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Company Information

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ACTUARIAL MEMORANDUM
2021 Vermont Exchange Filing

Purpose and Scope of Filing

This memorandum details the methods and assumptions underlying the proposed 2021 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 1/1/2021 and 12/31/2021. There are no benefit plans being retired, nor are there any new benefit plans being added. MVP modified several the benefits being offered, and the updated forms have been submitted in a separate SERFF filing. The rate increase including on-exchange Silver members (MVP's revenue increase) is 7.3%, with increases ranging from 0.5% to 9.5%.

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 (2021)). 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 in 2020, 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.

Exhibit 1A of the filing provides an overview of benefit changes for renewing plans from 2020 to 2021. As noted in the rate filing document, design changes from the previous year's plan design are shaded in gray.

All Essential Health Benefits (EHBs) are covered. Only one EHB substitution was made as required by the 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: FRVT366.

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 14,848 policyholders, 23,782 subscribers and 36,980 members based on February 2020 membership.

Experience Period Claims

MVP Health Plan historical claim data was the basis of the premium rate development. All ACA compliant individual and small employer group data are included in the experience period data set.

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 1/1/19 and 12/31/19, paid through 2/29/20. MVP has restated its incurred medical claim estimates to complete the claims through 3/31/20.

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 ACA compliant 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 2.4% which is our best estimate of ultimate liabilities as of 3/31/20. MVP uses a combined trended PMPM and completion factor method to value its ultimate claim liabilities. Note that the model used to calculate IBNR for this block of business includes all Vermont business, so the paid and incurred claims below will not match the paid and incurred claims in the filing. 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
201912	$10,119,416	$11,743,963	1.161
201911	$10,776,918	$11,521,206	1.069
201910	$11,662,988	$12,081,473	1.036
201909	$11,182,138	$11,322,827	1.013
201908	$10,858,640	$10,940,513	1.008
201907	$11,064,530	$11,112,628	1.004
201906	$10,559,629	$10,589,170	1.003
201905	$12,038,345	$12,059,192	1.002
201904	$11,255,116	$11,275,409	1.002
201903	$11,663,650	$11,685,456	1.002
201902	$9,500,237	$9,499,191	1.000
201901	$11,011,331	$11,017,826	1.001
Total	$131,692,938	$134,848,855	1.024

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	($3,047,079)	$12,870,055	-23.6%
ACA Compliant Individual	($2,727,581)	$11,114,006	-24.5%
Total	($5,774,660)	$23,984,062	-24.1%

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 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 12.4% 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 the experience period as well as the two preceding calendar years (2019, 2018, 2017). Please see the following table for the high cost claim percentage by year:

Time Period	High Cost Claim %
CY2017	13.6%
CY2018	11.1%
CY2019	12.3%
Average	12.4%

Line 12 of Exhibit 3 reflects MVP's 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	$1.15
Net Reinsurance Expense	$0.48
Medical Home and PCP Incentive	$2.93
Total Non-FFS and Capitation Amounts	$4.56

*Note: VT Paid Claim Surcharge (0.999% of paid claims) and NY HCRA Surcharge (0.15% of paid claims) are not reflected in figures above. Line 13 of Exhibit 3 = line 12 of Exhibit 3 * 1.149% + the applicable value shown above.

The line "Chiropractic and Acupuncture Cap" from this table in the 2020 filing has been removed. MVP is working toward carving these services back into our network and the FFS equivalent claim amounts have been reflected in the experience period claim data in Line 2.

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 after making the adjustments described above.

Market-Wide Adjustments to Experience Period Claims

Several 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.

Line 15- Adjustment for Pharmacy Benefit Carve-in

For plans that are considered Qualified High-Deductible Health Plans (QHDHPs), certain drugs are classified as preventive and are not subject to the member's deductible. MVP will be classifying antidepressants and antipsychotic/antimanic agents as "preventive" effective January 1, 2020.

Quantifying the effect of this benefit change takes place in two steps. First, MVP analyzed 2019 pharmacy claims that fall under those categories. In the experience period, QHDHP members spent $86,499 under their deductible for these drugs, which was then converted to a PMPM amount using total membership for each cohort in the experience period. These amounts are $0.12 for individual and $0.35 for small group and are reflected on line 15.

The second step was to adjust the benefit actuarial values to ensure that this load was only applied to QHDHPs. MVP adjusted the historical data in its benefit relativity model to capture these drugs as preventive before the benefit AVs were calculated. This loads the cost of covering the preventive drugs discussed above onto just the QHDHPs, as those plans have a higher relativity in the rating period than they did in the experience period.

Line 16- Adjustment for Medical Safe Harbor Coverage on QHDHP's

In July of 2019, the Internal Revenue Service released IRS Notice 2019-45, which allowed for the coverage of specific medical services and items before the deductible on QHDHPs. MVP analyzed the claim cost for QHDHPs from the entire commercial population for the services not currently covered under the Safe Harbor provision and found that the additional claim expense will be worth $0.23 for small group and $0.09 for individual.

The benefit actuarial values were then adjusted in a similar manner to the adjustment described in line 15 above, in order to ensure that the additional claim cost was reflected specifically on the QHDHP benefit designs for 2021.

Line 17- Adjustment for COVID-19 Immunization Cost

MVP is assuming that a vaccine to prevent the novel coronavirus (COVID-19) will be tested and widely available in 2021. To account for the costs an immunization would add to claim cost, MVP is assuming that an immunization would be covered in full at the cost of $75 per dose. MVP is also assuming that 80% of the population would obtain the vaccine (based on an analysis published by Wakely Consulting), which corresponds to a PMPM claim cost of $5.00 PMPM ($75 per dose times 80% utilization PMPY divided by 12 months). This adjustment is reflected on line 17 of Exhibit 3.

Line 18- Adjustment for COVID-19 Pent-up Demand

As a result of the COVID-19 pandemic, elective surgeries and associated services have been postponed for effectively all of MVP's service area. As of the time of the filing, both Vermont and New Hampshire have announced that they are allowing the ramp up of elective procedures again. Therefore, MVP is assuming that 2 months of elective surgeries have been canceled in 2020.

MVP analyzed its entire commercial population for 2019 and found that the claim cost related to elective services was $45.09 PMPM. To value what the delay of these elective services will be worth in 2021, MVP made the following assumptions:

- Resumption of a normal level of elective services will begin in mid-May 2020
- Twenty percent (20%) of elective services deferred during the 2 months will be eliminated
- In order to recoup lost revenue, beginning in August 2020 providers will perform 110% of their prior elective service volume until deferred services were fully performed

These assumptions combine to add $4.51 PMPM in claim cost for the time period of January to April 2021 (at which point all deferred services will be made up and providers will return to normal utilization levels). MVP is reflecting $1.50 PMPM ($4.51 PMPM for 4 months, converted to an annual PMPM) in this filing to account for the increased utilization.

Line 19- Adjustment for National High Cost Reinsurance Pool
In the 2021 Notice of Benefit and Payment Parameters issued by HHS, carriers will be compensated 60% for members' paid claims above $1 million in a given plan year. The total reinsurance received across all states will be aggregated and compared to the national average premium PMPM to determine a percentage of premium charged to each issuer to fund the program. Based on additional guidance provided, Vermont's merged market will be considered in the individual market for purposes of the pool.

Based on a national study performed by Wakely Consulting Group, the estimate of the load charged to individual issuers in 2021 will be 0.28%. MVP has not had any claimants above $1 million in this block of business since 2014 and does not anticipate any claimants for the rating period, so the net load for MVP would be the full 0.28% shown on line 19.

Medical Trend Factors
The development of annual medical paid claim trend factors for 2020 and 2021 is illustrated in Exhibit 2a.

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 2020 and MVP's best estimate of future budgeted changes for 2021. For VT providers not governed by the GMCB and non-VT providers, MVP is reflecting its best estimate of unit cost changes. Total allowed unit cost trend is 3.8% for 2020 and 6.1% for 2021.

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 use for medical utilization trend purposes. MVP attributes this volatility to the significant membership growth for this block of business. During the previous year's filing, "L&E [Lewis & Ellis Actuaries and Consultants] performed a series of independent trend calculations using market wide utilization data from 2015 to 2018" and found that "After assessing all the market wide results, L&E believes that a reasonable range for market wide utilization trend to be 1% to 4%" (L&E Actuarial Memo, SERFF # MVPH-131934219, page 7). Because MVP believes that their data still lacks necessary stability and L&E's view of utilization trend encompasses the entire market, MVP has built in a 1% annual utilization trend 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 6.0%. The annual paid leveraging factor is 0.7% which results in an average annual paid FFS medical trend of 6.7%. This can be found on line 21 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. 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. In addition to the market trend data provided by the PBM, MVP is also reflecting its best estimate of known contract changes for 2020 and 2021. Those contract changes are reflected in the unit cost trends shown on Exhibit 2a.

Supporting documentation illustrating how the Rx trends shown on Exhibit 2a were converted to paid trends for 2020 and 2021 can be found in Exhibit 2b.

To project rebates, MVP has taken the experience period rebates as a percentage of the experience period allowed claims (20.6%) and applied that percentage to the rating period allowed claims. This represents MVP's best estimate of future rebates that will be shared between the PBM and MVP.

The average annual allowed Rx trend in this filing is 7.3%, and the average annual paid Rx trend net of Rx rebates is 8.3% which can be found in line 22 of Exhibit 3.

The Annual FFS Claim Trend Projection factor shown in line 23 of Exhibit 3 represents the blended FFS annual trend projection. To arrive at the blended trend projection shown in line 23, the following calculation is performed: [line 6 * line 21 + line 9 * line 22] / [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 25 of Exhibit 3.

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

The paid claim surcharges, capitation, and non-FFS expenses shown in lines 26 and 27 of Exhibit 3 represent 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 27 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.

Summary of Rating Period Non-FFS and Capitation Amounts	
Other Medical Expenses not in claim warehouse	$1.49
Net Reinsurance Expense	$0.48
Medical Home and PCP Incentive	$2.93
Total Non-FFS and Capitation Amounts	$4.90

After analyzing historical data on Vermont's small group and individual population, MVP has determined that the NYS HCRA Surcharge of 0.25% included in last year's filing can be reduced to 0.15% for the 2021 filing. MVP is assuming that the VT paid claim surcharge will remain unchanged in 2021 and equal 0.999%.

Federal Risk Adjustment Program

Based on the Interim Risk Transfer results for 2019 provided by CMS, MVP is expected to pay $22,492,428 into the merged market transfer pool for 2019. This is $62.56 on a PMPM basis or 15.80% of experience period claims prior to market-wide adjustments. To calculate line 29 of Exhibit 3, MVP then applied this risk adjustment payment as a percentage of claim expense to line 28 of Exhibit 3, which the best estimate of the rating period claim expense. This results in an estimated payment of $72.84 PMPM or $26,187,563 using experience period membership.

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

Line 30 of Exhibit 3 represents MVP's projected paid index rate after adjustments for the single risk pool in 2021. This is the starting net claim cost that will be used to set 2021 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 30 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 adjusting 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 Federally 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 in-force 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 (0.7963) 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 $0.18 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis. This is comprised of the risk adjustment user fee levied by the Department of Health and Human Services. 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 2021. The charge is $0.19 per billable member per month, and so the amount added to premium rates is the $0.19 times MVP's ratio of billable to actual member months in the experience period (0.948).

State Taxes PMPM Based
$1.84 PMPM is added for fees MVP must pay to the State of Vermont to help fund expenses incurred by state agencies and other non-profit organizations on MVP's behalf, including the Green Mountain Care Board, the Vermont Program for Quality in Health Care, Inc. and the Office of the Health Care Advocate. This is found by using the best available information about the market-wide cost of each of the programs and then accounting for MVP's growth in market share from 2019 to 2021.

Federal Taxes Premium based
Based on current Federal regulations, the ACA Health Insurer Tax has been repealed for 2021 and future years. Therefore, MVP has removed the 1.0% of premium load from the prior year's filing. MVP is reflecting 0.0% for Federal Taxes as a percent of premium for 2021.

State Taxes Premium based – VT Vaccine Assessment
Based on information provided by the Vermont Vaccine Purchasing Program (VVPP), MVP's rates are $9.26 per covered child and $0.96 covered adult for January to March 2021, followed by an estimate of $10.60 per covered child and $1.09 per covered adult thereafter. Based on a blend of MVP's child and adult membership in the projection period, the total PMPM costs are $1.86 for the first quarter of 2021 followed by $2.12 PMPM for the final three quarters. MVP blended those two PMPMs together by applying 25% weight to the first quarter and 75% weight to the final three quarters. This blended PMPM was then compared to the projection period premium PMPM before the assessment load ($600.10) to convert the assessment to a percent of premium load of 0.34%.

General Administrative Expense Load (Including QI component)
The total administrative expense load included as a plan level adjustment equals $43.75 PMPM and is used to cover SG&A expenses as well as Quality Improvement/Cost Containment Programs (QI). MVP's best estimate of the premium load to cover base administrative expenses for 2021 is $43.26 PMPM. In response to the COVID-19 pandemic, MVP has begun to allow small groups to pay their premiums via credit card. This policy is slated to continue in 2021, so MVP needs to include estimated credit card fees incurred by MVP into the administrative costs. MVP is assuming that 10% of small group premiums will be paid via credit card at a fee of 2.8% premium. This translates to $0.49 PMPM across all individual and small group members.

Based on an analysis of MVP's historical Supplemental Health Care Exhibit (SHCE) expenses, approximately 6% of MVP's total administrative expense was spent on QI. Therefore, $2.60 PMPM of the $43.26 PMPM administrative expense (ignoring the new expense) is attributable to QI.

The following table summarizes the administrative expenses for small group and individual lines of business from the 2017, 2018, and 2019 SHCEs compared to the available admin expense built into the rates for the same time period:

Combined VT AR42 and AR44	Year	Exchange Available Admin PMPM	SHCE Admin PMPM*
Individual	2017	N/A	$38.54
Small Group	2017	N/A	$40.72
Combined	2017	$36.60	$39.59
Individual	2018	N/A	$42.78
Small Group	2018	N/A	$39.29
Combined	2018	$38.10	$40.72
Individual	2019	N/A	$41.04
Small Group	2019	N/A	$38.84
Combined	2019	$39.80	$39.86

**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 1.5% contribution to reserves/risk charge into the VT Exchange premium rates for 2021. 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 0.40% of premium was added to account for non-payment of premium risk.

Rider FRVT366 (Wellness Benefit in Addition to EHBs)
Members purchasing a non-standard plan will receive MVP's Member Wellness Incentive (Form: FRVT366). This is an enhancement to the current wellness benefit whereby primary subscribers can earn up to $600 in wellness-related rewards and/or be reimbursed for wellness-related activities. MVP projects the net cost of this benefit to equal $0.88 PMPM which is unchanged from the prior year.

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 0.630 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	1.048
Single Risk Pool Total	1.663
Catastrophic Adjustment	0.630

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 2020. 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 $5,372,118 during the experience period. In order to determine the expected federal subsidy outlay during the rating period, experience period federal CSR dollars by CSR level are re-weighted based on actual February 2020 membership as this calculation reflects MVP's best estimate of the members expected to enroll in on-Exchange Silver plans during the rating period. Please see the following table which details this calculation:

CSR Level	Federal CSR Dollars	CSR Membership, Experience Period	Federal CSR PMPM	Projected CSR Member Months	Projected CSR Dollars
Non-CSR APTC	$0	6,064	$0.00	6,768	$0
73% CSR	$0	4,718	$0.00	5,136	$0
77% CSR	$313,154	14,034	$22.31	14,580	$325,337
87% CSR	$3,477,460	32,547	$106.84	34,224	$3,656,637
94% CSR	$1,581,505	10,951	$144.42	12,036	$1,738,197
TOTAL	$5,372,118	68,314	$78.64	72,744	$5,720,172
				Projected CSR PMPM	$78.63

This amount was then completed with IBNR and trended at 1.3% for 24 months to get to a projected CSR load of $82.56 PMPM for the rating period. The 1.3% 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 90.1%. After adjusting for taxes/assessments and expenses associated with quality improvements, the Federal target loss ratio for the rates proposed in this filing is 91.1%. Please see the following table for a calculation of these loss ratios based on MVP's projected starting claim cost in 2021:

Target Loss Ratio for 2021 VT Exchange	
A) Claims Expense	$533.95
B) Taxes/Assessments	$3.86
C) Quality Improvement	$2.60
D) Premium	$592.82
E) Traditional Loss Ratio *= A) / D)*	90.1%
F) Federal Loss Ratio *= [A) + C)] / [D) - B)]*	91.1%

Please see the table below for a summary of the experience period loss ratios for the separate pools of data. This table includes estimated risk adjustment based on the CMS Interim Risk Adjustment results. MVP does not anticipate having to rebate members for 2019 per the ACA minimum MLR requirements.

VT Data Pool	Member Months	Claims Net RA PMPM	Earned Premium PMPM	Taxes / Assessments PMPM	Quality Improvement Expense	Traditional Loss Ratio	Federally Adjusted Loss Ratio
ACA Compliant Small Group	190,655	$465.25	$490.73	$1.06	$1.93	94.8%	95.4%
ACA Compliant Individual	168,861	$494.68	$523.63	$1.06	$2.37	94.5%	95.1%
Small Group + Individual Single Risk Pool	359,516	$479.07	$506.18	$1.06	$2.14	94.6%	95.3%

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 2020, the Federal URRT, and the Federal Actuarial Memorandum.

Projection Period Enrollment

MVP's projection period membership equals the February 2020 enrollment of the population eligible to purchase these products, or 36,980 members. On Worksheet 2 of the URRT, members are mapped based on their February 2020 benefit to the same benefits for 2021.

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 2021 plan year after this filing is submitted, including but not limited to changes to the enforcement of the individual mandate, changes to rules around selling across state lines or association groups and changes to cost sharing due to the COVID-19 pandemic, 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 2021 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.

_____ 05/08/2020

Eric Bachner, ASA Date
Leader, Actuarial, Commercial/Gov't Programs
MVP Health Care, Inc.