Contact Information

Company Information

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

Primary Contact Information

Contact Name:	Eric Bachner, ASA
Contact Title:	Senior Actuarial Analyst
Primary Contact Phone #:	1-800-777-4793, ext. 7213
Primary Contact Address:	625 State Street Schenectady, NY 12301-2207
Primary Contact E-mail:	ebachner@mvphealthcare.com

ACTUARIAL MEMORANDUM
2019 Vermont Exchange Filing

Purpose and Scope of Filing

This memorandum details the methods and assumptions underlying the proposed 2019 premium rates for the State of Vermont's individual and small group ACA compliant market. These products will be issued by MVP Health Plan, Inc. (MVP), 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 1/1/2019 and 12/31/2019. There are no benefit plans being retired, and there are 4 new "reflective" Silver plans being offered off the exchange. MVP made uniform modifications to a number of the benefits being offered, and the updated forms have been submitted in a separate SERFF filing as well as forms for the new plans. Assuming all members purchasing Cost Sharing Reduction (CSR) subsidy plans stay on the exchange while all other members purchasing Silver plans move to the "reflective" plans, the proposed rates reflect an average rate adjustment to prior rates of 10.9%, ranging from 4.2% to 30.7%. The average rate adjustment absent any loading to Silver plans for CSR defunding would be 6.4%, with increases ranging from 4.2% to 10.6%.

Market/Benefits

All benefit plans and rates included in this rate filing are available to both individuals and small employer groups with the exception of the Catastrophic plan (FRVT-HMO-C-001-N (2019)). The Catastrophic plan is only available to individuals that meet a specific set of qualifications per Federal ACA rules.

A description of benefits is included in Exhibit 1 of the rate filing. As stated previously, MVP has filed Silver plans to be sold off exchange known as "reflective" Silver plans. These plans are equivalent to the corresponding on exchange plan with the exception of a $5 copay or 5% coinsurance change to the ambulance benefit or a modification to the deductible/maximum out of pocket for the plan which has no cost sharing after the deductible. In addition, MVP has added Subsidized American Indian/Alaskan Native variations for its on exchange plan designs at the request of the Department of Vermont Health Access (DVHA).

Exhibit 1A of the filing provides an overview of benefit changes for renewing plans from 2018 to 2019. As noted in the rate filing document, design changes from the previous year's plan design are shaded in gray. Also, please note that we are showing plan design changes for plan FRVT-HMOH-S-002-N (2019) even though the 2018 version was ultimately not approved for sale by DVHA. Because MVP had the plan in the previous year's filing and the rates were approved by the Green Mountain Care Board, we are showing the changes for comparison purposes.

All Essential Health Benefits (EHBs) are covered. Only one EHB substitution was made as required by the Department DVHA, a substitution for the $2,000 annual Private Duty Nursing benefit limit in the benchmark plan. MVP previously contracted Milliman to determine an actuarially equivalent visit limit, and the claim data in the experience period represents this actuarially equivalent limit.

The non-standard plans 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 is 8,929 policyholders, 16,360 subscribers and 25,223 members based on February 2018 membership.

Experience Period Claims

MVP Health Plan, Inc. historical claim data was the basis of the premium rate development. ACA compliant individual and small employer group data are included in the experience period data set. There were no products excluded.

MVP combined the experience of these separate pools of data to satisfy the single risk pool requirement of the Federal ACA as well as Vermont rating requirements. The claim data is assumed to be fully credible. The experience period for the historical claims is incurred dates of service between 1/1/17 and 12/31/17, paid through 2/28/18. MVP has restated its incurred medical claim estimates to complete the claims through 3/31/18.

Please see Exhibit 3 for a summary of MVP's experience period claims, market-wide adjustments to experience period claims, and the development of the paid Index rate PMPM. MVP is illustrating the development of the paid index rate PMPM separately for ACA compliant small group and individual data. Market-wide adjustments and trend projections are being made to each of these experience period data sets which are then combined to determine the single risk pool paid Index rate PMPM. Details of the market-wide adjustments and trend projections being made to MVP's experience period data are discussed below.

Line 1 of Exhibit 3 provides the member months over the experience period for the rating pool.

Line 2 of Exhibit 3 provides the experience period fee for service medical claim expense on a "per member per month" (PMPM basis). This includes all claims for medical services paid by MVP for the rating pool during the experience period.

Line 3 of Exhibit 3 provides the FFS claims paid by MVP for pediatric dental services provided to members in the rating pool during the experience period.

Lines 4a and 4b reflect projected recoveries under the CSR subsidy program. Line 4a reflects the payments made to MVP by the federal government to cover the difference between the plan's filed cost sharing and the member's actual cost sharing under the program. Even though the federal subsidies were discontinued in October 2017, MVP is capturing the full amount of the reduction to claim expense in the filing and adding it back only on specific plans which will be discussed later. Because the state CSR program is still projected to continue in the rating period, MVP is reflecting these recoveries as a reduction to claim expense.

Line 5 reflects the assumption for claims Incurred but not Reported (IBNR) as of the latest date the claims data was paid through. We have completed the claims using an IBNR factor of 4.3% which is our best estimate of ultimate liabilities as of 3/31/18. MVP uses a combined trended PMPM and completion factor method to value its ultimate claim liabilities. Please see the following table comparing incurred and paid claim amounts by month for the experience period.

Incurred Month	Paid Claims	Incurred Claims	IBNR Factor
201712	$3,333,236	$3,826,775	1.148
201711	$3,933,390	$4,327,802	1.100
201710	$3,595,432	$3,695,079	1.028
201709	$3,436,238	$3,510,969	1.022
201708	$3,493,042	$3,538,797	1.013
201707	$3,131,452	$3,143,870	1.004
201706	$3,369,400	$3,387,996	1.006
201705	$3,404,967	$3,410,159	1.002
201704	$2,880,465	$2,889,938	1.003
201703	$3,044,142	$3,538,699	1.162
201702	$2,345,011	$2,348,013	1.001
201701	$2,677,705	$2,681,541	1.001
Total	$38,644,479	$40,299,638	1.043

MVP is applying an IBNR factor of 1.162 to March 2017 incurred claims to reflect that there were $492,590 worth of claims which were incurred in March 2017 and paid in March 2018. These claims are not reflected in MVP's experience period paid claims, but it is now known that those claims are MVP's responsibility for members in the rating pool. If these claims were included in the experience period paid data, the IBNR factor for the experience period would be reduced to 1.030 but there would be a corresponding increase on line 2 of Exhibit 3.

Line 6 reflects medical plus dental fee-for-service (FFS) claims, adjusted for CSR and completed with IBNR. The formula is the sum of lines 2 and 4 multiplied by line 5, then adding line 3. MVP is assuming that dental claims are fully complete with two months of run-out, and therefore IBNR is not applied to these claims.

Line 7 provides the experience period incurred pharmacy claims for the rating pool. Pharmacy claims includes any claims which are paid through the pharmacy portion of the member's benefits.

Experience period Rx rebates are reflected in line 8 of Exhibit 3. These values were determined by calculating the rebates received as a percentage of Rx claim expense for each of the separate pools of data over the experience period.

Category for Rating	Rx Rebates	Rx Claims	Rebate %
ACA Compliant Small Group	($691,314)	$3,978,898	-17.4%
ACA Compliant Individual	($801,838)	$4,235,456	-18.9%
Total	($1,493,152)	$8,214,353	-18.2%

Line 9 of Exhibit 3 reflects MVP's ultimate liability for pharmacy claims during the experience period, which nets manufacturer rebates from the incurred claims paid by MVP.

Lines 10 to 12 reflect MVP's attempt to smooth the volatility inherent in claim pools due to large claims. To account for volatility in high cost claims, claims in excess of $100,000 are being removed from the claim projection and replaced by a pooling charge. The pooling charge of 13.7% was determined by computing the annual average cost of claims exceeding $100,000 relative to claims less than $100,000 for the eligible population for rolling 12-month time periods ending between December 2015 and December 2017.

Please see the following table for the high cost claim percentage by year. Note that while MVP actually used all of the rolling 12-month time periods during this time frame to compute the pooling charge, annual percentages are shown for simplicity:

Time Period	High Cost Claim %
CY2015	18.5%
CY2016	17.2%
CY2017	11.2%
Average	13.7%

Line 12 of Exhibit 3 reflects MVP's best estimate of the experience period FFS claim expense for the rating pool, and is calculated by summing the medical and dental FFS incurred claims completed with IBNR (line 6 of Exhibit 3), the pharmacy incurred claims net of rebates (line 9 of Exhibit 3) and the impact of pooling (sum of lines 10 and 11 of Exhibit 3).

Line 13 of Exhibit 3 reflects expenses for services such as capitations and other non-FFS medical expenses which come from MVP's General Ledger and are not processed through MVP's claims system. Please see the table below for detail on the items that comprise the capitation and non-FFS expenses reflected in MVP's experience period claims.

Summary of Experience Period Non-FFS and Capitation Amounts

Other Medical Expenses not in claim warehouse	$2.09
Net Reinsurance Expense	$0.24
Medical Home and PCP Incentive	$2.36
Chiropractic and Acupuncture Cap	$0.68
Total Non-FFS and Capitation Amounts	$5.37

*Note: VT Paid Claim Surcharge (0.999% of paid claims) and NY HCRA Surcharge (0.25% of paid claims) are not reflected in figures above. Line 13 of Exhibit 3 = line 12 of Exhibit 3 * 1.249% + the applicable value shown above.

Line 14 of Exhibit 3 represents MVP's best estimate of the costs incurred to cover members in the rating pool during the experience period.

Market-Wide Adjustments to Experience Period Claims

Three adjustments to the experience period incurred claim costs were necessary to adjust for items not captured in the experience period. The adjustments are explained below.

Adjustment for Average Policy Duration Reflected in Experience Period

MVP is making an adjustment to the claim projection for the impact of membership not representing a full 12-month contract over the experience period. Because deductibles are present in most of these products, paid claims are suppressed in the early months of a member's contract and are higher than average in later contract months. Therefore if the experience period membership is not evenly distributed by contract month, an adjustment to the claim costs should be made to reflect the expected claim costs for a 12-month contract period.

To determine the adjustment factor for the experience period claims cost, MVP used deductible suppression factors which were developed by analyzing commercial claims for members with 12 months of medical and Rx benefit coverage. MVP assumed that allowed claims were uniformly distributed by month and determined the expected paid claim cost for a given month relative to the average paid amount for 12 months. Factors were developed for several deductible levels, and MVP split its experience period membership by these deductible levels to compute the appropriate adjustment factors.

An upward adjustment was required for the ACA Compliant Small Group and Individual data due to MVP's membership in these pools being more heavily weighted towards earlier contract months. This is consistent with MVP's increasing membership over the time period.

The impact of this adjustment can be found in line 15 of Exhibit 3. Please see the attached file, "Coverage Month Adjustments 2019 Exchange SERFF.xlsx" which provides a calculation of these factors for each cohort.

Adjustment for Pharmacy Benefit Mandate
Between the 2018 Exchange filing and the current filing, new regulation was implemented regarding the use of statins for the prevention of cardiovascular disease (CVD) in adults which will go into effect in November 2017. The United States Preventive Service Task Force has given low- and moderate-dose statins a grade of "B" when prescribed to adults aged 40 to 75 with no prior history of CVD but evidence of risk factors. This means that it will become mandatory that carriers cover these drugs in full with no member cost sharing. Because these drugs were previously covered by MVP but with the applicable member cost sharing applied, an adjustment needs to be made to the experience period data to reflect the removal of cost sharing. MVP has estimated the cost sharing during the experience period based on member's age and a lack of a CVD diagnosis, and the result was a $0.28 PMPM increase to the experience period pharmacy incurred claims. This has been reflected in line 16 of Exhibit 3 in the rate filing.

Adjustment for Individual Mandate Penalty Set to $0
The federal government eliminated the financial penalty for individuals not having qualifying health insurance coverage in December 2017. It is assumed that a portion of members with claim costs that are significantly less than their premium will exit the market due to the lack of a financial penalty. As healthier members drop coverage, the overall cost of the market will increase as the remaining members are higher utilizers of their health coverage.

The state of Vermont consulted Lewis and Ellis (L&E) to provide a best estimate of the overall increase to the merged market due to healthier members exiting the rating pool. L&E's best estimate of the increase is 2.0% of premium, using actual enrollment and claims for members in the state. MVP is reflecting a 2.0% increase to the experience period claim cost to account for this but has reflected the impact only on individual members since small groups are likely unaffected by this change. This adjustment equals to 3.7% of individual claim costs and is displayed on line 17 of Exhibit 3.

Medical Trend Factors
The development of annual medical paid claim trend factors for 2018 and 2019 is illustrated in Exhibit 2a. Please note that MVP has broken out its medical claims into an additional service category this year, Other. This contains items such as Ambulance visits and Durable Medical Equipment and is consistent with the definition in the federal Unified Rate Review Template (URRT) instructions. In previous filings, those claims were included in the Outpatient bucket.

For VT providers whose contractual reimbursement changes are governed by the GMCB, MVP is reflecting the GMCB's most recently approved budgeted changes as the unit cost trend. For VT providers not governed by the GMCB and non-VT providers, MVP is reflecting its best estimate of unit cost changes. Total unit cost trend is 3.1% for 2018 and 3.3% for 2019.

MVP analyzed historical medical utilization trends for its VT block of business and determined that the data has been too volatile in recent years to include medical utilization trend in this filing. MVP attributes this volatility to the significant membership growth for this block of business. Historical utilization was analyzed by performing a regression analysis of rolling 12-month time periods normalized for demographic changes and by analyzing calendar year data normalized for risk score changes using Johns Hopkins' ACG model. Both analyses provided volatile results which resulted in MVP applying a medical utilization trend of 0% for this filing.

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.

The trend applied to the deductible portion of the experience period was derived using the distribution of claims for MVP's entire book of business (consistent with the data in MVP's benefit relativity model). 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.

The average annual allowed trend factor applied to FFS medical claims in this filing is 3.2%. The annual paid leveraging factor is 0.4% which results in an average annual paid FFS medical trend of 3.6%. This can be found in line 19 of Exhibit 3.

Rx Trend Factors

Annual allowed Rx trend factors split by generic, brand, and specialty drugs are illustrated in Exhibit 2a. The trend forecast provided by MVP's PBM was determined using MVP's Vermont commercial data by drug class. Small group and Individual data was not separated as these blocks alone would not have been credible enough to produce a reliable forecast. The forecasts provided by MVP's PBM account for drugs coming off patent, changes in average wholesale price, new drugs being released to the market, and price competitiveness amongst generic and brand drug manufacturers.

Supporting documentation illustrating how the Rx trends shown on Exhibit 2a were converted to paid trends for 2018/2019 can be found in Exhibit 2b.

MVP received 2019 forecasted Rx rebate information from its PBM which is reflected in the projected Rx rebate calculation. Separate rebate per script information has been provided for brand and specialty drugs. These amounts were applied to MVP's projection period brand and specialty script utilization to obtain a PMPM estimate of the rebates in the projection period and equals $16.93 PMPM across all blocks in 2019.

The average annual allowed Rx trend in this filing is 13.3%, and the average annual paid Rx trend net of Rx rebates is 12.5% which can be found in line 20 of Exhibit 3.

The Annual FFS Claim Trend Projection factor shown in line 21 of Exhibit 3 represents the blended FFS annual trend projection. To arrive at the blended trend projection shown in line 21, the following calculation is performed: [line 6 * line 19 + line 9 * line 20] / [line 6 + line 9]. The annual trend is then applied for 24 months to move the experience period data from the experience period to the rating period, and the rating period FFS claim expense on a PMPM basis is reflected in line 23 of Exhibit 3.

Paid Claim Surcharges, Capitation, and Non-FFS PMPM Projection

The paid claim surcharges, capitation, and non-FFS expenses shown in lines 24 and 25 of Exhibit 3 represents MVP's best estimate of these costs in the projection period. Capitation and non-FFS expenses that were included in the experience period claims which will not be covered in the projection period have been removed. A summary of the expenses driving the capitation and non-FFS expenses in line 25 can be found below. Expenses captured in the "Other Medical Expense not in warehouse" line include: student out of area charges, a surcharge levied by the state of Massachusetts, and manual checks.

Capitation and Non-FRDM Expense Reflected in Rate Filing	
Other Medical Expense not in warehouse	$2.51
Chiropractic and Acupuncture Cap	$0.71
Net Reinsurance Expense	$0.24
Medical Home and PCP Incentive (VT Blueprint)	$2.36
Total	$5.82

The NYS HCRA Surcharge of 0.25% included in these rates reflects the historical average amount of this surcharge for MVP's VT members. MVP is assuming that the VT paid claim surcharge will remain unchanged in 2019 and equal 0.999%.

Federal Risk Adjustment Program

Based on the Interim Risk Transfer results for 2017 provided by CMS, MVP is expected to pay $7,006,932 into the merged market transfer pool for 2017. This is $51.74 on a PMPM basis or approximately 15.0% of experience period claims prior to market-wide adjustments.

CMS made a change to the risk adjustment formula which will be reflected in 2019 risk transfer payments and is not captured in 2017 results. The change removes a percentage of the money paid into/out of the transfer pool to reflect the portion of premium which is not claim-related. This percentage is 14%, and MVP has multiplied its projected 2017 payment by 0.86 to reflect the projected payment for 2019 which resulted in an anticipated risk transfer payment equal to 12.9% of MVP's Paid Index Rate on line 26 of Exhibit 3. This amount is converted to a PMPM basis and reflected in line 27 on Exhibit 3.

Plan Level Adjustments / Plan Specific Net and Gross Index PMPM rates

Line 28 of Exhibit 3 represents MVP's projected paid index rate after adjustments for the single risk pool in 2019. This is the starting net claim cost that will be used to set 2019 premium rates. Gross Index rates and contract tier rates are calculated in Exhibit 7. The plan specific net claim cost for each plan is computed as follows on Exhibit 7:

Adjusted Claim Cost For Pricing (see Exhibit 7) = Projected Paid Index Rate After Adjustments PMPM (line 28 of Exhibit 3) / [Avg Inforce Actuarial Value * Induced Utilization Factor]

Plan Specific Net Claim Cost PMPM (see Exhibit 7) = Adjusted Claim Cost for Pricing * Benefit Actuarial Value * Plan Induced Utilization Factor

The Plan Specific Gross Claim Cost PMPM for each plan is derived by making adjustments to the Plan Specific Net Claim Cost PMPM which account for Benefits in Excess of EHBs, PMPM non-claim expense loads, and percent of premium non-claim expense loads.

Actuarial Values and Induced Utilization Factors

The AV Metal Level for each plan was determined using the Federal prescribed Actuarial Value Calculator. Adjustments for aggregate deductibles, the VT Rx OOPM, and safe harbor prescription Rx benefits were made to the calculator results for the non-standard plans. The actuarial certification of these adjustments has been included as an attachment to this filing in SERFF.

The Benefit Actuarial Value for each plan was determined using MVP's in house benefit relativity model. The pricing tools value the expected net paid claim cost associated with unique benefit plan designs from a starting single risk pool allowed amount. The AV is the ratio of the expected paid to allowed amount for each plan design. The induced utilization factors used to set premium rates and compute the average inforce induced utilization factor are sloped to comply with the HHS prescribed induced utilization factors of 1.00 for Bronze, 1.03 for Silver, 1.08 for Gold, and 1.15 for Platinum. The experience period actuarial value times induced demand factor (0.728) can be found in Exhibit 7.

Non Claim Expense Plan Level Adjustments

Non claim expenses include both percent of premium loads and PMPM loads. The loads do not vary by plan. Each Standard and Non Standard plan is being loaded with the same PMPM and Percent of Premium loads. The loads are outlined below and summarized in Exhibit 5.

Federal Taxes PMPM based

A total of $0.15 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis and includes the following taxes: $0.15 HHS risk adjustment user fee. This reflects an increase of $0.01 PMPM from the prior filing and is based on information provided in CMS' National Benefit and Payment Parameters for 2019. The Federal PCORI funding fee in the previous filing sunsets in 2019, so this has been removed from the current filing.

State Taxes PMPM Based

$0.91 PMPM is added for fees MVP must pay to the State of Vermont to help fund expenses incurred by the Green Mountain Care Board on MVP's behalf under 18 V.S.A § 9374 (h)(1). Under this "billback", a new structure has been proposed for FY 2019 by the GMCB. MVP is assuming this proposal will be in effect for 2019. The GMCB performed a study which estimated MVP's liability for the 2019 billback under the new proposal at $317,000. MVP has divided this amount by its February 2018 membership to get an estimate of the billback on a PMPM basis for 2019. Please see the attached document named "GMCB FY19 Billback Presentation.2018.02.14.HHC.Final.Final.pdf" which provides the results of this study.

Federal Taxes Premium based

The ACA Insurer Tax is been removed for 2019 coverage dates. MVP is not reflecting any federal taxes on a percent of premium basis in the rating period.

State Taxes Premium based – VT Vaccine Assessment

Based on discussions with the state of Vermont, the assessment to fund the vaccine pool in Vermont has been suspended for 2019. MVP is reflecting no state taxes on a percent of premium basis in the rating period.

General Administrative Expense Load (Including QI component)

The total administrative expense load included as a plan level adjustment equals $39.80 PMPM and is used to cover SG&A expenses as well as Quality Improvement/Cost Containment Programs (QI). Based on an analysis of MVP's 2017 expenses, 10% of MVP's total administrative expense was spent on QI. Therefore, $3.98 PMPM of the $39.80 PMPM administrative expense is attributable to QI.

The following table summarizes the administrative expenses for small group and individual lines of business from the 2015, 2016, and 2017 Statutory Supplemental Health Care Exhibits (SHCE).

Combined VT AR42 and AR44	Year	SHCE Admin PMPM*
Individual	2015	$36.66
Small Group	2015	$34.04
Combined	2015	$35.15
Individual	2016	$43.81
Small Group	2016	$38.07
Combined	2016	$40.51
Individual	2017	$38.54
Small Group	2017	$40.72
Combined	2017	$39.59

**Reflects lines 1.07, 6.6, 8.3, 10.1, and 10.4 of SHCE, Part 1*

Contribution to Reserves/Risk Charge

MVP is building a 2.0% contribution to reserves/risk charge into the VT Exchange premium rates for 2019. This charge is added to premium rates to meet statutory reserve requirements for MVP's VT block of business and protect against adverse experience relative to pricing assumptions.

Bad Debt Expense

A plan level adjustment equal to 0.60% of premium was added to account for non-payment of premium risk. This charge is increased from 0.40% the 2018 Exchange filing and is reflective of MVP's concern that the lack of an individual mandate will entice members to sign up for coverage, have services covered and then later forego coverage without paying premium.

Rider FRVT-301 (Wellness Benefit in Addition to EHBs)

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 $0.07 PMPM and is unchanged from the cost of this rider in 2018.

Catastrophic Plan 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.

MVP determined the adjustment factor for this plan by calculating the HHS Age factor for the eligible population and comparing it to the HHS Age 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 0.629 and is reflected in the "Induced Utilization Factor" adjustment of Exhibit 7 for this plan.

Catastrophic Plan Level Adjustment	
	HHS Age Factor
Ages 0-29, Meeting Subscriber Qualifications	1.047
Single Risk Pool Total	1.663
Catastrophic Adjustment	0.629

Per Contract Premium Rates

The Plan Specific Gross Claim Cost PMPMs computed in Exhibit 7 are converted to per contract premium rates using the computed single conversion factor and the prescribed standard load ratios.

The single conversion factor (SCF) was calculated using subscriber and member data by contract type for the eligible population enrolled with MVP as of February 2018. The SCF = weighted average contract size/ weighted average load ratio. Please see Exhibit 4 for the derivation of the SCF.

Silver CSR Loading

As stated previously, the Federal government has cancelled reimbursement of incurred claims under the CSR program effective October 2017. However, members are still eligible for the reduced cost sharing plans in the program, which will have to be covered by increasing premiums. The state of Vermont's solution to this problem was to create two sets of Silver plans: one set for non-CSR members with premiums that do not reflect the CSR defunding and one set for CSR members which reflect the CSR defunding in the premium. This was done so that the second-lowest cost Silver plan on the exchange would have an increased premium, which is the plan used to determine how much lower-income members will receive in premium subsidies through the federal Advance Premium Tax Credits (APTC) program. That way, premium increases for CSR defunding will be met with corresponding increases in APTC subsidies and the net policyholder premium increase will be minimized.

Total subsidies under the federal CSR program were $2,239,875 during the experience period for 28,665 member months, or $78.14 per federal CSR member per month. This is not the total member months for MVP members that *were eligible* for CSR plans, however, just members that actually purchased the plan. Because of the federal APTC program, members that were eligible for CSR plans could also forego the reduced member cost sharing of a CSR plan and buy a Bronze plan for little to no premium cost.

Increasing the second-lowest cost Silver plan, and therefore the APTC subsidies, has the side effect of making this incentive even greater - it will reduce the subsidized Bronze premium to nearly $0 PMPM for single subscribers that could enroll in the 77% CSR plan. Based on current calculations performed by MVP, it could also decrease the subsidized premium for the lowest cost Gold plans below what a member would pay for a CSR plan with increased cost sharing.

MVP performed an analysis of its single membership for 2017 and found that approximately 60% of CSR-eligible members between 250% and 300% of the Federal Poverty Limit were purchasing CSR plans. Because of the APTC leveraging effect, we are assuming that number will be cut in half in the rating period. MVP is also assuming no change to the members purchasing 87% and 94% CSR plans, as their coverage will be rich enough to entice them to stay.

MVP compiled the Federal CSR dollars from the experience period by CSR level on a PMPM basis. This was then multiplied by the projected CSR membership in the rating period to determine the premium needed to cover the projected CSR claims. This amount is $88.09 PMPM, found on line 3 of Exhibit 6. Please see the following table which details this calculation.

CSR Level	Federal CSR Dollars	CSR Membership, Experience Period	Federal CSR PMPM	Projected CSR Membership	Projected CSR Dollars
77% CSR	$186,396	8,561	$21.77	4,259	$92,730
87% CSR	$1,410,299	14,988	$94.10	14,988	$1,410,299
94% CSR	$643,179	5,116	$125.72	5,116	$643,179
TOTAL	$2,239,875	28,665	$78.14	24,363	$2,146,209
				Projected CSR PMPM	$88.09

This amount was then completed with IBNR and trended at 1.5% for 24 months to get to a projected CSR load of $94.66 PMPM for the rating period. The 1.5% trend reflects the allowed trend for claims between the average CSR deductible and the average deductible of the non-subsidized plan. This amount can be found in line 8 of Exhibit 6 of the rate filing as well as in the rate buildup of the on-exchange Silver plans.

Loss Ratio Information

The traditional target loss ratio (claims cost / premium) for the rates proposed in this rate filing is 89.2%. After making adjustments for taxes/assessments and expenses associated with quality improvements, the Federal target loss ratio for the rates proposed in this filing is 90.2%. Please see the following table for a calculation of these loss ratios:

Target Loss Ratio for 2019 VT Exchange	
A) Claims Expense	$441.95
B) Taxes/Assessments	$1.06
C) Quality Improvement	$3.98
D) Premium	$495.70
E) Traditional Loss Ratio *= A) / D)*	89.2%
F) Federal Loss Ratio *= [A) + C)] / [D) - B)]*	90.2%

Please see the table below for a summary of the experience period loss ratios for the separate pools of data. Please note that the data presented below does not reflect the impact of the Federal Risk Adjustment or Risk Corridor programs. MVP does not anticipate having to rebate members for 2017 per the ACA minimum MLR requirements because of its estimated risk adjustment liability.

VT Data Pool	Member Months	Total Claims PMPM	Earned Premium PMPM	Taxes / Assessments PMPM	Quality Improvement Expense	Traditional Loss Ratio	Federally Adjusted Loss Ratio
ACA Compliant Small Group	55,568	$381.77	$449.01	$2.58	$3.51	85.0%	86.3%
ACA Compliant Individual	79,856	$312.68	$440.21	$2.53	$3.51	71.0%	72.2%
Small Group + Individual Single Risk Pool	135,424	$341.03	$443.82	$2.55	$3.51	76.8%	78.1%

Actuarial Dataset, Rate Increase Exhibit, URRT, and Federal Memorandum

Also included with this rate filing are L&E's Actuarial Dataset, a projection of rate increases for ACA compliant subscribers as of February 2018, the Federal URRT, and the Federal Actuarial Memorandum.

Projection Period Enrollment

MVP's projection period membership equals the February 2018 enrollment of the population eligible to purchase these products, or 25,223 members. On Worksheet 2 of the URRT, members are mapped based on their February 2018 benefit to the same benefits for 2019 with the exception of Silver members who are not purchasing a CSR plan. Those members are mapped to their same benefit design, but the "reflective" off-exchange version.

Actuarial Certification

I, Eric Bachner, am an Associate of the Society 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. The proposed premium rates were developed based on currently approved State and Federal regulations and statutes. If modifications are made to State or Federal regulations or statutes for the 2019 plan year after this filing is submitted, including but not limited to changes to the enforcement of the individual mandate or changes to rules around selling across state lines or association groups, the proposed premium rates may not be reasonable relative to the benefits being offered and could result in inadequate premium rates. If such modifications are made, MVP will pursue an adjustment to the proposed premium rates to reflect the regulations and statutes that will be in place for the 2019 plan year.

I certify that each rate filing has been prepared in accordance with the following Actuarial Standards of Practice; ASOP #5, ASOP#8, ASOP #12, ASOP #23, ASOP #25, ASOP#41, ASOP#42, ASOP#45, and ASOP#50.

_____ 05/09/2018

Eric Bachner, ASA Date
Senior Actuarial Analyst
MVP Health Care, Inc.