4,798 members.

Experience Period Claims (Rate Filing Exhibit 3)

In conjunction with the single risk pool requirement, the paid claims for MVP's small group EPO, small group PPO, small group HMO, small group HDHPs, and Individual Indemnity were combined together for the incurred experience period 1/1/2013 – 12/31/2013, paid through 3/31/2014 and used in the development of the Index Rate for premium rate development.

Paid claim data includes claims from our fee for service (FFS) claim warehouse along with additional medical expenses not captured in the claim warehouse such as: payments associated with medical home, physician incentive payments, FFS write-offs and net reinsurance expenses.

An allowance for incurred but not reported paid claims was added to the experience period FFS medical claims. The IBNR factors were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates. Vermont specific data for the experience period was used to develop the factors and they are consistent with the IBNR factors used in MVP's monthly financial statements.

Adjustments to Experience Period Claims (Rate Filing Exhibit 3)

MVP pooled FFS medical claims in excess of $100,000. To determine a pooling charge, MVP analyzed claims in excess of $100,000 for rolling 12 month periods with end dates between December 2011 and December 2012. These time periods were chosen to eliminate the impact of high cost claims over the experience period used to set the premium rates included with this filing. The result of this analysis resulted in a pooling charge of 10.4% being applied to FFS medical claims net of amounts in excess of $100,000.

Projection Factor Adjustments to Experience Period Claims (Rate Filing Exhibit 3)

Benefits covered in the experience period do not fully reflect mandates imposed by both the federal government and the state of Vermont as well as changes due to the EHB benchmark plan. The items listed below identify the necessary adjustments.

Benefits being removed

Included in MVP's current contracts are optional riders for coverage of elective abortion and vision benefits. The PMPM cost of these benefits in the experience period were identified and subtracted from the experience period base cost.

Expanded Benefits Due to EHB Requirements and Mandates

Disposable Supplies

The projected allowed cost to cover this benefit equals $0.14 PMPM. To account for the additional costs associated with this rider, MVP multiplied the projected allowed cost times the projected paid to allowed ratio (75.3%), or $0.11 PMPM.

Copay Adjustment for Mental Health/Substance Abuse

New legislation has been passed by the State of VT requiring carriers to charge a plan's PCP copay for mental health and substance abuse (MH/SA) claims taking place in the outpatient or office setting. MVP re-priced its experience period MH/SA claims to reflect this modification which resulted in $0.09 PMPM being added to the starting claim cost for 2015.

Pediatric Vision

Vision exams and a hardware allowance for children is now a standard benefit in the benchmark plan. MVP contracted Milliman to estimate the cost of this benefit. The supporting memorandum is included with the documents supplementing this filing. The projected allowed amount provided by Milliman is being multiplied by the projected paid to allowed ratio in 2015 to convert Milliman's allowed estimate to a paid claim estimate.

Pediatric Dental

Dental coverage for children is a standard benefit in the benchmark plan. MVP is adjusting the pediatric dental costs provided in the 2014 Exchange Filing for 1st dollar coverage of Type I services. Note that the adjustment for covering Type I services 1st dollar is not applicable to qualified high deductible health plans.

Mandatory Rx Coverage (Exhibits 2b and Exhibit 3)

Over the experience period, MVP had 201,474 member months enrolled in Rx products compared to 204,962 total member months. MVP analyzed the Rx utilization of members enrolled in Rx products over the experience period (Exhibit 2b) and developed a projected Rx claim cost for 2015. MVP assumed that members not receiving Rx coverage in the experience period would have the same Rx utilization in the projection period as members enrolled in Rx products over the experience period.

Bill H559 Impact

Bill H559 was effective beginning with October 2012 renewals. Included in this regulation is a new out of pocket maximum for prescription drug expenses. This mandate is applicable to drug rider coverage, as well as drug coverage that is part of an integrated benefit plan.

MVP has recently learned that claim adjustments attributable to Bill H559 were not being processed within MVP's claim system during the experience period driving this rate filing. Therefore, an adjustment to the experience period claims was needed. To quantify the impact of this mandate, MVP analyzed member level drug claims over the experience period. MVP captured amounts paid by members in excess of the Rx OOP maximum. The sum of these amounts was trended to the projection period to quantify the impact of this mandate on drug claims in 2015.

O*ther New Benefits*
In addition to the above, MVP will cover Private Duty Nursing, Sterilization Reversal, Couples Therapy and Wigs as a result of the EHB requirements. MVP contracted Milliman to estimate the cost of these additional benefits. The supporting memorandum is included with the documents supplementing this filing. The projected allowed amount provided by Milliman is being multiplied by the projected paid to allowed ratio in 2015 to convert Milliman's allowed estimate to a paid claim estimate.

Trend Factors

The development of annual medical trend factors is illustrated in Exhibit 2a. Consistent with recently submitted filings, MVP is applying 0% utilization trend to its medical data. The assumed unit cost trends reflect known and assumed price increases from MVP's provider network. Facility unit cost trends reflect the Green Mountain Care Board (GMCB) approved budget increases as well as contract changes signed between MVP and hospitals. Since the 2015 hospital budget increases have not yet been proposed by the GMCB, MVP has assumed the 2015 facility unit cost increases will equal the 2014 facility unit cost increases. The physician unit cost changes reflect the contractual rate changes negotiated between MVP and physician groups, weighted on the utilization of these physician groups by MVP's commercial population.

In addition to the medical cost inflation rate assumed from the historical experience period to the rating period, an adjustment is needed to reflect the impact of cost share leveraging on the carrier's share of the medical cost. Leveraging is a result of the fixed nature of deductibles and copays in health benefit plans. When there are fixed member deductibles and copays, the carrier bears a greater portion of the cost of medical inflation. Therefore, an additional factor adjustment is made to the trend assumption to capture this cost.

Annual Rx trend factors split by generic, brand and specialty drugs are also illustrated in Exhibit 2a. These trend factors were supplied by MVP's pharmacy vendor and reflect their best estimate of MVP's expected changes to pharmacy costs and drug utilization. MVP analyzed the distribution of Rx claims over the experience period within each Rx category and projected claims to the rating period. The development of MVP's aggregate Rx trend factor and Rx claim projection can be found in Exhibit 2b.

The trend applied to the deductible portion of the experience period was derived using the distribution of claims for MVP's VT book of business. Claims below the average deductible amount over the experience period were trended at the applicable allowed trend rate while claims greater than the deductible were held flat.

Rx Rebates
The basis of MVP's Rx rebate assumptions were formed by analyzing Rx rebates as a % of Rx claim expense over the experience period. Experience period rebates were then adjusted to reflect any contract changes occurring between the experience period and projection period. This amount was multiplied by MVP's projected gross Rx claim cost to derive a PMPM Rx rebate projection.

Other Adjustments to 2015 Projected Claim Cost (Rate Filing Exhibit 3)

Demographic/Morbidity Changes to MVP's Single Risk Pool
MVP is applying a 2.0% morbidity improvement factor to its projection of experience period data. This adjustment is consistent with the GMCB's decision and order from MVP's 2014 Exchange filing. MVP does not have sufficient Exchange data to support modifying this assumption, and as a result, has not removed it from this filing.

Risk Adjustment and Reinsurance

Permanent Risk Adjustment Program
No adjustment was made to the Adjusted Allowed Amount for anticipated receipts from or payments to HHS for this program. There was no market simulation done by the State of Vermont and therefore no basis for assuming anything other than a $0 payment transfer between carriers.

Individual Temporary Reinsurance Pool
MVP's paid claim projection is being adjusted down by 4.7% to account the anticipated payments from the temporary reinsurance pool in 2015. The adjustment was derived by analyzing claims in the reinsurance corridor from calendar year 2011, 2012, and 2013 after trending claims to the projection period. A coinsurance amount of 50% was applied to claims in the corridor and the average over the three calendar years was calculated to arrive at 7.6%. As of April 2014, 61.3% of enrollees in ACA compliant plans are individuals. The percentage of members enrolled in individual products was applied to the expected reinsurance recoveries to determine the aggregate adjustment factor for this program.

Temporary Risk Corridor
No adjustment was made to the Adjusted Allowed Amount due to the temporary program.

Actuarial Values

The AV Metal Level for each plan was determined using the federally prescribed Actuarial Value Calculator (AVC). No adjustments to the Federal AVC were required to certify to MVP's non-standard benefits. Screenshots from the Federal AVC are attached in SERFF for all of the benefits being offered by MVP in this filing.

The Pricing Actuarial Value for each plan was determined using MVP's in house benefit pricing tools. The pricing tools value the paid-to-allowed ratio of unique benefit plan designs from a starting single risk pool allowed amount. Induced utilization differences between benefit plans are not assumed in MVP benefit pricing model, but are reflected in the proposed premiums. To account for induced utilization, MVP is applying the induced utilization slope outlined in the HHS Notice of Benefit and Payment parameters for each plan design relative to the experience period paid to allowed ratio.

Single Conversion Factor and Tier Ratios

Over the experience period, MVP offered small groups the option of purchasing 2-tier, 3-tier, or 4-tier contracts. For 2015, carriers are required to offer only 4-tier contracts and charge the tier ratios dictated by the State of Vermont. MVP mapped its experience period membership into 4-tier contracts to determine the single conversion factor for 2015. The single conversion factor MVP uses to compute tiered premium rates for 2015 equals 1.165 and can be found in Exhibit 4 of the Rate Filing; this reflects an increase of 0.6% over the single conversion factor applicable in the 2014 rate filing.

Retention Loads, Taxes/Assessments, and Paid Claim Surcharges

Exhibit 5 of the Rate Filing summarizes the retention loads and paid claim surcharges MVP will charge in 2014. Note these retention components are broken out into five categories: % of Premium Retention Components, PMPM Retention Components, % of Premium Taxes and Assessments, % of Paid Claim Taxes and Assessments, and PMPM Taxes and Assessments.

Temporary Individual Reinsurance Pool
Beginning in 2014, carriers will be assessed a fee to fund the Temporary Reinsurance Pool which supports the individual reinsurance program both in and out of the exchange from 2014 through 2016. In the proposed HHS Notice of Benefit and Parameters for 2015, this fee is $3.67 PMPM.

ACA Insurer Tax
Beginning in 2014, carriers will be taxed based on earned premium. Based on estimates from consultants, this tax will be approximately 2.0% for 2015 dates of service.

Paid Claim Taxes
In addition to the State of Vermont 0.999% tax on paid claims, MVP is subject to New York HCRA taxes which are based on paid claims. The New York HCRA tax is based only on claims paid for services performed by New York hospitals. The New York HCRA load equals 0.25%, and is based on historical HCRA charges incurred by MVP for its Vermont members.

Premium Tax
As a not-for-profit insurer, MVP Health Plan, Inc. is not subject to premium taxes.

HHS Risk Adjustment User Fee
Carriers are assessed a fee to fund the administration of HHS Risk Adjustment program being run by HHS. This fee is $0.08 PMPM as stated in the Notice of Benefit and Payment Parameters notice for 2015.

Comparative Effectiveness Research Fee
A $0.17 PMPM fee is being charged to fund the Federal Research Fund.

VT Vaccine Pilot
A Vermont state assessment based on plan premiums used to fund immunizations provided by the state.

General Administrative Expense Load and QI component
A 9.5% administrative load (1.2% for QI, 8.3% for all other) is included in the premium rate to cover MVP's expenses to market, sell and administer health insurance products. MVP is currently working towards improving administrative efficiencies to reduce its operating expenses to align with pricing loads.

Contribution to Reserves/Risk Margin
A 1.5% charge is included in the premium rates to serve as either an expected contribution to reserves to maintain solvency requirements if actual costs are more favorable than projected or to mitigate losses if actual costs exceeds those projected.

National Network Fee
MVP has contracted with PHCS to provide an expanded network to members purchasing exchange products in VT. The access fee associated with this rental network is approximately $1.50 PMPM.

<u>Development of Rate Tables</u>

Exhibit 6 of the Rate Filing contains a list of premium rates MVP is proposing to charge for each policy form in 2015. Single rates for each plan were calculated by performing the following calculations:

Net Claim Cost for Plan$_x$ = [2015 Adjusted Paid Claim Cost / Experience Period Paid-to-Allowed] * [Plan$_x$ Induced Utilization / Experience Period Induced Utilization] * Plan$_x$ Pricing AV

Gross Claim Cost for Plan$_x$ = [[Net Claim Cost for Plan$_x$ + Pediatric Dental Cost$_x$ + Benefits > EHBs] * [1+ % of Paid Claims Taxes/Assessments] + PMPM Retention Components + PMPM Taxes/Assessments] / [1 - % of Premium Retention Components - % of Premium Taxes/Assessments]

Single Rate$_x$ = Gross Claim Cost for Plan$_x$ * Single Conversion Factor

Note that members purchasing a non-standard plan will receive MVP's Member Wellness Incentive (Form: FRVT-301). This benefit provides adult members with up to $50 per year in incentives. MVP projects the net cost of this benefit to equal $0.09. This figure was derived by analyzing the cost of MVP's current wellness program which

provides a $300 incentive per contract. The per-contract incentive of $300 was converted to a per-adult incentive at the reduced benefit of $50 per year. This additional cost was added to the plan specific values as a plan specific adjustment.

An additional plan level adjustment was applied to the catastrophic plan to account for the unique age eligibility requirements as permitted by the Federal ACA Rules. MVP did not reflect the fact that individuals facing financial hardship could also qualify to enroll in this plan. As of April 2014, it does not appear that anyone enrolled in this plan due to financial hardship as all of MVP's enrollees meet the age restrictions of this plan (< 30 years old). MVP determined the adjustment factor for this plan by calculating the age/gender factor for the eligible population and comparing it to the age/gender factor of the experience period membership. The eligible population was assumed to be any member under the age of 30 that was not attached to a subscriber age 30 or older. It was assumed that a member under the age of 30 and attached to a subscriber age 30 or older would enroll as a dependent in a non-catastrophic plan. The eligibility adjustment factor is equal to 0.549.

Loss Ratios

The target pricing loss ratios included in these proposed premium rates comply with Federal and State requirements. The projected Federal MLR reflected in these premium rates is 89.5% and derived in the table below.

Traditional and Federal Target Loss Ratio Summary for 2015 Vermont Exchange Filing

Non Claim Expense Categories	Included in Federal MLR	Type of Load	2015 Premium Rates
General Admin (excluding QI Expenses)	Y	% premium	8.3%
Contribution to Reserves/Risk Margin	Y	% premium	1.5%
Broker Load	Y	% premium	0.0%
Administrative Expenses for QI	N	% premium	1.2%
State Premium Tax	N	% premium	0.0%
Federal ACA Insurer Fees	N	% premium	2.0%
VT Vaccine Pilot	Y	% premium	0.6%
VT Paid Claim Surcharges	Y	% paid claims	1.0%
NY HCRA Claim Surcharges	Y	% paid claims	0.25%
National Network Fee	Y	PMPM	$1.50
Federal HHS Risk Adjustment User Fees	N	PMPM	$0.08
Federal Reinsurance Contribution Rate	N	PMPM	$3.67
Comparative Eff Research Tax	N	PMPM	$0.17
Projected Net Incurred Claims			$352.16
Paid Claim Surcharges/Vaccine Assessment			$6.80
Assumed Individual Reinsurance Recovery			($16.48)
Total Projected Medical Expense			$342.48
Total Projected Gross Premium			$399.88
Target Traditional MLR (total proj. medical expense/projected earned premium)			85.6%
Adjusted Medical Expense (add QI expenses)			$347.27
Adjusted Premium (Fed&State non claims taxes/fees removed)			$387.96
Target Federal MLR			89.5%

<u>Actuarial Data Set</u>

The section titled "Consumer Adjusted Premium Rate Development" is intended to crosswalk the URRT 2015 Allowed Index Rate to the plan specific required gross premiums. There were three challenges we faced to complete this crosswalk.

The first is based on our belief that the crosswalk needs to reflect the gross expected reinsurance recoveries to develop the Market Adjusted Index Rate, which is the starting point to develop plan specific premium rates. The reinsurance contribution rate ($3.67 PMPM) is added to each plan specific projected claim cost along with the other non claim expenses. If the net reinsurance PMPM is used to derive the Market Adjusted Index Rate, then the pricing AVs that

get applied to it distort the $3.67 load per plan. Therefore, we used the gross expected reinsurance recoveries for this line in the template and included the $3.67 in the administrative load per plan. Also to note is the PMPM gross reinsurance recovery assumed reflects the Allowed amount times the 4.7% (1-.953) assumption used in the paid claim projection in the rate filing.

The second is related to the fact that our premium rates were developed based on our historical paid claim data and benefit adjustment factors (from MVP's benefit pricing model) to reflect the differences between the average in force actuarial value and the actuarial values of each Exchange plan. However, the URRT requires the development of a projected Allowed PMPM Index rate from historical allowed claims and a paid claim projection based on the projected paid to allowed ratio. The projected paid claims in the URRT tie to our projected paid claims used to develop premium rates, but the projected paid to allowed ratio for the in force block (i.e. in force AV) illustrated in the URRT doesn't tie to that used in our rate filing. This is due to the fact that the URRT ratio is based on actual claims and the ratio used in the rate setting is based on our benefit pricing model. There will always be a calibration factor to tie actual paid to allowed ratios to those projected by any model projecting actuarial values. To address this issue, we made an adjustment to the Market Adjusted PMPM Index Rate.

The third is that in our rating methodology we added the cost of Pediatric Dental as the last step in the rate development, and therefore pricing AVs in this crosswalk need to be applied a Market Adjusted Index Rate that excludes pediatric dental. The pediatric dental is then added to each plan specific projected claim cost.

In the section titled "Trend and Projection Assumption" we wanted to point out that the utilization trend factors input for Facility and Physician claims reflect the average trend factor for Inpatient, Outpatient and Physician combined. This is consistent with how we applied trends in the rate filing. Detailed trend factors by service category are illustrated in the rate filing template in Exhibit 2A.

Reliance

I relied upon the Actuarial Certifications for the Actuarial Certification of the EHB substitution for the Private Duty Nursing annual benefit limit provided by Howard Kahn from Milliman Consulting. In addition, I relied on him for estimates of the cost of specific benefit expansions included in the EHB and pediatric dental claim costs.

Actuarial Certification

I, Matthew Lombardo, am a Member of the American Academy of Actuaries. The projected Index Rate and Adjusted Paid Amount used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and developed in compliance with the applicable Actuarial Standards of Practice. I have examined the assumptions and methods used in determining MVP's requested rates. Based on my review and examination, it is my opinion that the proposed premium rates are reasonable in relation to the benefits provided and that they are not excessive, nor inadequate, nor unfairly discriminatory. They are developed using only the permitted rating classifications. The Adjusted Paid Amount 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 Standard AV Calculator was used to determine the Metal AV Value to be show in Worksheet 2 of the Part I Unified Rate Review template for all the plans.

I certify that I am knowledgeable as to the Vermont laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits.

I am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the PPACA and the HCERA of 2010.

I certify that each rate filing has been prepared in accordance with the following; ASOP#5, ASOP#8, ASOP#12, ASOP#23, ASOP#25, ASOP#26, and ASOP#41.

_____ 05/30/2014

Matthew Lombardo, FSA, MAAA Date
Actuarial Manager, Commercial Pricing
MVP Health Plan, Inc.

General Information – Company and Contact Information

Company Information

Company Legal Name:	MVP Health Plan, Inc.
State:	Vermont
Market:	Combined - Small Group and Individual
HIOS Issuer ID:	77566
NAIC Number:	95521
Effective Date:	January 1, 2015

Primary Contact Information

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ACTUARIAL MEMORANDUM
2015 Vermont Exchange Rate Filing

Scope and Purpose

This memorandum details the methods and assumptions underlying the proposed 2015 premium rates for the State of Vermont's Individual and SHOP Exchange. These products will be issued by MVP Health Plan, Inc., a non-profit subsidiary of MVP Health Care, Inc. The rate filing has been prepared to satisfy the requirements of 8 V.S.A §5104 as well as the requirements of the Federal ACA including 45 CFR Part 156, §156.80. The premium rates are effective between 1/1/2015 and 12/31/2015. These rates reflect an average rate adjustment to prior rates of 15.4%, ranging from 10.7% to 18.3%.

Drivers of Rate Increase

The proposed premium rates reflect an increase over the prior rates due to medical inflation from 2014 to 2015, updated contract information impacting 2014 unit cost trends, and a change in the target loss ratio. Premium rate increases are varying by plan due to modifications of MVP's benefit relativity model as well as leveraging on leaner plans. As the cost of providing health care increases and while deductibles and copays remain fixed, carriers bear a larger portion of the cost. Leveraging has a larger impact on leaner plan designs (bronze) in comparison to rich plan designs (platinum).

Market/Benefits

All products and rates included in this rate filing are available to both individuals and small employer groups. A description of benefits is included in Exhibit 1 of the rate filing. All Essential Health Benefits (EHBs) are covered. Only one EHB substitution was made as required by the Department of VHA, a substitution for the $2,000 annual Private Duty Nursing benefit limit in the benchmark plan. MVP contracted Milliman to determine an actuarially equivalent visit limit. The supporting memorandum is included with the documents supplementing this filing. The non-standard products proposed by MVP and included in this rate filing include a wellness benefit in excess of the EHBs. This wellness benefit is included in all non-standard products and is filed as a mandatory rider, Form: FRVT-301.

To inform consumers of the availability and details of the products included in this filing, MVP will provide community outreach support as well as offer web and print product content and other printed product materials for VT plans. MVP will also have a mass media presence to further educate health care customers in Vermont.

The book of business affected by this rate filing reflects 2,371 policyholders, 3,134 subscribers and 4,798 members.

Experience Period Premium and Claims (Worksheet 1, Section 1 of Unified Rate Review Template)

Worksheet 1, Section 1 of the Unified Rate Review Template contains MVP Health Plan, Inc. Small Group HMO Data for Vermont members over the time period 1/1/2013 – 12/31/2013, completed through 3/31/2014. MVP's loss ratio

exceeds minimum loss ratio requirements, and therefore no adjustments were made to the earned premium amount reflected on Worksheet 1, Section 1 of the Unified Rate Review Template. The earned premium shown reflects the amount of premium MVP collected from groups over the experience period.

Allowed claim data includes claims from our fee for service (FFS) claim warehouse along with additional medical expenses not captured in the claim warehouse such as: payments associated with medical home, physician incentive payments, FFS write-offs and net reinsurance expenses.

An allowance for incurred but not reported paid claims was added to the experience period allowed claims. The IBNR factors were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates. Vermont specific data for the experience period was used to develop the factors and they are consistent with the IBNR factors used in MVP's monthly financial statements.

A summary of experience period claims processed through MVP's claim system, experience period costs not processed through MVP's claims system, as well as an estimate of IBNR are summarized below.

	Allowed	**Incurred**
Claims Processed Through Claim System	$922,323	$883,406
Experience Period Costs Not Processed Through Claims System	$96,103	$96,103
IBNR	$5,420	$4,959
Total	$1,023,846	$984,468

Benefit Categories (Worksheet 1, Section 2 of Unified Rate Review Template)

MVP determines benefit category based on the type of claim form submitted in conjunction with the code and type of code attached to the claim form (i.e. ICD-9, Diagnosis Code, or HCPCS). Member encounter data is used to determine utilization for claims falling under the "Other" category.

Projection Factors (Worksheet 1, Section 2 of Unified Rate Review Template)

Demographic/Morbidity Changes to MVP's Single Risk Pool
MVP is applying a 2.0% morbidity improvement factor to its projection of experience period data. This adjustment is consistent with the GMCB's decision and order from MVP's 2014 Exchange filing. MVP does not have sufficient Exchange data to support modifying this assumption, and as a result, has not removed it from this filing.

Benefits Being Removed: Included in MVP's current contracts are optional riders for coverage of elective abortion and vision benefits. The PMPM cost of these benefits in the experience period was identified and subtracted from the experience period base cost.

New benefits due to EHB and Federal and State Mandates:

Disposable Supplies
The projected allowed cost to cover this benefit equals $0.14 PMPM.

Copay Adjustment for Mental Health/Substance Abuse
New legislation has been passed by the State of VT requiring carriers to charge a plan's PCP copay for mental health and substance abuse (MH/SA) claims taking place in the outpatient or office setting. MVP re-priced its experience period MH/SA claims to reflect this modification which resulted in $0.09 PMPM being added to the starting claim cost for 2015.

Pediatric Vision
Vision exams and a hardware allowance for children is now a standard benefit in the benchmark plan. MVP contracted Milliman to estimate the cost of this benefit. The supporting memorandum is included with the documents supplementing this filing.

Pediatric Dental
Dental coverage for children is a standard benefit in the benchmark plan so the expected costs for this new benefit were added to the cost projection.

Mandatory Rx Coverage (Exhibits 2b and Exhibit 3)
Over the experience period, MVP had 201,474 member months enrolled in Rx products compared to 204,962 total member months. MVP analyzed the Rx utilization of members enrolled in Rx products over the experience period (Exhibit 2b) and developed a projected Rx claim cost for 2015. MVP assumed that members not receiving Rx coverage in the experience period would have the same Rx utilization in the projection period as members enrolled in Rx products over the experience period.

O*ther New Benefits*
In addition to the above, MVP will cover Private Duty Nursing, Sterilization Reversal, Couples Therapy and Wigs as a result of the EHB requirements. MVP contracted Milliman to estimate the cost of these additional benefits. The supporting memorandum is included with the documents supplementing this filing.

Pooling Charge
MVP pooled FFS medical claims in excess of $100,000. To determine a pooling charge, MVP analyzed claims in excess of $100,000 for rolling 12 month periods with end dates between December 2011 and December 2012. These time periods were chosen to eliminate the impact of high cost claims over the experience period used to set the premium rates included with this filing. The result of this analysis resulted in a pooling charge of 10.4% being applied to FFS medical claims net of amounts in excess of $100,000. The impact of the pooling claims in excess of $100,000 is included in the "Other" projection factors on Worksheet 1, Section 2.

Trend Factors
MVP is applying 0% utilization trend to its medical data. The assumed unit cost trends reflect known and assumed price increases from MVP's provider network. Facility unit cost trends reflect the Green Mountain Care Board (GMCB) approved budget increases as well as contract changes signed between MVP and hospitals. Since the 2015 hospital budget increases have not yet been proposed by the GMCB, MVP has assumed the 2015 facility unit cost increases will equal the 2014 facility unit cost increases. The physician unit cost changes reflect the contractual rate changes negotiated between MVP and physician groups, weighted on the utilization of these physician groups by MVP's commercial population.

Annual Rx trend factors split by generic, brand and specialty drugs were supplied by MVP's pharmacy vendor and reflect their best estimate of MVP's expected changes to pharmacy costs and drug utilization. To develop an aggregate Rx trend factor, MVP analyzed the distribution of claims over the experience period within each Rx category.

Credibility Manual Rate Development (Worksheet 1, Section 2 of Unified Rate Review Template)

MVP is filing its 2015 Exchange products on its HMO license, MVP Health Plan, Inc. (MVP HMO) which contained 1,195 member months for calendar year 2013. From January 2010 to December 2013, MVP's small group and individual HMO membership has decreased by 97%. Due to the size of the HMO block and the instability of the population in recent years, 0% credibility is being assigned to the data included in Section 1, Worksheet 1 of the Unified Rate Review Template and the first portion of Section 2, Worksheet 1 of the Unified Rate Review Template.

In conjunction with the single risk pool requirement, the allowed claims for MVP's small group EPO, small group PPO, small group HMO, and Individual Indemnity products were combined together for the incurred experience period 1/1/2013 – 12/31/2013, completed through 3/31/2014 and used in the development of the Allowed Index rate. The majority of the experience period members were enrolled in products on MVP's Insurance Company license, MVP Health Insurance Co. (MVP HIC). MVP assumes the merged risk pool data of 204,962 member months is 100% credible. MVP consulted with Milliman regarding credibility and according to Milliman's HCC cost guidelines, full credibility is assumed with 5,074 members.

A portion of the index rate claims are covered under a capitation arrangement. The cost associated with these claims reflects the PMPM payment MVP will owe its capitated vendors in 2015.

Paid-to-Allowed Ratio (Worksheet 1, Section 3 & Worksheet 2, Section 4 of Unified Rate Review Template)

MVP projects a 75.4% actuarial value in 2015 assuming metal level requirements do not exist in the projection period. The paid-to-allowed ratio shown on Worksheet 2, Section 4 differs from the amount shown on Worksheet 1, Section 3 as members enrolled in plans outside of a metal level will be required to purchase plans with a different expected paid-to-allowed ratio in 2015.

Risk Adjustment and Reinsurance

Permanent Risk Adjustment Program
No adjustment was made to the Index rate for anticipated receipts from or payments to HHS for this program. There was no market simulation done by the State of Vermont and therefore no basis for assuming anything other than a $0 payment transfer between Carriers.

Individual Temporary Reinsurance Pool
MVP's paid claim projection is being adjusted down by 4.7% to account for the anticipated payments from the temporary reinsurance pool in 2015. The adjustment was derived by analyzing claims in the reinsurance corridor from calendar year 2011, 2012, and 2013 after trending claims to the projection period. A coinsurance amount of 50% was applied to claims in the corridor and the average over the three calendar years was calculated to arrive at 7.6%. As of April 2014, 61.3% of enrollees in ACA compliant plans are individuals. The percentage of members enrolled in individual products was applied to the expected reinsurance recoveries to determine the aggregate adjustment factor for this program. This translates to a value of $12.81 PMPM net of the reinsurance contribution of $3.67 PMPM.

Temporary Risk Corridor
No adjustment was made to the Index rate due to the temporary program.

Non-Benefit Expenses and Risk Margin

Temporary Individual Reinsurance Pool
Beginning in 2014, carriers will be assessed a fee to fund the Temporary Reinsurance Pool which supports the individual reinsurance program both in and out of the exchange from 2014 through 2016. In the proposed HHS Notice of Benefit and Parameters for 2015, this fee is $3.67 PMPM.

ACA Insurer Tax
Beginning in 2014, carriers will be taxed based on earned premium. Based on estimates from consultants, this tax will be approximately 2.0% for 2015 dates of service.

Paid Claim Taxes
In addition to the State of Vermont 0.999% tax on paid claims, MVP is subject to New York HCRA taxes which are based on paid claims. The New York HCRA tax is based only on claims paid for services performed by New York hospitals. The New York HCRA load equals 0.25%, and is based on historical HCRA charges incurred by MVP for its Vermont members.

Premium Tax
As a not-for-profit insurer, MVP Health Plan, Inc. is not subject to premium taxes.

HHS Risk Adjustment User Fee
Carriers are assessed a fee to fund the administration of HHS Risk Adjustment program being run by HHS. This fee is $0.08 PMPM as stated in the Notice of Benefit and Payment Parameters notice for 2015.

Comparative Effectiveness Research Fee

A $0.17 PMPM fee is being charged to fund the Federal Research Fund.

VT Vaccine Pilot
A Vermont state assessment based on plan premiums used to fund immunizations provided by the state.

General Administrative Expense Load and QI component
A 9.5% administrative load (1.2% for QI, 8.3% for all other) is included in the premium rate to cover MVP's expenses to market, sell and administer health insurance products. MVP is currently working towards improving administrative efficiencies to reduce it operating expenses to align with pricing loads. The percent being charged is less than the administrative percent charge reflected in MVP's Supplemental Health Care Exhibit for 2013 in the State of VT.

Contribution to Reserves
A 1.5% charge is included in the premium rates to serve as either an expected contribution to reserves to maintain solvency requirements if actual costs are more favorable than projected or to mitigate losses if actual costs exceed those projected.

National Network Fee
MVP has contracted with PHCS to provide an expanded network to members purchasing exchange products in VT. The access fee associated with this rental network is approximately $1.50 PMPM.

Loss Ratio

The target pricing loss ratios included in these proposed premium rates comply with Federal and State requirements. The projected Federal MLR reflected in these premium rates is 89.5%. Please see the table below for an illustrative calculation:

Traditional and Federal Target Loss Ratio Summary for 2015 Vermont Exchange Filing

Non Claim Expense Categories	Included in Federal MLR	Type of Load	2015 Premium Rates
General Admin (excluding QI Expenses)	Y	% premium	8.3%
Contribution to Reserves	Y	% premium	1.5%
Broker Load	Y	% premium	0.0%
Administrative Expenses for QI	N	% premium	1.2%
State Premium Tax	N	% premium	0.0%
Federal ACA Insurer Fees	N	% premium	2.0%
VT Vaccine Pilot	Y	% premium	0.6%
VT Paid Claim Surcharges	Y	% paid claims	1.0%
NY HCRA Claim Surcharges	Y	% paid claims	0.25%
National Network Fee	Y	PMPM	$1.50
Federal HHS Risk Adjustment User Fees	N	PMPM	$0.08
Federal Reinsurance Contribution Rate	N	PMPM	$3.67
Comparative Eff Research Tax	N	PMPM	$0.17
Projected Net Incurred Claims			$352.16
Paid Claim Surcharges/Vaccine Assessment			$6.80
Assumed Individual Reinsurance Recovery			($16.48)
Total Projected Medical Expense			$342.48
Total Projected Gross Premium			$399.88
Target Traditional MLR (total proj. medical expense/projected earned premium)			85.6%
Adjusted Medical Expense (add QI expenses)			$347.27
Adjusted Premium (Fed&State non claims taxes/fees removed)			$387.96
Target Federal MLR			89.5%

Index Rate and Premium Rate Development

The experience period index rate of $823.82 is equal to the small group HMO allowed claim data for the time period, 1/1/2013 – 12/31/2013, completed through 3/31/2014. Note, MVP HMO has experienced significant membership losses over the past four years and there were only 1,195 member months enrolled in this product over the experience period. As a result, MVP does not deem this data to be credible.

The projection period index rate of $475.35 equals the projected single risk pool allowed claim cost adjusted to reflect the essential health benefits covered in the Exchange. A summary of the adjustments made to the experience period data to arrive at the index rate can be found in this memorandum under the section, "Projection Factors". The projection period index rate does not reflect expected risk adjustment payments/charges or the impact of the federal reinsurance program.

To arrive at plan-specific premium rates, the impact of pediatric dental claims were removed as MVP's benefit relativity model does not account for dental claims. Next, the expected recoveries from the Temporary Reinsurance Pool were removed from the index rate and the projected paid-to-allowed ratio was applied to arrive at an adjusted paid amount of $330.30; this amount represents the starting point for which all plan premiums were developed after making market-wide adjustments. Single rates for each plan were calculated by performing the following calculations:

Net Claim Cost for Plan$_x$ = [2015 Adjusted Paid Claim Cost / Experience Period Paid-to-Allowed] * [Plan$_x$ Induced Utilization / Experience Period Induced Utilization] * Plan$_x$ Pricing AV

Gross Claim Cost for Plan$_x$ = [[Net Claim Cost for Plan$_x$ + Pediatric Dental Cost$_x$ + Benefits > EHBs] * [1+ % of Paid Claims Taxes/Assessments] + PMPM Retention Components + PMPM Taxes/Assessments] / [1 - % of Premium Retention Components - % of Premium Taxes/Assessments]

Single Rate$_x$ = Gross Claim Cost for Plan$_x$ * Single Conversion Factor

MVP is applying the induced utilization slope outlined in the HHS Notice of Benefit and Payment parameters for each plan design relative to the experience period paid to allowed ratio. Non-single contract rates were computed using the mandated standard tier ratios.

Note that members purchasing a non-standard plan will receive MVP's Member Wellness Incentive (Form: FRVT-301). This benefit provides adult members with up to $50 per year in incentives. MVP projects the net cost of this benefit to equal $0.09. This figure was derived by analyzing the cost of MVP's current wellness program which provides a $300 incentive per contract. The per-contract incentive of $300 was converted to a per-adult incentive at the reduced benefit of $50 per year. This additional cost was added to the plan specific values as a plan specific adjustment.

An additional plan level adjustment was applied to the catastrophic plan to account for the unique age eligibility requirements as permitted by the Federal ACA Rules. MVP did not reflect the fact that individuals facing financial hardship could also qualify to enroll in this plan. As of April 2014, it does not appear that anyone enrolled in this plan due to financial hardship as all of MVP's enrollees meet the age restrictions of this plan (< 30 years old). MVP determined the adjustment factor for this plan by calculating the age/gender factor for the eligible population and comparing it to the age/gender factor of the experience period membership. The eligible population was assumed to be any member under the age of 30 that was not attached to a subscriber age 30 or older. It was assumed that a member under the age of 30 and attached to a subscriber age 30 or older would enroll as a dependent in a non-catastrophic plan. The eligibility adjustment factor is equal to 0.549.

Actuarial Values

The AV Metal Level for each plan was determined using the federally prescribed Actuarial Value Calculator (AVC). No adjustments to the Federal AVC were required to certify to MVP's non-standard benefits. Screenshots from the Federal AVC are attached in SERFF for all of the benefits being offered by MVP in this filing.

The AV Pricing Value for each plan was determined using MVP's in-house benefit pricing tools. The pricing tools value the paid-to-allowed ratio of unique benefit plan designs from a starting single risk pool allowed amount. Induced utilization differences between benefit plans are not assumed in the model, but are reflected in the proposed premiums. To account for induced utilization, MVP is applying the induced utilization slope outlined in the HHS Notice of Benefit and Payment parameters for each plan design relative to the experience period paid to allowed ratio.

Membership Projection

MVP has assumed the 2015 Exchange membership will equal the current Exchange membership enrollment by product and CSR level. MVP recognizes that groups and individuals that have not yet renewed their benefits in 2014 are not reflected in this figure.

Terminated Products

MVP is terminating its non-grandfathered existing small group and individual Vermont portfolio of products in 2014. Internal discussions are still taking place regarding the decision to retire MVP's grandfathered individual products. The following is a list of the HIOS Product IDs reflected in the "Terminated Products" field of Worksheet 2: 92802VT002, 92802VT003, 92802VT004, 92802VT005, 92802VT006, 92802VT007, 92802VT010, 77556VT001, 77556VT002, 77556VT004.

Warning Alerts

There are no warning alerts.

Reliance

I relied upon the Actuarial Certifications for the Actuarial Certification of the EHB substitution for the Private Duty Nursing annual benefit limit provided by Howard Kahn from Milliman Consulting. In addition, I relied on him for estimates of the cost of specific benefit expansions included in the EHB and pediatric dental claim costs.

Actuarial Certification

I, Matthew Lombardo, am a Member of the American Academy of Actuaries. The projected Index Rate and Adjusted Paid Amount used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and developed in compliance with the applicable Actuarial Standards of Practice. I have examined the assumptions and methods used in determining MVP's requested rates. Based on my review and examination, it is my opinion that the proposed premium rates are reasonable in relation to the benefits provided and that they are not excessive, nor inadequate, nor unfairly discriminatory. They are developed using only the permitted rating classifications. The Adjusted Paid Amount 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 Standard AV Calculator was used to determine the Metal AV Value to be show in Worksheet 2 of the Part I Unified Rate Review template for all the plans.

I certify that I am knowledgeable as to the Vermont laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits.

I am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the PPACA and the HCERA of 2010.

I certify that each rate filing has been prepared in accordance with the following; ASOP#5, ASOP#8, ASOP#12, ASOP#23, ASOP#25, ASOP#26, and ASOP#41.

_____ 05/30/2014

Matthew Lombardo, FSA, MAAA Date
Actuarial Manager, Commercial Pricing
MVP Health Plan, Inc.

Consumer Disclosure about Proposed Health Insurance Rate Increase

2015 Vermont Exchange Rate Filing

MVP Health Plan, Inc. (MVP) is a not-for-profit health care payer operating in Vermont and New York. MVP's mission is to provide high quality and affordable health care with a focus on wellness to our members.

MVP must obtain approval from the Green Mountain Care Board (GMCB) for the health insurance premium rates charged. MVP files premium rates for the Exchange annually which are guaranteed for 12 months. This rate filing seeks approval of MVP's 2015 premium rates (dates of coverage between January 1, 2015 and December 31, 2015).

The premium rates filed for approval reflect MVP's current estimate of the cost to provide health insurance for that coverage period. The filed premium rates may be higher or lower than the previously filed premium rates. However, premium rates generally increase over time. Increases in premium rates are driven by many factors including increases in use of medical services by the insured population, increases in hospital and physician required charges for medical care, expanded covered services due to government mandates, fees and assessments charged by the government to insurers, and the exit of healthier individuals from the insurance market place as the cost of insurance increases.

The premium rates included in this rate filing reflect a 15.4% increase over the prior rates. The minimum proposed rate change for members renewing is 10.7% while the maximum rate change is 18.3%. 4,798 members are enrolled in products included in this filing.

The proposed premium rates for this filing are subject to a public comment period which begins on the day the GMCB posts this filing to its website and concludes after 15 days.

Certification of Compliance	
I hereby certify that I have reviewed the applicable filing requirements for this filing and the filing complies with all applicable statutory and regulatory provisions for the state of Vermont.	
Print Name: James Hynek	Title: Executive Vice President & CFO
Signature: James Hynek	Date: 5/29/14

Unified Rate Review v2.0.2

Company Legal Name: **MVP Health Plan, Inc.** State: **VT**
HIOS Issuer ID: **77566** Market: **Combined**
Effective Date of Rate Change(s): **1/1/2015**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2013 to 12/31/2013

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$870,440	$728.40	100.00%
Incurred Claims in Experience Period	$984,468	823.82	113.10%
Allowed Claims:	$1,023,846	856.78	117.62%
Index Rate of Experience Period		$856.78	
Experience Period Member Months	1,195		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2015 to 12/31/2015 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Days	1,020.66	$1,668.92	$141.95	0.980	1.003	1.060	1.000	1,000.25	$1,882.37	$156.90	204.00	$4,931.26	$83.83
Outpatient Hospital	Visits	3,799.69	965.91	305.85	0.980	1.003	1.054	1.000	3,723.70	1,076.16	333.94	2113.95	1,005.06	177.05
Professional	Visits	8,084.45	343.90	231.69	0.980	1.003	1.092	1.000	7,922.76	411.59	271.75	5003.53	319.07	133.04
Other Medical	Other	495.17	965.74	39.85	0.980	1.003	1.054	1.000	485.27	1,075.97	43.51	305.37	814.71	20.73
Capitation	Benefit Period	12,000.00	80.42	80.42	0.980	1.000	1.000	1.000	11,760.00	80.42	78.81	11760.00	6.78	6.64
Prescription Drug	Prescriptions	18,707.95	36.57	57.02	0.980	1.000	1.040	1.026	19,280.88	39.52	63.50	10026.39	64.68	54.04
Total				$856.78							$948.42			$475.35

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$475.35	$27,368,464
Paid to Allowed Average Factor in Projection Period			0.741	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$352.16	$20,275,912
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$352.16	$20,275,912
Projected ACA reinsurance recoveries, net of rein prem, PMPM			12.84	739,372
Projected Incurred Claims			$339.32	$19,536,540
Administrative Expense Load		10.12%	40.60	2,337,470
Profit & Risk Load		1.50%	6.02	346,324
Taxes & Fees		3.76%	15.07	867,935
Single Risk Pool Gross Premium Avg. Rate, PMPM			$401.01	$23,088,269
Index Rate for Projection Period			$475.35	
% increase over Experience Period			-44.95%	
% Increase, annualized:			-25.80%	
Projected Member Months				57,576

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**MVP Health Plan, Inc.**	State:	**VT**
HIOS Issuer ID:	**77566**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2015**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Vermont HMO Contract Ind										Vermont HMO Contract Grp									Terminated Products
Product ID:	77566VT004										77566VT005									77566VT002
Metal:	Platinum	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Catastrophic	Platinum	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Catastrophic
AV Metal Value	0.880	0.795	0.780	0.712	0.692	0.681	0.615	0.606	0.599	0.604	0.880	0.795	0.780	0.712	0.692	0.681	0.615	0.606	0.599	0.000
AV Pricing Value	0.907	0.836	0.839	0.741	0.709	0.713	0.609	0.620	0.617	0.596	0.907	0.836	0.839	0.741	0.709	0.713	0.609	0.620	0.617	0.000
Plan Type:	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Name	FRVT-HMO-P-001-S	FRVT-HMO-G-001-S	FRVT-HMO-G-002-N	FRVT-HMO-S-001-S	FRVT-HMOH-S-001-S	FRVT-HMO-S-001-N	FRVT-HMO-B-001-S	FRVT-HMOH-B-001-S	FRVT-HMO-B-001-N	FRVT-HMO-C-001-S	FRVT-HMO-P-001-S	FRVT-HMO-G-001-S	FRVT-HMO-G-002-N	FRVT-HMO-S-001-S	FRVT-HMOH-S-001-S	FRVT-HMO-S-001-N	FRVT-HMO-B-001-S	FRVT-HMOH-B-001-S	FRVT-HMO-B-001-N	Terminating Products: 2013 Experience
Plan ID (Standard Component ID):	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040005	77566VT0040006	77566VT0040007	77566VT0040009	77566VT0040010	77566VT0040011	77566VT0040013	77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050005	77566VT0050006	77566VT0050007	77566VT0050009	77566VT0050010	77566VT0050011	77566VT0020001
Exchange Plan?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Historical Rate Increase - Calendar Year - 2	0.00%										0.00%									8.70%
Historical Rate Increase - Calendar Year - 1	0.00%										0.00%									12.20%
Historical Rate Increase - Calendar Year 0	0.00%										0.00%									0.00%
Effective Date of Proposed Rates	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)	12.49%	15.23%	14.15%	17.27%	10.04%	13.47%	17.61%	10.11%	17.27%	10.35%	12.49%	15.23%	14.15%	17.27%	10.04%	13.47%	17.61%	10.11%	17.27%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	12.49%	15.23%	14.15%	17.27%	10.04%	13.47%	17.61%	10.11%	17.27%	10.35%	12.49%	15.23%	14.15%	17.27%	10.04%	13.47%	17.61%	10.11%	17.27%	0.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	-100.00%
Product Threshold Rate Increase %	15.32%										13.19%									#DIV/0!

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040005	77566VT0040006	77566VT0040007	77566VT0040009	77566VT0040010	77566VT0040011	77566VT0040013	77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050005	77566VT0050006	77566VT0050007	77566VT0050009	77566VT0050010	77566VT0050011	77566VT0020001
Inpatient	$0.00	$16.69	$17.99	$16.84	$17.16	$9.39	$12.82	$13.79	$8.10	$13.73	$4.45	$16.69	$16.69	$16.69	$16.69	$16.69	$16.69	$16.69	$16.69	$16.69	$0.00
Outpatient	$0.00	$5.07	$5.46	$5.11	$5.21	$2.85	$3.89	$4.19	$2.46	$4.17	$1.35	$5.07	$5.07	$5.07	$5.07	$5.07	$5.07	$5.07	$5.07	$5.07	$0.00
Professional	$0.00	$34.68	$37.37	$34.98	$35.64	$19.51	$26.63	$28.64	$16.82	$28.52	$9.24	$34.68	$34.68	$34.68	$34.68	$34.68	$34.68	$34.68	$34.68	$34.68	$0.00
Prescription Drug	$0.00	-$4.20	-$4.52	-$4.23	-$4.31	-$2.36	-$3.22	-$3.46	-$2.04	-$3.45	-$1.12	-$4.20	-$4.20	-$4.20	-$4.20	-$4.20	-$4.20	-$4.20	-$4.20	-$4.20	$0.00
Other	$0.00	-$3.56	-$3.84	-$3.60	-$3.66	-$2.01	-$2.74	-$2.94	-$1.73	-$2.93	-$0.95	-$3.56	-$3.56	-$3.56	-$3.56	-$3.56	-$3.56	-$3.56	-$3.56	-$3.56	$0.00
Capitation	$0.00	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.05	$0.00
Administration	$0.00	$7.75	$8.09	$7.71	$7.71	$5.12	$6.26	$6.48	$4.62	$6.47	$3.20	$7.75	$8.09	$7.71	$7.71	$5.12	$6.26	$6.48	$4.62	$6.47	$0.00
Taxes & Fees	$0.00	$1.52	$1.54	$1.41	$1.29	$0.32	$0.73	$0.72	$0.05	$0.72	-$0.69	$1.52	$1.54	$1.41	$1.29	$0.32	$0.73	$0.72	$0.05	$0.72	$0.00
Risk & Profit Charge	$0.00	$6.09	$5.45	$5.46	$4.65	$4.26	$4.35	$3.67	$3.64	$3.72	$1.95	$6.09	$5.45	$5.46	$4.65	$4.26	$4.35	$3.67	$3.64	$3.72	$0.00
Total Rate Increase	$0.00	$64.09	$67.59	$63.74	$63.74	$37.14	$48.77	$51.12	$31.98	$51.00	$17.48	$64.09	$63.82	$63.32	$62.39	$58.43	$60.07	$59.60	$57.04	$59.64	$0.00
Member Cost Share Increase	$0.00	$0.37	-$0.85	-$0.66	$0.60	$14.49	$5.24	$1.78	$16.42	$0.55	$9.82	$0.37	-$0.85	-$0.66	$0.60	$14.49	$5.24	$1.78	$16.42	$0.55	$0.00
Average Current Rate PMPM	$354.39	$513.21	$443.72	$450.42	$369.18	$370.10	$361.98	$290.27	$316.25	$295.29	$168.92	$513.21	$443.72	$450.42	$369.18	$370.10	$361.98	$290.27	$316.25	$295.29	$0.00
Projected Member Months	57,576	2,664	924	336	4,452	2,160	4,152	14,760	1,584	3,072	1,188	4,848	1,044	672	3,024	4,860	1,548	1,944	2,868	1,476	0

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040005	77566VT0040006	77566VT0040007	77566VT0040009	77566VT0040010	77566VT0040011	77566VT0040013	77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050005	77566VT0050006	77566VT0050007	77566VT0050009	77566VT0050010	77566VT0050011	77566VT0020001
Average Rate PMPM	$728.40																				$728.40
Member Months	1,195																				1,195
Total Premium (TP)	$870,440	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$870,440
EHB Percent of TP, [see instructions]	0.00%																				0.00%
state mandated benefits portion of TP that are other than EHB	0.00%																				0.00%
Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$1,023,846																				$1,023,846
EHB Percent of TAC, [see instructions]	100.00%																				100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%																				0.00%
Other benefits portion of TAC	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$39,378																				$39,378
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%
Total Incurred claims, payable with issuer funds	$984,468	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$984,468
Net Amt of Rein	$0.00																				$0.00
Net Amt of Risk Adj	$0.00																				$0.00
Incurred Claims PMPM	$823.82	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$823.82
Allowed Claims PMPM	$856.78	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$856.78
EHB portion of Allowed Claims, PMPM	$856.78	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$856.78

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040005	77566VT0040006	77566VT0040007	77566VT0040009	77566VT0040010	77566VT0040011	77566VT0040013	77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050005	77566VT0050006	77566VT0050007	77566VT0050009	77566VT0050010	77566VT0050011	77566VT0020001
Plan Adjusted Index Rate	$405.50	$577.30	$511.31	$514.16	$432.92	$407.24	$410.75	$341.39	$348.23	$346.29	$186.40	$577.30	$511.31	$514.16	$432.92	$407.24	$410.75	$341.39	$348.23	$346.29	
Member Months	57,576	2,664	924	336	4,452	2,160	4,152	14,760	1,584	3,072	1,188	4,848	1,044	672	3,024	4,860	1,548	1,944	2,868	1,476	-
Total Premium (TP)	$23,347,087	$1,537,927	$472,450	$172,758	$1,927,360	$879,638	$1,705,434	$5,038,916	$551,596	$1,063,803	$221,443	$2,798,750	$533,808	$345,516	$1,309,150	$1,979,186	$635,841	$663,662	$998,724	$511,124	$0
EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.98%	100.00%	100.00%	99.97%	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.98%	100.00%	100.00%	99.97%	
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Total Allowed Claims (TAC)	$27,655,513	$1,429,321	$475,991	$173,407	$2,179,132	$1,039,806	$2,002,686	$6,880,827	$741,442	$1,436,488	$305,390	$2,601,106	$537,807	$346,814	$1,480,165	$2,339,564	$746,666	$906,255	$1,342,459	$690,188	
EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.98%	100.00%	100.00%	99.97%	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.98%	100.00%	100.00%	99.97%	
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Allowed Claims which are not the issuer's obligation	$8,055,728	$132,655	$77,667	$27,772	$559,272	$300,683	$570,942	$2,666,394	$279,351	$546,025	$121,647	$241,408	$87,754	$55,544	$379,883	$676,538	$212,866	$351,184	$505,795	$262,348	
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$139,620	$0	$0	$0	$49,882	$25,237	$64,501	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Portion of above payable by HHS on behalf of insured person, as %	1.73%	0.00%	0.00%	0.00%	8.92%	8.39%	11.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!

Total Incurred claims, payable with issuer funds	$19,599,785	$1,296,666	$398,323	$145,635	$1,619,860	$739,123	$1,431,744	$4,214,433	$462,091	$890,463	$183,742	$2,359,698	$450,054	$291,270	$1,100,282	$1,663,026	$533,800	$555,072	$836,665	$427,840	$0
Net Amt of Rein	$739,372	$61,984	$21,499	$7,818	$103,587	$50,258	$96,606	$343,427	$36,856	$71,478	$27,642	-$17,792	-$3,831	-$2,466	-$11,098	-$17,836	-$5,681	-$7,134	-$10,526	-$5,417	
Net Amt of Risk Adj	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	

Please provide Company specific inputs for any cells shaded in blue that currently has dummy variables.

Purpose, Scope, and Reason for Rate Increase

Insurance Company Name	MVP Health Care, Inc.
HIOS ID	77566
SERFF Filing Number	MVPH-129560321
Date of Submission	6/2/2014
Proposed Effective Date	1/1/2015

	Before Rate Increase	After Rate Increase
Average annual premium per policy	$4,253	$4,866

Proposed Overall Rate Change	14.42%	Difference between figure quoted in Actuarial Memoradum and cell B15 due
Proposed Minimum Rate Change	10.70%	
Proposed Maximum Rate Change	18.32%	

Relationship of Proposed Rate Scale to Current Rate Scale Due to:	Description	Relativity
Claims Experience	2015 Trend, Impact of 2014 Contract Changes after 2014 Exchange filing submission, Correction to Claim Projection in 2014 Rate Filing	1.0836
Age / Gender	N/A	1.0000
Tier	Change in Single Conversion Factor	1.0060
Geography	N/A	1.0000
Tobacco	N/A	1.0000
Benefit Plan Relativities	Changes to pricing model	1.0291
Mandated Benefit Changes	Pediatric Dental (Class 1 Covered in Full), Mental Health/ Sub Abuse Changes	1.0013
Non-Mandated Benefit Changes	Addition of National Network	1.0026
Other	Change in Temporary Reinsurance Recoveries assumed and Contribution Rate, Impact of GMCB decision on 2014 Rates (excluding morbidity impact)	1.0160
	Total Average Relativity of Proposed vs. Current Scale	1.1442

Annual Rate Change Distribution

	Impacted # of Subscribers	Impacted # of Members	Impacted # of Policyholders
Reduction of 15.00% or more	0	0	0
Reduction of 10.01% to 14.99%	0	0	0
Reduction of 5.01% to 10.00%	0	0	0
Reduction of 0.01% to 5.00%	0	0	0
No Change	0	0	0
Increase of 0.01% to 5.00%	0	0	0
Increase of 5.01% to 10.00%	0	0	0
Increase of 10.01% to 14.99%	1,414	2,240	894
Increase of 15.00% or more	1,720	2,558	1,477
Total	3,134	4,798	2,371

History of Rate Changes

Rate Effective Month and Year:	Average Annual Proposed Rate Change	Average Annual Approved Rate Change
2012	0.00%	0.00%
2013	0.00%	0.00%
2014	0.00%	0.00%

Experience Period Used in Rate Development

General Description of Experience Used in Rate Development (may be different than experience shown in URRT)	Calendar Year 2013 data for Small Group AR42, AR44, and Individual Indemnity products	
Does experience include pools/blocks of business not affected by propoed rate change?	Yes	(Yes or No)

	Incurred From Month/Year	Incurred To Month/Year
Time period used for Experience Data in Rate Development	1/1/2013	12/31/2013

Total Written Premium in Experience Period	$76,268,269
Total Earned Premium in Experience Period	$76,188,105
Total Incurred Claims in Experience Period	$66,330,611
Loss Ratio	87.06%
Paid Through Date For Claims	3/31/2014
IBNR as % of Incurred Claims	2.54%
IBNR as # of Months of Paid Claims	0.30
Number of Policyholders	2,371
Number of Covered Lives	4,798

Service Category	Incurred Claims $ PMPM	% Incurred
Inpatient Facility	$73.11	22.6%

Outpatient Facility	$126.54	39.1%
Professional	$76.37	23.6%
Prescription Drugs	$31.48	9.7%
Capitation and Other Provider Payments	$6.78	2.1%
Other	$9.34	2.9%
Total	$323.62	

Credibility Analysis

Assumed Experience Credibility %	100.00%
Description of Credibility Formula and the Theoretical Basis for Use	The assumption of 100% credibility is consistent with Milliman's HCC cost guidelines, which assumes full credibility for pricing at 5,074 members.

Alternative Data Sources

Description of Any Alternative Experience Data Used in Rate Development	N/A
Description of Any Manual Rate Data Used in Rate Development	N/A

Retention

	PMPM in effect during the experience period	PMPM from Most Recent Approved Rate Filing	Proposed PMPM for Effective Date
Payroll and Benefits	$21.01	$29.47	N/A
Outsourced Services (EDP, claims, etc.)	$3.31	$6.31	N/A
Auditing and consulting	$0.33	$0.49	N/A
Marketing & Advertising	$2.52	$2.58	N/A
Legal Expenses	$0.22	$0.36	N/A
Other General Admin Expense	$9.28	$13.70	N/A
Commissions & Brokers Fees	$13.68	$0.09	N/A
Taxes, Licenses & Fees	$9.90	$0.00	N/A
Reinsurance	$0.68	$0.00	N/A
Profit/Risk Margin	-$26.41	-$23.61	N/A

	As % of Premium during the experience period	As % of Premium from Most Recent Approved Rate Filing	Proposed As % of Premium for Effective Date
Payroll and Benefits	5.65%	8.31%	N/A
Outsourced Services (EDP, claims, etc.)	0.89%	1.78%	N/A
Auditing and consulting	0.09%	0.14%	N/A
Marketing & Advertising	0.68%	0.73%	N/A
Legal Expenses	0.06%	0.10%	N/A
Other General Admin Expense	2.50%	3.87%	N/A
Commissions & Brokers Fees	3.68%	0.02%	N/A
Taxes, Licenses & Fees	2.66%	0.00%	N/A
Reinsurance	0.18%	0.00%	N/A
Profit/Risk Margin	-7.11%	-6.66%	N/A

Trend & Projection Assumptions

			Util. Adjustments to Current Rate
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change
Inpatient Facility	1.0000	1.003	0.990
Outpatient Facility	1.0000	1.003	0.990
Professional	1.0000	1.003	0.990
Prescription Drugs	1.0240	1.000	0.990
Capitation and Other Provider Payments	1.0000	1.000	0.990
Other	1.0000	1.003	0.990

			Util. Adjustments to Current Rate
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change
Inpatient Facility	1.0000	1.003	0.990
Outpatient Facility	1.0000	1.003	0.990
Professional	1.0000	1.003	0.990
Prescription Drugs	1.0250	1.000	0.990
Capitation and Other Provider Payments	1.0000	1.000	0.990
Other	1.0000	1.003	0.990

Service Category	Incurred Claims $ PMPM	Medical Trend
Inpatient Facility	$73.11	1.08759
Outpatient Facility	$126.54	1.08759
Professional	$76.37	1.08759
Prescription Drugs	$31.48	1.11431
Capitation and Other Provider Payments	$6.78	0.99586
Other	$9.34	1.08759
Aggregate	$323.62	1.088272634

end Analysis Based on Experience Data Time Period used for Rate Development	Month	Member Months	Monthly Incurred Claims $ PMPM

Jan-2011	19,543	$206.57
Feb-2011	19,584	$226.93
Mar-2011	19,546	$266.12
Apr-2011	19,562	$270.08
May-2011	19,346	$261.56
Jun-2011	19,224	$273.57
Jul-2011	19,222	$279.98
Aug-2011	19,209	$291.11
Sep-2011	19,094	$278.32
Oct-2011	19,089	$302.50
Nov-2011	19,038	$317.16
Dec-2011	18,891	$299.26
Jan-2012	18,373	$268.31
Feb-2012	18,270	$260.99
Mar-2012	18,036	$288.74
Apr-2012	17,962	$287.86
May-2012	17,871	$269.49
Jun-2012	17,832	$252.26
Jul-2012	17,800	$253.42
Aug-2012	17,754	$295.15
Sep-2012	17,702	$250.06
Oct-2012	17,704	$359.11
Nov-2012	17,682	$312.49
Dec-2012	17,546	$305.80
Jan-2013	17,483	$300.55
Feb-2013	17,353	$273.50
Mar-2013	17,292	$296.14
Apr-2013	17,272	$297.79
May-2013	17,180	$338.84
Jun-2013	17,197	$309.82
Jul-2013	17,105	$285.51
Aug-2013	17,043	$328.77
Sep-2013	16,912	$325.31
Oct-2013	16,806	$373.47
Nov-2013	16,675	$331.13
Dec-2013	16,644	$336.57

Solvency

	Most Recent Quaterly Financial Statement	Most Recent Annual Financial Statement
Total Adjusted Capital	0	0
Authorized Control Level	0	0
RBC Ratio		

Loss Ratio

Time Period	Period Beginning Date	Period Ending Date	Member Months
Historical Year -4	1/1/2009	12/31/2009	204,704
Historical Year -3	1/1/2010	12/31/2010	242,100
Historical Year -2	1/1/2011	12/31/2011	242,669
Historical Year -1	1/1/2012	12/31/2012	220,949
Historical Year 0	1/1/2013	12/31/2013	204,962
Historical Totals			1,115,384

Interim Time Period	1/1/2014	12/31/2014	57,576

Future Year 1	1/1/2015	12/31/2015	57,576

Anticiptated Federal loss ratio standard in market: 89.5%

Justification for relationship of Federal MLR standard and the projected future loss ratio including detailed break down of adjustments

Please see the Actuarial Memoradum for a detailed breakdown of the future loss ratio and projected Federal ML

Note:
The historical time periods should represent calendar years since the inception date of the plan type through the most recent date available allowing for the appropriate amount of run-out.
In instances where the start dates and end dates do not line up with a calendar year, partial years should be used.
The interim time period the time between the end date of the "Most Recent Date Available" and the rate effective date.
The future year should represent the 12 months immediately following the rate effective date.

Consumer Adjusted Premium Rate Development

Index Rate for Projected Period PMPM	$475.35
Risk Adjustment PMPM	$0.00
Gross Reinsurance Contributions PMPM	($22.29)
Removing Pediatric Dental Allowed Cost	($8.00)
Exchange User Fees PMPM	$0.00
Market Adjusted Index Rate PMPM	$445.06
Adjusted Market Index Rate based on Paid Claim Pricing Methodology	$26.12
Starting Allowed Amount for Pricing	$471.18

Product	Vermont HMO Contract Ind/Grp	N/A	Vermont HMO Contract Ind/Grp
Product ID	77566VT004	N/A	77566VT004
Plan ID	77566VT0040001	N/A	77566VT0040002
Metal Tier	Platinum (with highest Metal AV)	Platinum (with lowest Metal AV)	Gold (with highest Metal AV)
Metal AV Value	0.880	N/A	0.795
Pricing AV Value	0.907	N/A	0.836
Projected Member Months	7512	N/A	1968
Market Adjusted Index Rate PMPM	$471.18	$471.18	$471.18
Plan Adjustments (in multiplicative format)			
Actuarial value and cost-sharing design of the plan	1.016	N/A	0.899
Adding in Plan Specific Pediatric Dental Net Claim Cost	1.015	N/A	1.014
Provider network, delivery system characteristics and utilization management practices	1.003	N/A	1.003
Plan benefits in addition to EHB	1.000	N/A	1.000
Expected impact of special eligibility categories (only for catastrophic plans)	1.000	N/A	1.000
Plan Adjustments (in % format)			
Distribution and administration costs	15.6%	N/A	15.7%
Plan Adjusted Index Rate	$577.30	#VALUE!	$511.31
Age Calibration Factor	1.000	1.000	1.000
Geography Calibration Factor	1.000	1.000	1.000
Aggregate Calibration Factor	1.000	1.000	1.000
Consumer Adjusted Premium Rate PMPM	$577.30	#VALUE!	$511.31

2015 Rates Table Template v4.0

To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.

If you are a community rating state, select Family Option under Age and fill in all columns.

If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.

If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.

To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.

HIOS Issuer ID*	77566
Federal TIN*	14-1640868
Rate Effective Date*	1/1/2015
Rate Expiration Date*	12/31/2015

					Family Tier						
Plan ID* Required: Enter the 14-character Plan ID	**Rating Area ID*** Required: Select the Rating Area ID	**Tobacco*** Require: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Age*** Required: Select the age of a subscriber eligible for the rate	**Individual Rate*** Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Couple *** Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	**Primary Subscriber and One Dependent*** Required: Enter the rate of a family based on a single parent with one dependent	**Primary Subscriber and Two Dependents*** Required: Enter the rate of a family based on a single parent with two dependents	**Primary Subscriber and Three or More Dependents*** Required: Enter the rate of a family based on a single parent with three or more dependents	**Couple and One Dependent*** Required: Enter the rate of a family based on a couple with one dependent	**Couple and Two Dependents*** Required: Enter the rate of a family based on a couple with two dependents	**Couple and Three or More Dependents*** Required: Enter the rate of a family based on a couple with three or more dependents
77566VT0050001	Rating Area 1	No Preference	Family Option	672.55	1345.10	1298.02	1298.02	1298.02	1889.87	1889.87	1889.87
77566VT0050002	Rating Area 1	No Preference	Family Option	595.68	1191.36	1149.66	1149.66	1149.66	1673.86	1673.86	1673.86
77566VT0050004	Rating Area 1	No Preference	Family Option	599.00	1198.00	1156.07	1156.07	1156.07	1683.19	1683.19	1683.19
77566VT0050005	Rating Area 1	No Preference	Family Option	504.35	1008.70	973.40	973.40	973.40	1417.22	1417.22	1417.22
77566VT0050006	Rating Area 1	No Preference	Family Option	474.43	948.86	915.65	915.65	915.65	1333.15	1333.15	1333.15
77566VT0050007	Rating Area 1	No Preference	Family Option	478.52	957.04	923.54	923.54	923.54	1344.64	1344.64	1344.64
77566VT0050009	Rating Area 1	No Preference	Family Option	397.72	795.44	767.60	767.60	767.60	1117.59	1117.59	1117.59
77566VT0050010	Rating Area 1	No Preference	Family Option	405.69	811.38	782.98	782.98	782.98	1139.99	1139.99	1139.99
77566VT0050011	Rating Area 1	No Preference	Family Option	403.43	806.86	778.62	778.62	778.62	1133.64	1133.64	1133.64

	NON-STANDARD PLANS				STANDARD PLANS									
	GOLD	SILVER		BRONZE	PLATINUM	GOLD	SILVER				BRONZE		Catastrophic	Total Annual Premium
		CSR	Non-CSR				CSR		Non-CSR					
							HDHP	Non-HDHP	HDHP	Non-HDHP	HDHP	Non-HDHP		
2015 Proposed Rates														
Single Rate	$599.00	$478.52	$478.52	$403.43	$672.55	$595.68	$474.43	$504.35	$474.43	$504.35	$405.69	$397.72	$217.16	
Couple Rate	$1,198.00	$957.04	$957.04	$806.86	$1,345.10	$1,191.36	$948.86	$1,008.70	$948.86	$1,008.70	$811.38	$795.44	$434.32	
Adult and Child(ren) Rate	$1,156.07	$923.54	$923.54	$778.62	$1,298.02	$1,149.66	$915.65	$973.40	$915.65	$973.40	$782.98	$767.60	$419.12	
Family Rate	$1,683.19	$1,344.64	$1,344.64	$1,133.64	$1,889.87	$1,673.86	$1,333.15	$1,417.22	$1,333.15	$1,417.22	$1,139.99	$1,117.59	$610.22	$24,671,514.72
2014 Approved Rates														
Single Rate	$521.59	$419.17	$419.17	$341.95	$594.30	$513.83	$428.58	$427.51	$428.58	$427.51	$366.22	$336.13	$195.61	
Couple Rate	$1,043.18	$838.34	$838.34	$683.90	$1,188.60	$1,027.66	$857.16	$855.02	$857.16	$855.02	$732.44	$672.26	$391.22	
Adult and Child(ren) Rate	$1,006.67	$809.00	$809.00	$659.96	$1,147.00	$991.69	$827.16	$825.09	$827.16	$825.09	$706.80	$648.73	$377.53	
Family Rate	$1,465.67	$1,177.87	$1,177.87	$960.88	$1,669.98	$1,443.86	$1,204.31	$1,201.30	$1,204.31	$1,201.30	$1,029.08	$944.53	$549.66	$21,420,166.32
2015 Proposed Rate Increases														
Single Rate	14.8%	14.2%	14.2%	18.0%	13.2%	15.9%	10.7%	18.0%	10.7%	18.0%	10.8%	18.3%	11.0%	
Couple Rate	14.8%	14.2%	14.2%	18.0%	13.2%	15.9%	10.7%	18.0%	10.7%	18.0%	10.8%	18.3%	11.0%	
Adult and Child(ren) Rate	14.8%	14.2%	14.2%	18.0%	13.2%	15.9%	10.7%	18.0%	10.7%	18.0%	10.8%	18.3%	11.0%	
Family Rate	14.8%	14.2%	14.2%	18.0%	13.2%	15.9%	10.7%	18.0%	10.7%	18.0%	10.8%	18.3%	11.0%	**15.2%**
Actual 2014 Contracts														
Single Rate	38	113	132	157	196	59	181	149	52	122	145	714	95	
Couple Rate	10	27	40	56	86	22	27	34	21	33	34	180	2	
Adult and Child(ren) Rate	0	5	1	3	18	5	13	4	1	3	9	25	0	
Family Rate	7	18	4	24	53	13	51	42	2	7	33	68	0	
Total	**55**	**163**	**177**	**240**	**353**	**99**	**272**	**229**	**76**	**165**	**221**	**987**	**97**	
Projected 2015 Contracts														
Single Rate	38	113	132	157	196	59	181	149	52	122	145	714	95	
Couple Rate	10	27	40	56	86	22	27	34	21	33	34	180	2	
Adult and Child(ren) Rate	0	5	1	3	18	5	13	4	1	3	9	25	0	
Family Rate	7	18	4	24	53	13	51	42	2	7	33	68	0	
Total	**55**	**163**	**177**	**240**	**353**	**99**	**272**	**229**	**76**	**165**	**221**	**987**	**97**	

April 2014 Membership Snapshot by Product and Market Segment

Plan Name	Product Type	Metal Level	Standard/Non-Standard	Subsidy Level	Single	Double	Parent/Child	Family	Total Members
FRVT-HMO-P-001-S	HyHMO	Platinum	Standard	N/A	196	172	43	215	626
FRVT-HMO-G-001-S	HyHMO	Gold	Standard	N/A	59	44	14	47	164
FRVT-HMO-G-002-N	HyHMO	Gold	Non-Standard	N/A	38	20	0	26	84
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	N/A	149	68	12	167	396
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	73%	24	18	0	0	42
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	77%	32	18	2	19	71
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	87%	44	20	3	7	74
FRVT-HMO-S-001-S	HyHMO	Silver	Standard	94%	22	10	5	3	40
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	N/A	181	54	32	211	478
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	73%	7	8	0	6	21
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	77%	11	20	4	0	35
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	87%	22	12	0	3	37
FRVT-HMOH-S-001-S	HDHMO	Silver	Standard	94%	12	2	0	0	14
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	N/A	113	54	10	70	247
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	73%	22	12	0	3	37
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	77%	38	20	0	8	66
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	87%	47	30	2	0	79
FRVT-HMO-S-001-N	HyHMO	Silver	Non-Standard	94%	25	18	0	3	46
FRVT-HMO-B-001-S	HMO	Bronze	Standard	N/A	714	360	56	262	1,392
FRVT-HMOH-B-001-S	HDHMO	Bronze	Standard	N/A	145	68	22	136	371
FRVT-HMO-B-001-N	HMO	Bronze	Non-Standard	N/A	157	112	6	104	379
FRVT-HMO-C-001-S	HMO	Catastrophic	Standard	N/A	95	4	0	0	99
				Total	**2,153**	**1,144**	**211**	**1,290**	**4,798**

Experience Period Age Factor
1.57
Current Exchange Snapshot Age Factor
1.61
Change in HHS Age Factor
2.8%

April 2014 Exchange Membership Snapshot by Age

Age	Members	HHS Age Factor
0	14	0.635
1	17	0.635
2	13	0.635
3	25	0.635
4	14	0.635
5	24	0.635
6	27	0.635
7	27	0.635
8	24	0.635
9	31	0.635
10	35	0.635
11	37	0.635
12	29	0.635
13	28	0.635
14	33	0.635
15	36	0.635
16	34	0.635
17	46	0.635
18	39	0.635
19	60	0.635
20	62	0.635
21	60	1.000
22	51	1.000
23	60	1.000
24	66	1.000
25	61	1.004
26	107	1.024
27	81	1.048
28	105	1.087
29	94	1.119
30	78	1.135
31	81	1.159
32	81	1.183
33	92	1.198
34	79	1.214
35	64	1.222
36	82	1.230
37	71	1.238
38	68	1.246
39	66	1.262
40	70	1.278
41	65	1.302
42	74	1.325
43	103	1.357

April 2014 Exchange Membership Snapshot by Age

Age	Members	HHS Age Factor
44	88	1.397
45	95	1.444
46	101	1.500
47	104	1.563
48	85	1.635
49	111	1.706
50	118	1.786
51	117	1.865
52	131	1.952
53	119	2.040
54	99	2.135
55	120	2.230
56	141	2.333
57	106	2.437
58	127	2.548
59	107	2.603
60	108	2.714
61	106	2.810
62	115	2.873
63	123	2.952
64	124	3.000
65	14	3.000
66	5	3.000
67	3	3.000
68	1	3.000
69	2	3.000
70	4	3.000
71	3	3.000
72	0	3.000
73	2	3.000
74	0	3.000
75	1	3.000
76	1	3.000
77	0	3.000
78	0	3.000
79	0	3.000
80	0	3.000
81	1	3.000
82	0	3.000
83	1	3.000
84	0	3.000
85	0	3.000
86	0	3.000
87	0	3.000
88	0	3.000
89	1	3.000
90	0	3.000
91	0	3.000
92	0	3.000
93	0	3.000
Total	**4,798**	**1.61**

2014 & 2015 Projected IP Unit Cost Trend, 2015 Exchange Filing

Hospital State	Name	Unit Cost Trend Change Between Filings?	% of IP Utilization	2014 Unit Cost Increase	2015 Unit Cost Increase
[redacted]					
			IP Unit Cost Trend	**6.0%**	**6.0%**

2014 Projected IP Unit Cost Trend, 3Q/4Q 2014 SG Filing

Hospital State	Name	% of IP Utilization	2014 Unit Cost Increase
[redacted]			
		IP Unit Cost Trend	**5.4%**

Medical Claims Summarized Over the Past 36 Months

DOS YYYYMM	Fee-for-Service Medical Claim Expense * IBNR	Members	PMPM	R12 Trend
201101	$3,553,092	19,543	$181.81	
201102	$3,989,459	19,584	$203.71	
201103	$4,639,869	19,546	$237.38	
201104	$4,706,138	19,562	$240.58	
201105	$4,474,157	19,346	$231.27	
201106	$4,643,670	19,224	$241.56	
201107	$4,781,211	19,222	$248.74	
201108	$4,911,039	19,209	$255.66	
201109	$4,693,079	19,094	$245.79	
201110	$5,153,602	19,089	$269.98	
201111	$5,377,258	19,038	$282.45	
201112	$5,007,418	18,891	$265.07	
201201	$4,458,852	18,373	$242.69	
201202	$4,279,979	18,270	$234.26	
201203	$4,591,103	18,036	$254.55	
201204	$4,576,413	17,962	$254.78	
201205	$4,228,997	17,871	$236.64	
201206	$3,933,831	17,832	$220.61	
201207	$3,971,631	17,800	$223.13	
201208	$4,638,516	17,754	$261.27	
201209	$3,863,694	17,702	$218.26	
201210	$5,731,644	17,704	$323.75	
201211	$4,945,086	17,682	$279.67	
201212	$4,731,654	17,546	$269.67	4.0%
201301	$4,818,981	17,483	$275.64	3.0%
201302	$4,348,400	17,353	$250.58	2.4%
201303	$4,603,279	17,292	$266.21	2.2%
201304	$4,592,351	17,272	$265.88	2.1%
201305	$5,303,527	17,180	$308.70	4.2%
201306	$4,828,180	17,197	$280.76	6.9%
201307	$4,341,200	17,105	$253.80	8.8%
201308	$4,993,812	17,043	$293.01	9.7%
201309	$4,953,028	16,912	$292.87	13.2%
201310	$5,682,489	16,806	$338.12	11.7%
201311	$5,004,960	16,675	$300.15	12.6%
201312	$4,989,466	16,644	$299.78	13.4%

Rx Claims Summarized Over the Past 36 Months

DOS YYYYMM	Rx Claim Expense	Members with Rx Coverage	Total Members	PMPM (Total Members)	R12 Trend
201101	$483,844	18,904	19,543	$24.76	
201102	$454,651	18,988	19,584	$23.22	
201103	$561,670	18,963	19,546	$28.74	
201104	$577,176	18,968	19,562	$29.50	
201105	$585,953	18,761	19,346	$30.29	
201106	$615,356	18,646	19,224	$32.01	
201107	$600,638	18,656	19,222	$31.25	
201108	$680,907	18,657	19,209	$35.45	
201109	$621,204	18,560	19,094	$32.53	
201110	$620,889	18,555	19,089	$32.53	
201111	$660,831	18,515	19,038	$34.71	
201112	$645,963	18,405	18,891	$34.19	
201201	$470,725	17,930	18,373	$25.62	
201202	$488,286	17,837	18,270	$26.73	
201203	$616,586	17,639	18,036	$34.19	
201204	$594,101	17,599	17,962	$33.08	
201205	$587,020	17,503	17,871	$32.85	
201206	$564,556	17,470	17,832	$31.66	
201207	$539,307	17,444	17,800	$30.30	
201208	$601,535	17,404	17,754	$33.88	
201209	$562,814	17,358	17,702	$31.79	
201210	$625,971	17,363	17,704	$35.36	
201211	$580,414	17,343	17,682	$32.83	
201212	$633,852	17,195	17,546	$36.13	4.1%
201301	$435,467	17,161	17,483	$24.91	3.7%
201302	$397,584	17,035	17,353	$22.91	1.7%
201303	$517,538	16,990	17,292	$29.93	-0.9%
201304	$551,007	16,973	17,272	$31.90	-2.1%
201305	$517,747	16,883	17,180	$30.14	-3.5%
201306	$499,717	16,904	17,197	$29.06	-4.1%
201307	$542,503	16,814	17,105	$31.72	-3.5%
201308	$609,433	16,757	17,043	$35.76	-2.6%
201309	$548,662	16,634	16,912	$32.44	-2.2%
201310	$594,008	16,532	16,806	$35.34	-3.0%
201311	$516,672	16,406	16,675	$30.98	-3.0%
201312	$612,431	16,385	16,644	$36.80	-3.3%

Summary of Experience Period Claims and Premium by Product Type

Product Type	Incurred Claims	Earned Premium	Membership
EPO/PPO	$21,814,845	$20,888,858	38,239
HDHP	$39,395,047	$48,850,911	139,230
HMO/POS	$920,290	$824,940	1,195
Individual Indemnity	$4,200,428	$5,623,396	26,298
Total	$66,330,611	$76,188,105	204,962

Historical Rx Rebates for Vermont Small Group and Individual Merged Market

	CY 2011	CY 2012	CY 2013
Member Months with Rx Coverage	224,578	210,085	201,474
A) Rx Rebates PMPM	($4.13)	($4.33)	($4.35)
B) Rx Claims Expense PMPM	$31.66	$32.68	$31.48
C) Rx Rebates as a % of Rx Claims Expense *= A) / B)*	**-13.1%**	**-13.3%**	**-13.8%**

Support for Projected Rebates Used for Rating

A) Rx Rebates as a % of Rx Claim Expense (Experience Period)	-13.8%
B) Impact of Contract Changes on Rx Rebate Projection	0.867
C) Rx Rebates as a % of Rx Claim Expense for Projection Period *= A) * B)*	-12.0%
D) Rx Claim Expense Projection	$37.40
E) Rx Rebate Projection Used in Rate Development	**($4.48)**

Derivation of Transitional Reinsurance Recovery Adjustment Factor and Supporting Information

2014 Exchange Membership Snapshot	
Small Group	1,857
Individual	2,941
% Individual Enrollment	61.3%

Average % of FFS Claims in Reinsurance Threshold	
2011	6.7%
2012	7.1%
2013	9.1%
Average Reins Recoveries 2011 - 2013	7.6%
Individual Membership	61.3%
Merged Market Adjustment for Temp Reins Pool	**-4.7%**

Worksheet 1 of URRT Reinsurance Calculation	
Projected Incurred Claims, Index Rate	$352.16
* Merged Market Adjustment for Fed Reins.	-4.7%
Projected Reinsurance Recoveries	($16.51)
ACA Reinsurance Fee	$3.67
Net Projected ACA Reinsurance Recoveries	($12.84)

Development of Pooling Charge Assumption

Rolling 12 End Date	FFS Medical Claim Expense, PMPM	FFS Medical Claim Expense, Excess of $100K PMPM	Claims > $100K / Claims < $100K
201112	$254.66	$22.53	9.7%
201201	$260.25	$24.70	10.5%
201202	$262.92	$23.90	10.0%
201203	$263.77	$24.13	10.1%
201204	$265.93	$25.12	10.4%
201205	$266.78	$26.20	10.9%
201206	$265.34	$25.67	10.7%
201207	$263.60	$24.68	10.3%
201208	$264.35	$24.31	10.1%
201209	$261.87	$23.79	10.0%
201210	$267.44	$26.72	11.1%
201211	$268.54	$26.34	10.9%
201212	$268.41	$26.27	10.9%
		Average Pooling Charge	**10.4%**

Summary of Capitations and Non-FRDM Claim Expenses	
Other Medical Expense Not in Warehouse	$1.33
Healthways	$1.61
Net Reinsurance Expense	$0.21
Medical Home and PCP Incentive	$3.63
Capitations and Non-FRDM Claim Expenses	**$6.78**

Induced Utilization Support

Induced Utilization from HHS Notice of Benefits and Payments

Platinum	1.15
Gold	1.08
Silver	1.03
Bronze	1.00

Metal Level	Plan AV	Pricing Value (MVP Model Plan AV * Induced Utilization)	Plan AV Change from Bronze	Pricing Value Change from Bronze	Induced Utilization Used for Pricing
Platinum	0.900	0.855	1.500	1.727	1.15
Gold	0.800	0.715	1.333	1.444	1.08
Silver	0.700	0.595	1.167	1.202	1.03
Bronze	0.600	0.495	1.000	1.000	1.00

Retention Loads, Taxes/Assessments, and Paid Claim Surcharges - 2014 vs 2015

% of Premium Retention Components

	2015	2014
General Administrative Load	9.50%	9.50%
Broker Load	0.00%	0.00%
Bad Debt	0.25%	0.25%
Contribution to Reserves	1.50%	0.50%
Total % of Premium Retention Components	11.25%	10.25%

PMPM Retention Components

	2015	2014
National Network Fee	$1.50	$0.00
Total % of Premium Retention Components	$1.50	$0.00

% of Premium Taxes and Assessments

	2015	2014
Premium Tax	0.00%	0.00%
VT Vaccine Pilot	0.60%	0.44%
ACA Insurer Tax	2.00%	2.00%
Total % of Premium Taxes/Assessments	2.60%	2.44%

% of Paid Claim Taxes and Assessments

	2015	2014
Vermont Paid Claim Surcharge	0.999%	0.999%
New York State HCRA Surcharge	0.250%	0.250%
Total % of Paid Claim Taxes/Assessments	1.249%	1.249%

PMPM Taxes and Assessments

	2015	2014
HHS Risk Adjustment User Fee	$0.08	$0.08
Fed Reinsurance Assessment	$3.67	$5.25
Comparative Eff Research Tax	$0.17	$0.17
Total PMPM Taxes/Assessments	$3.92	$5.50

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June 17, 2014

Ms. Rita Tansen A.S.A., M.A.A.A
Lewis & Ellis, Inc.
P.O. Box 851857
Richardson, TX 75085

Re: MVP 2015 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-129560321

Dear Ms. Tansen:

This letter is in response to your correspondence received 06/10/14 regarding the above mentioned rate filing. The verbal responses to your questions are provided below and any numerical examples are included in the attached excel workbook with tabs corresponding to each numbered question.

Q1. As discussed in our email correspondence, the 15.4% average rate increase is a member weighted average versus the 14.2% is a gross PMPM premium weighted average. The drivers of the increase are the same.

Q2. Attached is the completed "Rate Increase Exhibit" you provided. The average rate increase in this exhibit is a per contract weighted average increase and therefore it is not equal to either the 15.4% or the 14.2% mentioned above.

Q3. Please see the attached excel file.

Q4. Please see the attached excel file.

Q5. We have not attempted to make any projections of membership changes for 2015. Our current distribution of 2014 membership by age and product was used. The 2.8% change in the HHS age factor illustrated in the HHS Age Summary Table and current Exchange membership summary snapshot is comparing the average age factor for the 2013 experience period membership vs. the actual Exchange membership as of April 2014.

Q6. The projected enrollment eligible for CSR subsidies at each subsidy level assumes the same distribution enrolled as of April 2014.

Q7. Please see the attached excel file for quantitative support. [redacted] The 5.4% trend used in the 3Q/4Q filings was determined using 2012 allowed claim data by facility while this filing is using 2013 allowed claim data by facility to determine the weights.

Q8. Please see the attached excel file.

Q9. Please see the attached excel file. The PMPMs shown in the attached file include members that did not have Rx coverage in the last 36 months. The data was presented in this fashion so the Medical + Rx PMPMs would be consistent with the Actuarial Memo Dataset file.

Q10. Pharmacy trends are higher in this rate filing as we received an updated forecast from the industry experts, our pharmacy vendor. It was explained to MVP that the period of more favorable pharmacy trends has ended as the "generic cliff" from highly utilized brand drugs like Lipitor rolling off patent has also ended. When these drugs were coming off patent, Rx manufacturers had lower trends on brand drugs to remain as competitive as possible with the

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generic equivalents. As the generic cliff has ended, cost trends for brand drugs are reverting back to more historical levels. The trend forecasts provided to MVP from our pharmacy vendor did not account for MVP's Vermont specific book of business, but this is only because the partnership is brand new. Going forward, they will be able to provide more robust customized trend projections for us when they have our actual claim utilization.

It was confirmed with our pharmacy vendor that drug patent expirations in 2014 and expected in 2015 were taken into consideration when establishing the forecasted trends. MVP did not perform a regression analysis on its historical Rx data. After discussions with our Rx vendor, it was determined that using historical data to set future trend rates would not be a sound assumption due to the reasons discussed above.

Q11. Please see the attached excel file.

Q12. MVP's provider contracts and networks within MVP's footprint (NY, VT, & NH) are the same for MVP HMO products and MVP EPO/PPO products. For MVP's EPO and PPO products there is an expanded national network available to members using CIGNA providers. MVP partners with CIGNA to share networks in our non-competing service areas. CIGNA's discounts off of billed charges are comparable to MVP's discounts so no adjustment is required for network differences.

Q13. MVP no longer offers the Catamount product and as of January 2013 no members were enrolled.

Agriservices was included in the rating pool for 2014 because at the time of rating, MVP was instructed to include all association business in the development of Exchange rates. After the rate filing was submitted, MVP learned that grandfathered associations would not yet be required to join the Exchange. Because Agriservices is a grandfathered group, their data was excluded from the 2015 rating pool. There are no other differences between the rating pools used in 2014 and 2015.

Q14. The projected paid index rate is shown on Exhibit 3 of the rate filing and equals $352.16. The projected allowed index rate is shown on Worksheet 1 of the URRT and equals $475.35. The paid-to-allowed ratio shown on Worksheet 1 of the URRT was determined by dividing these two values and equals 0.741.

Q15. Please see the attached excel file for a historical summary of Rx rebates. MVP applied an adjustment factor to its experience period Rx rebates to reflect contract changes which would result in a reduction to the guaranteed rebates received for each brand script filled in 2015. This factor is equal to 0.867.

Q16. Please see the attached excel file for quantitative support of the transitional reinsurance recovery assumption used to develop premium rates. The data used to develop MVP's temporary reinsurance recovery assumption included all members eligible to enroll in Exchange products. This approach was chosen because MVP did not offer individual products similar to what was being offered on the Exchange, and MVP did not have credible membership enrolled in individual products.

Q17. Please see the attached excel file. Note that Individual Indemnity claims were not included in this calculation as the products being offered are not comparable to the products offered on the Exchange. Had MVP included Individual Indemnity claims in the calculation, the pooling charge would have changed from 10.4% to 10.3%.

Q18. Please see the attached excel file.

Q19. MVP used a 'coinsurance equivalent' calculator that computes the 'effective coinsurance' for a given copay amount based on an assumed average annual cost per service assumption derived by the New York Insurance Department and used in all of our benefit plans with surgery copays. The New York Standard Plans utilized copays for surgery and therefore the Department computed coinsurance equivalents. To be consistent with the Standard

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Plans in New York, MVP utilized the same methodology and carried that forward to VT this year when copays were introduced in the benefit plans. It is important to note that this is just a Federal AVC assumption and that in determining actual pricing AV's for each plan, we used our own benefit pricing models which accommodate copay inputs for all services.

Q20. The AV screenshot and the policy form are aligned. The $5,300 OOP limit is the correct limit and was the assumption used in our benefit pricing model. The $5,350 OOP limit shown in Exhibit 1was in error and will be corrected in MVP's final submission.

Q21. MVP's non-standard products have a prescription drug feature that provides lower copay amounts for drugs on a specific list, the "VBID" list. For the non-standard bronze plan, the copay for the VBID drug list is $3 vs. $20 copay for other generic drugs. This lower copay is noted on Exhibit 1. Approximately 23.5% of generic drugs were on the VBID list in the experience period resulting in an average copay of $16.00.

Q22. The non-standard bronze plan does have an integrated OOP limit equal to $6,600, but due to the Vermont Rx OOP regulation in Bill H559, there is effectively a secondary OOP limit under the plan limit specific to the Rx spend. The Federal AVC can't accommodate this benefit requirement and therefore an adjustment was made.

Q23. MVP's benefit pricing tool determines the paid-to-allowed ratio of any plan design input from a static starting allowed amount. Because the same average allowed PMPM is used to value the expected paid-to-allowed ratio for each plan, there is no induced utilization assumed.

Q24. Yes, the "Pricing AVs" reflect the expected paid-to-allowed ratio for each plan assuming the same starting allowed amount. There were no other considerations in computing the pricing AV for each plan. All of the products reflect the same network and EHB package, and the induced utilization differences between the in-force block and each Exchange plan were reflected in the column labeled "induced utilization factor". This induced utilization factor is the ratio of the Exchange plan induced utilization factor divided by the in-force induced utilization factor therefore adjusting for the plan richness of each plan relative to the in-force average.

We recognize that the URRT instructions indicate that the Pricing Values should include an adjustment for induced utilization. MVP will make this correction to the Pricing Values and re-submit the URRT if instructed to do so. Note that this modification will not have any bearing on the proposed premium rates or any other information provided in the URRT.

Please see the attached excel file for a quantitative example demonstrating that MVP's induced utilization factors tie out to the induced utilization factors in the HHS Notice of Benefits and Payments.

Q25. MVP anticipates a negative profit margin equal to (5.5%) for the approved 2014 Exchange rates. 2.5% of this anticipated loss is due to rate cuts by the Green Mountain Care Board while the other 3% is attributable to an unfavorable physician contract being signed after rates were submitted and a change in the mix of children vs. adults.

Q26. Please see the attached excel file.

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If you have any questions or require any additional information, please contact me at 518-388-2483.

Sincerely,

Matthew Lombardo, FSA, MAAA
Actuarial Manager, Commercial Pricing
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June 27, 2013

To Kathleen Fish, Matt Lombardo (MVP)
From Howard Kahn (Milliman)
Subject Vermont Pediatric Dental Pricing

As requested, we have estimated the incremental cost of adding pediatric dental in the individual and small group plans MVP Health Care (MVP) intends to offer in Vermont during 2014.

Results

Below are our estimates for the incremental 2014 allowed and paid Per Member Per Month (PMPM) costs for embedding pediatric dental into each plan MVP will be offering in Vermont.

MVP Health Plan - Vermont Pediatric Dental Costs - Individual			
Plan Description	Form Number	Estimated 2014 Allowed Cost PMPM	Estimated 2014 Net Claims Cost PMPM
[redacted]			

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MVP Health Plan - Vermont
Pediatric Dental Costs – Small Group

Plan Description	Form Number	Estimated 2014 Allowed Cost PMPM	Estimated 2014 Net Claims Cost PMPM
[redacted]			

[redacted]

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[redacted]

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[redacted]

Howard Kahn, FSA, MAAA
Consulting Actuary
June 27, 2013

Rx Claims Summarized Over the Past 36 Months

DOS YYYYMM	Rx Claim Expense	Members with Rx Coverage	PMPM (Members with Rx Coverage)	R12 Trend
201101	$483,844	18,904	$25.59	
201102	$454,651	18,988	$23.94	
201103	$561,670	18,963	$29.62	
201104	$577,176	18,968	$30.43	
201105	$585,953	18,761	$31.23	
201106	$615,356	18,646	$33.00	
201107	$600,638	18,656	$32.20	
201108	$680,907	18,657	$36.50	
201109	$621,204	18,560	$33.47	
201110	$620,889	18,555	$33.46	
201111	$660,831	18,515	$35.69	
201112	$645,963	18,405	$35.10	
201201	$470,725	17,930	$26.25	
201202	$488,286	17,837	$27.37	
201203	$616,586	17,639	$34.96	
201204	$594,101	17,599	$33.76	
201205	$587,020	17,503	$33.54	
201206	$564,556	17,470	$32.32	
201207	$539,307	17,444	$30.92	
201208	$601,535	17,404	$34.56	
201209	$562,814	17,358	$32.42	
201210	$625,971	17,363	$36.05	
201211	$580,414	17,343	$33.47	
201212	$633,852	17,195	$36.86	3.2%
201301	$435,467	17,161	$25.38	2.8%
201302	$397,584	17,035	$23.34	0.8%
201303	$517,538	16,990	$30.46	-1.7%
201304	$551,007	16,973	$32.46	-2.9%
201305	$517,747	16,883	$30.67	-4.2%
201306	$499,717	16,904	$29.56	-4.7%
201307	$542,503	16,814	$32.26	-4.1%
201308	$609,433	16,757	$36.37	-3.1%
201309	$548,662	16,634	$32.98	-2.7%
201310	$594,008	16,532	$35.93	-3.4%
201311	$516,672	16,406	$31.49	-3.3%
201312	$612,431	16,385	$37.38	-3.7%

Historical Rx Rebates for Vermont Small Group and Individual Merged Market

	CY 2011	CY 2012	CY 2013
Member Months with Rx Coverage	224,578	210,085	201,474
A) Rx Rebates PMPM	($4.13)	($4.33)	($4.35)
B) Rx Claims Expense PMPM	$31.66	$32.68	$31.48
C) Rx Rebates as a % of Rx Claims Expense *= A) / B)*	**-13.1%**	**-13.3%**	**-13.8%**

Revised Rx Rebate Assumption and Claim Projection

A) Rx Rebates as a % of Rx Claim Expense (Experience Period)	-13.8%
B) Impact of Contract Changes on Rx Rebate Projection	1.000
C) Rx Rebates as a % of Rx Claim Expense for Projection Period *= A) * B)*	-13.8%
D) Rx Claim Expense Projection	$37.40
E) Revised Rx Rebate Projection Used in Rate Development	**($5.17)**
F) Impact of Bill H559	$2.28
G) Revised Net Rx Claim Expense Projection *= D) + E) + F)*	**$34.51**

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June 27, 2014

Ms. Rita Tansen A.S.A., M.A.A.A
Lewis & Ellis, Inc.
P.O. Box 851857
Richardson, TX 75085

Re: MVP 2015 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-129560321

Dear Ms. Tansen:

This letter is in response to your correspondence received 06/25/14 regarding the above mentioned rate filing. The verbal responses to your questions are provided below and any numerical examples are included in the attached excel workbook with tabs corresponding to each numbered question.

Q1. The subscriber months and member months illustrated in Exhibit 4 and used to derive the single conversion factor (SCF) represent the 2013 experience period membership used to derive the 2015 gross required revenue PMPM. The SCF is computed using experience period membership by contract tier to ensure that the aggregate revenue collected based on per contract premium rates will be equivalent to the aggregate revenue collected on a gross PMPM basis. They are actuarially equivalent. If the mix of contracts by tier or the average contract size by tier changes between the 2013 experience period and 2014 actual enrollment, then a SCF computed using the 2014 actual enrollment would not produce revenue neutral premium rates.

If a member was not enrolled in a 4-tier product in 2013, they were mapped to the contract type it would be expected they enroll when presented with a 4-tier option. Please see how members were mapped below:

2-Tier to 4-Tier Mapping

Subscriber Count	Spouse Count	Child(ren) Count	2-Tier Contract	4-Tier Contract
1	0	0	Single	Single
1	1	0	Family	Double
1	0	1+	Family	Parent/Child(ren)
1	1	1+	Family	Family

3-Tier to 4-Tier Mapping

Subscriber Count	Spouse Count	Child(ren) Count	2-Tier Contract	4-Tier Contract
1	0	0	Single	Single
1	1	0	Double	Double
1	0	1	Double	Parent/Child(ren)
1	0	2+	Family	Parent/Child(ren)
1	1	1+	Family	Family

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Q2. MVP's benefit pricing model accounts for the impact of the aggregate family deductibles through factor adjustments to the deductible credits computed using member based claims distribution tables. The factor adjustments were computed from a pricing study using MVP's historical claims. Using member based allowed claim detail for a 12 month period, net paid expenses were computed under various deductible and coinsurance scenarios assuming both member based embedded deductibles and family based (per contract based) aggregate deductibles. The relative cost difference between the two projected costs was the source of the factor adjustments for each deductible/coinsurance combination.

Q3. a) The Rx PMPM calculation of MVP's 6/17/14 response to Question #9 includes all members, but the claims shown only reflect those members with Rx coverage. MVP's Rx PMPM was calculated using all members to be consistent with the calculation of total claim expense in the "Actuarial Memo Dataset" file. The calculation of Rx claim expense PMPM has been modified in the attached excel exhibit to reflect only members with Rx coverage.

b) MVP is changing Rx vendors as of 1/1/15. Once the new Rx vendor has a full year of data from MVP, we intend to utilize this information in conjunction with the Rx vendor's recommended trends to arrive at projected trend figures. It's worth noting that MVP's Rx vendor provided three sets of trend forecasts: a low set of trend factors, an average set of trend factors, and a high set of trend factors; MVP is using the low set of trend factors to project future Rx claim costs.

c) The Rx vendor has expertise in understanding future Rx utilization patterns, drug patent expirations, drugs expected to be approved by the FDA in the near future, and changes in average wholesale price which are not reflected in MVP's historical data. Because all of these changes are occurring, MVP's historical VT data and trends would not be a good predictor of future trends. We choose to use the information provided by the industry expert, the Rx vendor, to provide Rx trend forecasts.

Q4. MVP revisited the contract changes with its new Rx vendor, and it was recognized that the reduction in expected rebates was already reflected in the trends applied to Rx claim costs in rate development. Therefore, MVP was applying Rx rebate changes in its rate development twice. Please see the attached excel file which includes a revised Rx claim projection after modifying the Rx rebate assumption. MVP will reflect this revision in its final rate filing submitted to the Green Mountain Care Board for approval.

Q5. MVP files its VT Exchange plans on an HMO platform. In 2014, the network of providers available to members purchasing an Exchange product through MVP was limited to MVP's network. MVP has contracted with PHCS to provide an expanded network to members purchasing exchange products in VT. The access fee associated with this rental network is based on a percentage of the discount savings. We have estimated this to be approximately a $1.50 PMPM.

Q6. The benefit relativity reflected in MVP's index rate development was 0.701. MVP's Silver Standard plan has a benefit relativity of 0.709. Because these benefit relativities are very similar, MVP chose to use the pediatric dental cost associated with the Silver Standard plan in its index rate development.

Please note that the value of the pediatric dental benefit used in the index rate development does not impact MVP's premium rate development. The pediatric dental PMPMS is removed from the "Adjusted Paid Amount" shown on Exhibit 3 which is used as the starting point to calculate premium rates.

Q7 & Q8. In support of the 2014 Exchange rate filing, MVP hired Milliman to provide estimated costs by plan for the pediatric dental benefit by plan. These are the PMPM costs illustrated in Exhibit 3a in the column labeled "2014 Net Claims Cost". The actuarial memorandum supporting these cost estimates was included as part of the 2014 Exchange rate filing and is attached to this response for your reference. Because these were estimates and the actual cost is yet to be determined, MVP decided they were reasonable baseline estimates for the 2015 rate filing as well and it would not be necessary to commission Milliman again to recast these.

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To estimate the impact of the benefit change for class I preventive services, MVP consulted with Milliman on their methodologies used and determined that we could derive the benefit factor adjustments using our own pricing model and claim distribution tables. The factor adjustments were derived by comparing the model projected cost of each benefit plan with the class I pediatric dental benefit subject to the deductible/coins versus the class I pediatric dental benefit covered in full.

If you have any questions or require any additional information, please contact me at 518-388-2483.

Sincerely,

Matthew Lombardo, FSA, MAAA
Actuarial Manager, Commercial Pricing
MVP Health Care