PRIMMER PIPER EGGLESTON & CRAMER PC
ATTORNEYS AT LAW
30 Main Street, Suite 500| P.O. Box 1489 |Burlington, VT 05402-1489

GARY F. KARNEDY
ADMITTED IN VT AND NH
gkarnedy@primmer.com
TEL: 802-864-0880
FAX: 802-864-0328

July 7, 2020

VIA E-MAIL ONLY – Michael.Barber@vermont.gov

Michael Barber, Esq.
General Counsel
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan, Inc. 2021 Vermont Health Connect
Rate Filing – Docket No. GMCB-006-20rr

Dear Hearing Officer Barber:

On behalf of MVP Health Plan, Inc., attached please find the *[CONFIDENTIAL] MVP's Prefiled Testimony* and *[REDACTED] MVP's Prefiled Testimony* and *Certificate of Service.*

Respectfully submitted,

/s/ Michelle T. Bennett

Michelle T. Bennett

Cc: ***(VIA E-MAIL ONLY)***
Kaili Kuiper, Esq., kkuiper@vtlegalaid.org
Eric Schultheis, Esq., ESchultheis@vtlegalaid.org
Christina McLaughlin, Christina.McLaughlin@vermont.gov
Amerin Aborjaily, Esq., Amerin.Aborjaily@vermont.gov
Thomas Crompton, Thomas.Crompton@vermont.gov

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2021	)	
Vermont Health Connect Rate Filing	)	Docket No. GMCB-006-20rr
	)	
SERFF No. MVPH-132371260	)	
	)	

PREFILED TESTIMONY OF MATT LOMBARDO

1. WITNESS QUALIFICATIONS AND BACKGROUND

Q1: Please state your name and employer for the record.

A1: Matthew Lombardo, I work for MVP Health Care.

Q2: What is your position at MVP Health Care?

A2: Senior Leader of actuarial services. *See* ***Exhibit 8***, Matt Lombardo's CV.

Q3: The filing was authored by MVP Health Plan, Inc.? What is MVP Health Plan, Inc. and how does it relate to MVP Health Care?

A3: MVP Health Plan, Inc. is MVP's Health Maintenance Organization ("HMO") subsidiary. It is a legal entity, a non-profit HMO company that falls under the umbrella company of MVP Health Care.

Q4: Are you a member of any professional associations?

A4: Yes. I am a fellow in the Society of Actuaries and a member of the American Academy of Actuaries.

Q5: How long have you been employed in the health insurance industry?

A5: Approximately 15 years.

Q6: What are your job duties as Senior Leader of actuarial services?

A6: In addition to overseeing premium rate setting, I am also responsible for reserving our incurred but not reported amounts ("IBNR"), financial forecasting, financial competitive intelligence, and value-based contracting or risk share arrangements with provider groups.

2. RATE FILING SUMMARY

Q7: What is MVP's average proposed rate increase for 2021?

A7: 7.3%. *See* ***Exhibit 1***, 2021 MVP Rate Filing 2021 Rate Filing, p. 112.

Q8: What is the book of business affected by this rate filing?

A8: 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. *See* ***Ex. 1***, p. 112.

Q9: Can you explain the difference between those categories?

A9: Policyholders are contract holders, such as an employer. Subscribers are the contract holder for a parent-child or family contract. Members are individual insureds.

Q10: Can you explain the CSR subsidy program?

A10: The CSR subsidy program is a feature of the ACA designed to alleviate some of the pressure of cost sharing for policyholders in the individual market that meet certain income criteria. Cost sharing refers to deductibles, co-insurance or copays. Both the federal government and the State of Vermont funded the CSR program initially, but in 2017 the federal government stopped funding the program. MVP is an opt-in class member of the CSR reduction class action captioned *Common Ground Healthcare Coop. v. United States*, 142 Fed. Cl. 38 (2019). In that case, MVP seeks monetary damages for amounts due to MVP for the cost-sharing payments MVP did not receive from the federal government in 2017 and 2018. That case is currently before the United States Court of Appeals for the Federal Circuit and remains pending. Generally, because of COVID-19, courts have been delayed in deciding cases. At this time, it is unknown when MVP will receive a decision. The Government and MVP have also begun the CSR reconciliation process for 2019 CSR payments that have not been paid to MVP but have not yet come to an agreement on the amount of 2019 reconciliation payments. *See* ***Exhibit 4***, 2020 MVP Responses to GMCB Interrogatories (Non-Actuarial), p. 1-2.

Q11: Can you summarize what benefits are covered by the 2021 plans?

A11: All Essential Health Benefits ("EHBs") are covered. EHBs are a list of benefits defined by the Affordable Care Act ("ACA") as a means to ensure that adequate services are rendered and covered under ACA compliant insurance policies.

Q12: Can you explain the difference between standard and non-standard plans?

A12: Standard plans provide consumers with an apples-to-apples shopping experience between carriers. Non-standard plans give the carriers the ability to offer different products, such as different cost sharing elements (deductibles or copays), or to offer additional benefits.

Q13: What is MVP proposing for contribution to reserves in 2021?

A13: MVP is building a 1.5% contribution to reserves/risk charge into the VT exchange premium rates for 2021.

Q14: And what did MVP propose last year?

A14: 1.5%.

Q15: Describe MVP's Wellness Plan?

A15: MVP's dedication to the wellness of our members is reflected in offering a benefit in our non-standard products that covers up to 600 dollars of reimbursement to subscribers that meet certain wellness criteria.

3. NON-ACTUARIAL STATUTORY CRITERIA (8 V.S.A. §4062): AFFORDABLE, PROMOTES QUALITY CARE, PROMOTES ACCESS TO HEALTH CARE.

Q16: What steps has MVP taken to lower costs and establish that its proposed rates promote affordability, access to care and quality of care for Vermonters?

A16: MVP has taken multiple steps, including but not limited to:

1. MVP strives to put forth the lowest premium possible relative to the benefits we are covering, which has resulted in growth in our market share in Vermont.
2. MVP promotes an affordable rate with a quality product.
3. MVP maintains its premium rate advantage against Blue Cross Blue Shield.
4. MVP supports Vermont providers in achieving quality for its members through the Marketplace Primary Care Improvement Program. See Q & A 18.
5. MVP promotes primary care. See Q & A 19.
6. MVP employs a comprehensive staff of clinicians. See Q & A 20.
7. MVP administers over 10 specific care management programs directly with our members. See Q & A 21.
8. MVP engages in a competitive bidding process. See Q & A 22.
9. MVP contracts with a Pharmacy Benefit Manager ("PBM"), to get the best prices on prescription pharmaceuticals. See Q & A 25.
10. MVP undertakes an annual initiative focused on reducing administrative costs. See Q & A 22.
11. MVP has sought to increase member engagement and cost transparency via its website. See Q & A 26.
12. MVP supports the use of telemedicine. See Q & A 17.
13. MVP has created special enrollment period guidelines and a user-friendly website to help Vermonters who did not start coverage during the open

enrollment period determine if they are eligible for a special enrollment period and how they can obtain coverage outside of open enrollment.

14. MVP maintains a nationwide network of providers. See Q & A 29.

15. MVP offers both standard and non-standard plans, See Q & A 27.

16. MVP has a dedicated unit that investigates fraud. See Q & A 22.

17. MVP has met with Vermont Health Connect and Blue Cross Blue Shield of Vermont to discuss and create consumer outreach programs. See Q & A 27.

18. MVP has robust evidence-based guidelines such as MVP's Medical Policies and Utilization Management Program designed to decrease unwarranted variations in care and support appropriate utilization. These medical policies undergo continuous review and are vetted by community physicians throughout our service area. Vermont physicians serve as representatives on MVP's Medical Management Committee, Pharmacy and Therapeutics Committee, and Quality Improvement Committee.

19. MVP supports and guides taxpayers who may be eligible for premium assistance, cost-sharing incentives or subsidies. See Q & A 28.

20. MVP reduces out-of-pocket costs for enrollees earning from 100% to 300% of the federal poverty level through cost sharing reductions. See Q & A 28.

21. MVP's New York and Vermont business is accredited by The National Committee for Quality Assurance (NCQA), which employs a set of more than 60 quality standards and requires reporting in more than 40 areas.

MVP believes that it offers quality services and that the providers with which it has contracted are high performing.

[redacted]

Q17: How has telehealth been promoted and supported by insurers this year because of COVID-19 and how will its continued use improve quality, access, and affordability?

A17: The following response was prepared with the help of our Clinical and Marketing teams. New York State was one of the earliest areas affected, and as such, we feel we have been aggressive and extremely proactive in our response from its earliest days. As a result, we were quite well positioned for the decisions that later came from Vermont Department of Financial Regulation, as we had already implemented across our network much of what was ultimately placed into regulation.

The MVP website provides a detailed summary of all of the changes MVP has made in response to COVID-19 to date as well as detailed coding guidance. See https://www.mvphealthcare.com/providers/covid19.

Since the beginning of this pandemic response, the MVP approach has been three-fold:

1. Maintain seamless access to all needed care for our members;
2. Maintain optimal level of service and access to health insurance functions for members and providers; and,
3. Support providers in their ability to provide care to their patients, our members.

MVP made a business decision to waive cost share for ALL Telemedicine services. We were well positioned to help Primary Care Providers ("PCPs") and other physicians in our network to be able to provide their own telemedicine services because we had already put telemedicine and telehealth reimbursement policies in place back in January. We were able to quickly ramp up what providers were able to do and get paid for as the telehealth regulatory restrictions were relaxed regarding HIPAA compliance requirements and allowance for telephone only visits.

Telephone only visits were allowed initially for mental health providers, given the nature of the care they provide, and in addition, effective March 13, 2020, in Vermont, physical health providers were also included for coverage of audio only visits. Medicare and the Centers for Medicare & Medicaid Services ("CMS") continue to require use of CMS telephone codes for Medicare members.

We have communicated with Vermont doctors and providers about the relaxation of telehealth restrictions including that during the state of emergency:

1. Existing patient relationship NOT required;

2. HIPAA still paramount, but non-HIPAA compliant, non-public facing platforms such as Apple FaceTime, Google G Suite Hangouts Meet, Skype for Business are allowed;
3. Rates are the same as in person visits, based on Provider Agreement;
4. Services can be provided in any state, as long as member is active and provider is participating with MVP; and,
5. Physical therapists, occupational therapists, speech therapists, and Certified Athletic Trainers may render telemedicine services to MVP commercial members.

We quickly stood up myErNow, a virtual emergency room telemedicine service, powered by United Concierge Medicine that allows MVP members to connect 24/7 with trained emergency providers from the comfort of their home. We have been directing members who have symptoms of COVID-19 to use this service first, to help ensure people can remain safely in the home as well as to prevent unnecessary surge on the Vermont healthcare system. We continue to provide myVisitnow, telemedicine services to our membership which provides access to a national network the Online Care Group for urgent care, Behavioral Health/Psychiatry, Nutrition, and lactation consultation needs. We are encouraging this for our members at low risk for COVID-19 with other urgent care needs.

In an effort to increase public awareness of telemedicine resources during the COVID-19 pandemic, MVP created a new, brand-agnostic, public service website called www.TryTelemedicineFirst.com; a directory of available telemedicine services throughout NY and VT. It can be searched by health insurance company name, or by zip code. When

searching by zip code, the user will be served up information on hospitals and providers that offer telemedicine services.

MVP telemedicine website traffic from **January 1, 2020 through June 10, 2020**:

- **mvphealthcare.com/myVisitNow:** 6,000+ Users and 9,200 Sessions (this represents a year over year increase of approximately 300% in users and 145% increase in sessions).
- **myVisitNow.com:** 24,000 Users and 28,000 Sessions (a year over year increase of 600% in Users and 435% in Sessions)
- **mvphealthcare.com/myERnow (launched on March 10, 2020):** 2,800 Users and 3,500+ Sessions
- **TryTelemedicineFirst.com (launched on April 14, 2020):** 815 Users and 975 Sessions)

Information on COVID-19, telemedicine options, and coverage information is updated regularly on **mvphealthcare.com/COVID19**. MVP launched the site on March 10, 2020. As of June 10, 2020, the site had more than 12,000 Users and 15,000 Sessions.

Q18: How does MVP promote affordability, quality and access in primary care?

A18: The following response was prepared with the help of our Clinical team. MVP incentivizes and supports Vermont providers to achieve quality for its members through the Marketplace Primary Care Improvement Program in which Vermont providers are eligible to receive a dollar amount based on their overall score for specific quality measures. [redacted]

[redacted]

Q19: How does MVP promote affordability by encouraging strong relationships with PCPs?

A19: The following response was prepared with the help of our Clinical team. MVP is a strong believer that primary care should be central to a patient's medical experience because having a consistent relationship with a PCP can avoid future higher costs. Regular contact with a PCP helps establish a relationship where efficiencies are created because the PCP knows your medical history, and the PCP can delegate or refer care in the most efficient way possible. MVP aligns fees to increase access to primary care physicians in the community and makes efforts to incentivize members to seek care from primary care physicians. MVP is hopeful that our entry into a shared savings arrangement with OneCare will further strengthen the relationships between MVP, PCPs, and members.

Q20: How does MVP's hiring and use of clinician staff improve affordability, quality and access to care?

A20: The following response was prepared with the help of our Clinical team. MVP offers medical and behavioral health care management programs to members tailored to their needs. Drawing on the combined strengths of our registered nurses, social workers, respiratory therapists, behavioral health professionals, wellness teams, physicians, pharmacists and community providers, MVP provides a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum.

Q21: How do MVP's case management programs help create efficiencies that improve affordability, quality and access to care?

A21: The following response was prepared with the help of our Clinical team. The goal of MVP's case management programs is to help members regain optimum health or improved functional capability, in the right setting and in a safe, cost-effective manner. It includes comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring, assessing for barriers and follow-up. [redacted]

[redacted]

[redacted]

Q22: What steps does MVP take to manage costs and contracts to improve affordability?

A22: MVP engages in a competitive bidding process to obtain the best terms possible as a way of keeping administrative costs down when contracting out for a vendor or a service. MVP negotiates rates that reflect appropriate reimbursement levels across all provider types in MVP's network. MVP keeps indirect costs down through contract negotiations with doctors, hospitals, and pharmacies.

MVP constantly reviews and regularly updates its information technology infrastructure to increase efficiency and reduce administrative expenses and overhead. Administrative cost includes credentialing and accreditations. MVP also maintains a nationwide network of providers contracted with CIGNA, reducing costs paid for out of network fees.

MVP has a dedicated unit that investigates fraud and recovers monies improperly paid. This unit regularly monitors for irregular prescribing patterns and other practice patterns. Employees must complete an internal course annually on how to detect and report suspicious activity. Members are also encouraged to report any suspicious activity. Daily monitoring, employee education and member education create an efficient way to spot fraud immediately and recover those funds so they can be reallocated for the benefit of our members.

Q23: In this years' rate filing you state the total administrative expense load equals $43.75 PMPM, can you explain that?

A23: PMPM means "per member per month". The proposed rates included in this filing assume that administrative costs such as overhead, maintaining claims operating systems and so on will cost $43.75 per member per month. *See **Ex. 1***, p. 119. This year, 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 into 2021 so MVP had to include estimated credit card fees into administrative costs. Our proposed rate for 2021 adds $0.49 PMPM across all individual and small group members to account for credit card fees which is included in the administrative PMPM fee of $43.75. This number is based off assuming that 10% of small group premiums will be paid via credit card at a fee of 2.8% per premium.

Excluding the increase in administrative charges associated with credit card fees, MVP is proposing a 3.0% increase to its PMPM administrative load in 2021. Approximately 45% of the increase to the administrative costs in 2021 are attributable to MVP's operational work to bill individual exchange members in 2022.

Recently approved rate filings in the State of Vermont have accepted a PMPM increase to administrative loads significantly exceeding 3.0% as percent of premium administrative loads were held flat, but the approved rates are increasing materially which leads to a higher PMPM administrative load.

MVP's proposed administrative load of $43.75 PMPM is a source of competitive edge in the VT Exchange market. The proposed administrative loads included in MVP's rates have been more competitively priced than our competition, which is one of the ways MVP has been able to maintain a premium advantage in the VT Exchange.

Q24: Does membership growth in Vermont help keep per person administrative costs down and therefore improve affordability?

A24: MVP's percentage of the Vermont exchange market has grown from around 10% to nearly 50% as of January 2020. Even though we have experienced substantial growth in Vermont, unfortunately that growth has been more than offset by contraction in our membership in our New York business, and we have fixed costs spread across both states. MVP manages its administrative expenses across its entire organization because many of the costs are fixed and not applicable to only one state. We have consistently taken this approach in our rate filings. In prior years when MVP only insured 10% of the VT Exchange, our VT administrative cost PMPM was not loaded up to account for our reduced membership. An example of fixed costs would be that both states share the same claims operating system, which is housed in New York State, so the cost of that and other items needs to be viewed relative to our enterprise-wide membership. There are certain expenses that are Vermont specific and with expansion, those expenses would decrease, all else being equal. However, the enterprise-wide membership shift has had an overall negative impact on the overall PMPM charge to New Yorkers and Vermonters.

Q25: What has MVP done to manage prescription drug costs to improve affordability, access and quality of care?

A25: MVP contracts with a Pharmacy Benefit Manager ("PBM"), to obtain the best prices on prescription pharmaceuticals. MVP's pharmacy team works with the PBM through negotiating unit cost reductions and/or increasing rebates from the manufacturer. MVP continuously analyzes MVP's formulary to make sure the most cost efficient

medications are on it. MVP incentivizes members to use lower cost generic drugs where possible. Generic prescriptions account for 93.5% of all prescriptions to MVP members in 2019. We project that generic prescriptions will be 94.0% of all prescriptions by 2021. *See* ***Ex. 1***, p. 12.

Q26: How does MVP use current technology to manage costs and improve affordability, access to care and quality of care?

A26: The following answer was authored with support from our Marketing team. MVP has sought to increase member engagement and cost transparency via its website, which had approximately 1.1 million users logging 3.8 million sessions in 2019. This reflects a 12.6% increase in users and a 1.7% increase in sessions from 2018.

MVP's "Shop for a Plan" tool had approximately 124,000 visitors shopping for individual and family plans in 2019, with 67,000 using the subsidy calculator to check if they were eligible for lower costs. MVP's dedicated VT webpage, mvphealthcare.com/Vermont, had 11,500 visitors in 2019.

MVP supports the use of telemedicine, which continues to climb steeply across all of MVP membership. Vermont members, using their phone, tablet or computer can have an online doctor's visit 24/7, and even be able to get a prescription. In Vermont, from its introduction in 2017, 85% of telemedicine visits were for adult and pediatric urgent care needs and 14% were for mental health (behavioral health counseling and psychiatry). Vermont users report extremely high satisfaction with their telemedicine provider and with the online telemedicine experience (>94% rating 4 or 5 stars for both categories). Over the past year, the highest use of telemedicine is for urgent care, replacing possible trips to the

emergency room. As such, there is significant cost savings because of the difference in prices between a telemedicine visit (around $49 for urgent care visit) and a visit to an urgent care clinic (usually between $150-300). Even more is saved by avoiding visits to the emergency room. MVP provides welcome packets to help members understand benefits, to increase utilization and help make members healthier. Information about telemedicine is part of a new member's welcome packet and is included periodically in our member newsletters to remind members of the availability of this benefit.

MVP promotes an online cost calculator tool where members can enter their location in Vermont and the procedure or test to be performed and the tool will tell members the cost of the procedure, MVP's contractual arrangement with providers in the location selected, and whether the member has satisfied their deductible and how much they will pay out of pocket. This also allows members to compare prices between different providers.

MVP has an online tool where members can see the prices of prescription drugs at different pharmacies and compare their out of pocket costs, also in an effort to move members toward the most affordable and effective solutions possible. MVP has online tools to help members with a number of health and well-being activities, such as quitting smoking and eating healthier.

Q27: How does MVP strategically design its plans to promote affordability for consumers?

A27: MVP offers both standard and non-standard plans so members can compare plans and choose a plan that lines up with the benefits they want. MVP has participated in

meetings with Vermont Health Connect and Blue Cross Blue Shield of Vermont to discuss and create outreach programs and communications to encourage consumers to maintain coverage and make educated decisions in light of CSR defunding and the introduction of the silver reflective plans. MVP participates in silver reflective plan efforts to help mitigate loss of the subsidy eliminated by the federal government.

Q28: How does MVP increase affordability by helping lower the cost of premiums for subscribers?

A28: MVP supports and guides taxpayers who may be eligible for premium assistance through federal Advanced Premium Tax Credits, which further increases affordability. As of March 2020, we have 11,781 members receiving premium tax credits.

MVP works with its members to help members take advantage of federal and state cost-sharing incentives or subsidies in order to help members maximize their benefit and pick the right cost plan. MVP reduces out-of-pocket costs for enrollees earning from 100% to 250% of the federal poverty level through cost sharing reductions. Vermont cost-sharing assistance further reduces enrollees' deductibles and copayments. Vermonters at or below 300% of the federal poverty level may be eligible for Vermont premium assistance that reduces their premium contribution by 1.5% below the amount available under the federal law.

Q29: Do MVP plans cover providers that are not under the Green Mountain Care Board's jurisdiction to improve access to health care and quality of care?

A29: Yes, MVP's benefits and products offered in this filing cover a nationwide network of providers, facilities and pharmacies. MVP contracts directly with providers and facilities in upstate New York and with Dartmouth Hitchcock in New Hampshire. After that, we rely on a national carrier and use their network. If a Vermonter is vacationing far from home or their child is attending college out of state and they need medical care, they can access a provider facility with an in-network provider with no additional cost sharing above what is in their benefits if they saw a local provider.

4. IMPACT OF COVID-19

Q30: How has the COVID-19 pandemic affected MVP's 2021 proposed rates?

A30: MVP expects the decreased utilization of early 2020 to result in an increase of utilization in 2021. Elective procedures were halted in March 2020 and were resumed in May 2020. MVP is accounting for the fact that approximately two months of elective surgeries were cancelled in 2020. To value what the effect of the delay of elective services will be in 2021, MVP assumed that 20% of the elective services that were deferred will be eliminated, and that beginning in August 2020 providers will perform at 110% of their prior elective service volume until deferred services were fully performed in order to recoup lost revenue. Based on feedback from our medical management team, elective procedures are generally booked at full capacity by providers and hospitals. There are also increased sanitization protocols being put in place due to COVID-19, but based on feedback from the provider community, a number of providers will be working longer hours or over weekends to perform the elective surgeries that were canceled. Due to these factors, we settled on the 110% assumption by balancing patient need for these services

with the limits on services a hospital can provide due to physical space, human capital, and sanitization protocols. These assumptions combine to add $4.51 PMPM in claim cost for the time period of January to April 2021. MVP is reflecting $1.50 PMPM ($4.51 for four months, converted to annual PMPM) in this filing to account for the increased utilization.

Additionally, MVP is assuming that a vaccine to prevent COVID-19 will be 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 analysis published by Wakely Consulting) which corresponds to a PMPM claim cost of $5.00 PMPM ($75 per dose times 80% utilization per member per year divided by 12 months.)

Q31: What concerns do you have if the Board reduces rates for 2021 based on reduced 2020 claims in recent months during the COVID-19 crisis?

A31: The 2021 rates proposed by MVP are developed to be actuarially sound. That is, the proposed rates have been developed to align premiums with the claims, administrative costs, taxes/assessments, and a contribution to reserves to meet statutory guidelines in calendar year 2021. If the Board reduces rates for 2021 without actuarial support, policyholders may see a larger rate increase in future years so the rates being offered are actuarially sound. *See **Exhibit 12***, Actuarial Standard of Practice #26, Section 2.1.

Q32: MVPHP is proposing an increase for pent-up demand from COVID-19. These are services which were expected to be performed in 2020. As such, the HCA expects

that the cost was built into the premium rates for 2020. Please demonstrate how this additional cost in 2021 premiums is not double charging members.

A32: The rates proposed by MVP are developed to be actuarially sound. According to Actuarial Standard of Practice #26, Section 2.1, actuarial soundness is defined as "for business in the state for which the certification is being prepared ***and for the period covered by the certification***, ***projected premiums in the aggregate***, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, ***are adequate to provide for all expected costs, including health benefits***, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital." *See* ***Ex. 12***, (emphasis added). Therefore, MVP must consider health claims expected to incur in and only in 2021 when setting premium rates that are effective for 2021. If MVP were to reduce rates in 2021 for claims that were expected to occur but did not in 2020, those rates would be considered inadequate based on actuarial principles.

Q33: Is MVP anticipating returning premium in 2020?

A33: It is too early to understand how COVID-19 is going to impact MVP's 2020 claim costs. Although claims have been suppressed in recent months, MVP is already seeing claim receipts trending back towards normal levels in June and it is unknown if pent-up demand will push utilization beyond normal levels later in the year and if deferral of care will lead to higher severity of claims.

Q34: Why should there be any rate increase with suppressed utilization in late Winter/Spring of 2020?

A34: The proposed rates set forth by MVP are established to be actuarially sound as described in the response to Q32. Excluding pent-up demand for services deferred in the Winter/Spring of 2020, MVP is assuming that utilization will return to normal levels in 2021. The social distancing and safety measures established in recent months has provided society with a better understanding of how to cautiously perform daily activities to mitigate the spread of COVID-19. With this cautious approach to daily activities, MVP is expecting claim volume in 2021 to return to normal levels. Given that 2019 utilization is the base period used to set 2021 rates, and 2019 did not include a global pandemic, no adjustment to the base period data should be made to establish an actuarially sound rate.

Q35: Why is a Contribution to Reserves necessary in 2021?

A35: MVP's rates are set to be actuarially sound which includes a contribution to reserves to meet statutory solvency requirements. Although the outbreak of COVID-19 in late Winter/Spring of 2020 suppressed claim utilization, the ongoing impact of COVID-19 is unknown. For example, some employers will be testing employees on a regular basis to ensure a safe workplace which could lead to significant costs incurred by MVP which are not captured in the proposed rates for 2021. Additionally, the deferral of care in late Winter/Spring of 2020, could lead to members being in a higher morbidity state than if they were receiving proper care, which could increase claims cost to be higher than expected. These scenarios could result in the 2021 proposed rates being deficient and would lead to MVP using its reserves to pay for claims and exemplify the importance of approving actuarially sound rates. Failing to approve rates with an adequate level of

reserve margin could result in higher rate increases in future years to meet solvency requirements.

4. PROPOSED HOSPITAL BUDGET RATE IMPACT

Q36: How do hospital budget proposals affect the rate review process for MVP?

A36: There are generally two years of hospital unit cost trends that need to be reflected in every filing. For example, this year needs trend to reflect 2020 unit cost increases relative to 2019 as well as 2021 relative to 2020. Under the current hospital budget process, MVP has access to the approved budgets for the earlier of the two years, but has no knowledge of the proposed or approved budgets for the latter. MVP has a strong preference for the trends reflected in rates to be aligned with the hospital budget increases because hospital budgets impact rates. The more accurate and complete information we have, the better we can accurately reflect the impact of hospital budgets in the rates. When we see the proposed hospital budgets for the latter of the two years, we update our trends to reflect what is in the 2021 proposed budgets. Last year, we proposed an additional rate increase of 0.5% based on hospital budgets and the Board ultimately approved a 0.3% increase.

Q37: How does MVP consider past hospital budget requests and approvals experience in its proposed rates this year, particularly in light of the anomaly of 2020?

A37: We take into account the "charge increase" that the hospitals are proposing for all commercial patients. We prefer to look at the proposed hospital budgets for the current year, as opposed to just looking at the history of the difference between what hospitals submit and what the board has approved. What has happened in past years may not be indicative of what is going to happen this year, so the best data that we have available is

the proposed hospital budget for the upcoming year. This year we will not have access to the proposed hospital budgets before the hearing. The Board has afforded MVP the opportunity to provide post-hearing briefs in the first week of August, after reviewing what proposals are filed.

Q38: What concerns does MVP have about the hospital trend for 2020 and forecasted for 2021?

A38: This year due to the pandemic, the Board is allowing hospitals to request an increase in charges to offset commercial revenue loss due to COVID-19. MVP's proposed rates do not reflect additional unit cost trend for hospitals to offset their COVID-19 related revenue losses. Any hospital trend increases above and beyond what is captured in MVP's proposed rates must be reflected in the final approved rates or else the rates are at risk of not being actuarially sound.

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2021	)	
Vermont Health Connect Rate Filing	)	DOCKET NO. GMCB-006-20rr
	)	
SERFF No. MVPH-132371260	)	
	)	

CERTIFICATE OF SERVICE

I, Michelle Bennett, Esq., hereby certify that I have served a copy of the [***CONFIDENTIAL] MVPs Prefiled Testimony and [REDACTED] MVP's Prefiled Testimony*** via e-mail upon the following:

Michael Barber, Esq.
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
Michael.Barber@vermont.gov

Amerin Aborjaily, Esq.
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
Amerin.Aborjaily@vermont.gov

Kaili Kuiper, Esq.
Office of the Health Care Advocate
Vermont Legal Aid
56 College Street
Montpelier, VT 05602
kkuiper@vtlegalaid.org

Eric Schultheis, Esq.
Office of the Health Care Advocate
Vermont Legal Aid
56 College Street
Montpelier, VT 05602
ESchultheis@vtlegalaid.org

Dated at Burlington, Vermont, this 7th day of July, 2020.

PRIMMER PIPER EGGLESTON & CRAMER PC

By: */s/ Michelle T. Bennett*

Gary F. Karnedy, Esq.
Michelle T. Bennett, Esq.
Ryan Long, Esq.
30 Main Street, Suite 500
P.O. Box 1489
Burlington, VT 05402-1489
(802) 864-0880
gkarnedy@primmer.com
rlong@primmer.com
mbennett@primmer.com

Attorneys for MVP Health Plan, Inc.

EXHIBIT
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Filing at a Glance

Company:	MVP Health Plan, Inc.
Product Name:	VT Exchange 2021
State:	VermontGMCB
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.002C Any Size Group - HMO
Filing Type:	GMCB Rate
Date Submitted:	05/08/2020
SERFF Tr Num:	MVPH-132371260
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2021
Author(s):	Matt Lombardo, Eric Bachner, Christopher Pontiff
Reviewer(s):	Thomas Crompton (primary), David Dillon, Jacqueline Lee, Christina McLaughlin, Amerin Aborjaily, Michael Barber
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 Exchange 2021*
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: Employer, Other
Overall Rate Impact: 7.34%

Deemer Date:
Submitted By: Eric Bachner

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Explanation for Other Group Market Type: Individual
Filing Status Changed: 05/08/2020
State Status Changed:
Created By: Christopher Pontiff
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: Plans are proposed to be sold on the state of Vermont's exchange.

Filing Description:

These rates are for Small Group and Individual members purchasing coverage through the VT Exchange (or ACA-compliant plans directly from MVP) effective January 1, 2021

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? No
Retaliatory? No
Fee Explanation:

003

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	10.080%
Effective Date of Last Rate Revision:	01/01/2020
Filing Method of Last Filing:	SERFF
SERFF Tracking Number of Last Filing:	MVPH-131934219

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	7.340%	7.340%	$18,270,092	14,848	$248,934,672	9.550%	0.540%

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
VT Individual HMO	77566VT004		16137
VT Small Group HMO	77566VT005		20843

Trend Factors:

FORMS:

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

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 443,760
Benefit Change: Increase
Percent Change Requested: Min: 0.54 Max: 9.55 Avg: 7.34

PRIOR RATE:

Total Earned Premium: 248,934,672.00
Total Incurred Claims: 222,083,202.00
Annual $: Min: 336.24 Max: 784.52 Avg: 560.97

REQUESTED RATE:

Projected Earned Premium: 267,204,764.00
Projected Incurred Claims: 240,484,288.00
Annual $: Min: 354.84 Max: 835.03 Avg: 602.14

005

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	VT 2021 Exchange Rate Filing_SERFF.xlsx VT 2021 Exchange Rate Filing_SERFF.pdf Actuarial Memo Dataset 2021 _SERFF.xlsx Actuarial Memo Dataset 2021 _SERFF.pdf Federal AVC Actuarial Certification for Non-standard Plans - 2021_032620.pdf Non-Standard AVC Screenshots VT 2021 Exchange.pdf Wakely - VT Standard Plan Designs - AV Certification_2020-03-09.pdf Rate Increase Exhibit 2020-2021_SERFF.pdf Rate Increase Exhibit 2020-2021_SERFF.xlsx 2021 Actuarial Memorandum Vermont Exchange.pdf PY21RateTables_VTSMON_050820.xls PY21RateTables_VTINDOFF_050820.xls PY21RateTables_VTINDON_050820.xls
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	2021 Federal Act Memo Vermont Exchange.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Civil Union Rating Requirements
Comments:	MVP's rating rules satisfy 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 - 2021 VT Exchange.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Filing Compliance Certification
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 Exchange 2021*
Project Name/Number: */*

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

Bypassed - Item:	Third Party Filing Authorization
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	Unified-Rate-Review-VT Combined 2021.pdf Unified-Rate-Review-VT Combined 2021.xlsm
Item Status:	
Status Date:	

Attachment VT 2021 Exchange Rate Filing_SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment Actuarial Memo Dataset 2021 _SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment Rate Increase Exhibit 2020-2021_SERFF.xlsx is not a PDF document and cannot be reproduced here.

Attachment PY21RateTables_VTSMON_050820.xls is not a PDF document and cannot be reproduced here.

Attachment PY21RateTables_VTINDOFF_050820.xls is not a PDF document and cannot be reproduced here.

Attachment PY21RateTables_VTINDON_050820.xls is not a PDF document and cannot be reproduced here.

Attachment Unified-Rate-Review-VT Combined 2021.xlsm is not a PDF document and cannot be reproduced here.

MVP Health Care -- 2021 Exchange Rate Filing

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Exhibit 1 -- Summary of Medical Coplans Offered

Exhibit 1a -- Comparison of 2020 to 2021 Benefits

Exhibit 2a -- Pricing Trend Assumptions

Exhibit 2b -- Support for Rx Trend Assumptions used in Development of Index R

Exhibit 3 -- Index Rate Development

Exhibit 4 -- Conversion Factor and Tier Ratios

Exhibit 5 -- Retention Loads and Paid Claim Surcharges

Exhibit 6 -- Calculation of CSR Defunding Load

Exhibit 7 -- 2021 Premium Rates

Exhibit 1 -- Summary of Medical Coplans Offered

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

					In-Network Benefits																	
Form ID	Product Type	Metal Level	Standard/Non-Standard	On/Off Exchange	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-P-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	$15 No DD	$40 No DD	10%	$100	10%	$60 No DD	$350	$700	Embedded	10%	Embedded	Embedded	$1,400	$2,800	$1,400	$2,800	Separate	$10/$50/50%
FRVT-HMO-G-001-S (2021)	HyHMO	Gold	Standard	On Exchange	$20 No DD	$50 No DD	30%	$150	30%	$70 No DD	$1,100	$2,200	Embedded	30%	Embedded	Embedded	$5,200	$10,400	$1,400	$2,800	Separate	$12/$55/50% $100/$200 Brand Ded
FRVT-HMO-G-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	$20 No DD	$40 No DD	20%	$250	20%	$50	$700	$1,400	Embedded	20%	Embedded	Embedded	$6,500	$13,000	$1,400	$2,800	Separate	$10 / $40 / 50%, $250 / $500 Brand Ded, VBID = $1 #
FRVT-HMOH-G-003-N (2021)	HDHMO	Gold	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$3,000	$6,000	Aggregate	0%	Aggregate	Aggregate	$3,000	$6,000	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S-003-S (2021)	HyHMO	Silver	Standard	On Exchange	$35 No DD	$80 No DD	50%	$250	50%	$100 No DD	$3,200	$6,400	Embedded	50%	Embedded	Embedded	$8,150	$16,300	$1,400	$2,800	Integrated	$15 / $60 / 50%, $350/$700 Brand Ded
FRVT-HMOH-S-004-S (2021)	HDHMO	Silver	Standard	On Exchange	10%	30%	30%	30%	30%	30%	$1,750	$3,500	Aggregate	30%	Stacked	Aggregate	$6,900	$13,800*	$1,400	$2,800	Integrated	$10/$40/50%, Subject to Med Deductible
FRVT-HMOH-S-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$5,075	$10,150	Embedded	0%	Embedded	Aggregate	$5,075	$10,150	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$30**	$60	50%	$400	$1,400 (Fac) $300 (Phys)	$100	$1,500	$3,000	Embedded	50%	Embedded	Embedded	$6,700	$13,400	$1,400	$2,800	Separate	$500/$1000 Ded then $5/50%/50%, VBID = $1 #
VT-HMO-S-003-S II (2021)	HyHMO	Silver	Standard	Off Exchange	$35 No DD	$80 No DD	50%	$250	50%	$105 No DD	$3,200	$6,400	Embedded	50%	Embedded	Embedded	$8,150	$16,300	$1,400	$2,800	Integrated	$15 / $60 / 50%, $350/$700 Brand Ded
VT-HMOH-S-004-S II (2021)	HDHMO	Silver	Standard	Off Exchange	10%	30%	30%	30%	30%	35%	$1,750	$3,500	Aggregate	30%	Stacked	Aggregate	$6,900	$13,800*	$1,400	$2,800	Integrated	$10/$40/50%, Subject to Med Deductible
VT-HMOH-S-002-N II (2021)	HDHMO	Silver	Non-Standard	Off Exchange	0%	0%	0%	0%	0%	0%	$5,100	$10,150	Embedded	0%	Embedded	Aggregate	$5,075	$10,150	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
VT-HMO-S-001-N II (2021)	HyHMO	Silver	Non-Standard	Off Exchange	$30**	$60	50%	$400	$1,400 (Fac) $300 (Phys)	$105	$1,500	$3,000	Embedded	50%	Embedded	Embedded	$6,700	$13,400	$1,400	$2,800	Separate	$500/$1000 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-B-002-S (2021)	HMO	Bronze	Standard	On Exchange	$35	$90	50%	50%	50%	$100	$6,250	$12,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	$1,400	$2,800	Integrated	$1000/$1,200 Ded then $15/$85/60%
FRVT-HMOH-B-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	50%	50%	50%	50%	50%	50%	$5,500	$11,000	Aggregate	50%	Stacked	Aggregate	$6,900	$13,800*	$1,400	$2,800	Integrated	$12/40%/60%, Subject to Med Deductible
FRVT-HMO-B-004-S (2021)	HMO	Bronze	Standard	On Exchange	$40 No DD	$100 No DD	0%	0%	0%	0%	$8,400	$16,800	Embedded	0%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$30 No DD/0%/0%, Subject to Med Deductible
FRVT-HMO-B-005-N (2021)	HMO	Bronze	Non-Standard	On Exchange	0%**	0%	0%	0%	0%	0%	$7,850	$15,700	Embedded	0%	Embedded	Embedded	$7,850	$15,700	N/A	N/A	N/A	$30 No DD / $0 / $0, Subject to Med Deductible, VBID = $3 #
FRVT-HMO-B-001-N (2021)	HMO	Bronze	Non-Standard	On Exchange	$40	$100	50%	50%	50%	$100	$7,250	$14,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$25/$100/60%, $700/$1400 Ded, VBID = $3 #
FRVT-HMO-C-001-N (2021)	HMO	Catastrophic	Standard	On Exchange	$0**	0%	0%	0%	0%	0%	$8,550	$17,100	Embedded	0%	Embedded	Embedded	$8,550	$17,100	$1,400	$2,800	Integrated	$0 / $0 / $0 Subject to Med Deductible

Subsidized Cost-Sharing Benefits (Non AI/AN)					In-Network Benefits																	
Coplan	Product Type	Metal Level	Standard/Non-Standard	On/Off Exchange	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-S3-001-S (2021)	HyHMO	Silver	Standard	On Exchange	$35 No DD	$70 No DD	50%	$250	50%	$100 No DD	$3,100	$6,200	Embedded	50%	Embedded	Embedded	$6,750	$13,500	$1,250	$2,500	Integrated	$12 / $60 / 50%, $350 / $700 Brand Ded
FRVT-HMO-S3-002-S (2021)	HyHMO	Silver	Standard	On Exchange	$10 No DD	$30 No DD	40%	$250	40%	$100 No DD	$1,100	$2,200	Embedded	40%	Embedded	Embedded	$2,200	$4,400	$450	$900	Integrated	$10 / $50 / 50%, $200 / $400 Brand Ded
FRVT-HMO-S3-003-S (2021)	HyHMO	Silver	Standard	On Exchange	$5 No DD	$15 No DD	10%	$75	10%	$50 No DD	$200	$400	Embedded	10%	Embedded	Embedded	$900	$1,800	$200	$400	Integrated	$5 / $20 / 30%
FRVT-HMO-S3-004-S (2021)	HyHMO	Silver	Standard	On Exchange	$25 No DD	$50 No DD	50%	$250	50%	$100 No DD	$2,600	$5,200	Embedded	50%	Embedded	Embedded	$6,000	$12,000	$1,100	$2,200	Integrated	$12 / $60 / 50%, $300 / $600 Brand Ded
FRVT-HMOH-S4-001-S (2021)	HDHMO	Silver	Standard	On Exchange	Ded then 10%	25%	25%	25%	25%	25%	$1,750	$3,500	Aggregate	25%	Stacked	Aggregate	$5,200	$10,400	$1,400	$2,800	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S4-002-S (2021)	HMO	Silver	Standard	On Exchange	0%	0%	0%	0%	0%	$0	$1,400	$2,800	Aggregate	0%	Aggregate	Aggregate	$1,400	$2,800	$1,400	$2,800	Integrated	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-003-S (2021)	HMO	Silver	Standard	On Exchange	0%	0%	0%	0%	0%	$0	$550	$1,100	Aggregate	0%	Aggregate	Aggregate	$550	$1,100	$550	$1,100	Integrated	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-004-S (2021)	HDHMO	Silver	Standard	On Exchange	Ded then 10%	25%	25%	25%	25%	25%	$1,600	$3,200	Aggregate	25%	Stacked	Aggregate	$4,400	$8,800	$1,400	$2,800	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S2-001-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$4,250	$8,500	Embedded	0%	Embedded	Aggregate	$4,250	$8,500	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-002-N (2021)	HMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$1,500	$3,000	Embedded	0%	Embedded	Embedded	$1,500	$3,000	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-003-N (2021)	HMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$550	$1,100	Embedded	0%	Embedded	Embedded	$550	$1,100	$550	$1,100	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-004-N (2021)	HMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$3,250	$6,500	Embedded	0%	Embedded	Aggregate	$3,250	$6,500	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S1-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$30**	$60	50%	$350	$1400 (Fac) $300 (Phys)	$100	$1,300	$2,600	Embedded	50%	Embedded	Embedded	$5,500	$11,000	$1,400	$2,800	Separate	$450 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-S1-002-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$10 No DD	$30	10%	$50	$200 (Fac) $100 (Phys)	$50	$0	$0	Embedded	10%	Embedded	Embedded	$2,600	$5,200	$700	$1,400	Separate	$5 / 20% / 40%, VBID = $1 #
FRVT-HMO-S1-003-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$5 No DD	$10	5%	$25	$40 (Fac) $20 (Phys)	$25	$0	$0	Embedded	5%	Embedded	Embedded	$1,450	$2,900	$350	$700	Separate	$5 / 5% / 5%, VBID = $1 #
FRVT-HMO-S1-004-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$10**	$40	30%	$100	$800 (Fac) $200 (Phys)	$100	$500	$1,000	Embedded	30%	Embedded	Embedded	$5,400	$10,800	$1,350	$2,700	Separate	$5 / 40% / 40%, $200 / $400 Ded, VBID = $1 #

American Indian and Alaskan Native (AI/AN) Benefits (Unsubsidized)^					In-Network Benefits																	
Form ID	Product Type	Metal Level	Standard/Non-Standard	On/Off Exchange	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-PA2-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	$15 No DD	$40 No DD	10%	$100	10%	$60 No DD	$350	$700	Embedded	10%	Embedded	Embedded	$1,400	$2,800	$1,400	$2,800	Separate	$10/$50/50%
FRVT-HMO-GA2-001-S (2021)	HyHMO	Gold	Standard	On Exchange	$20 No DD	$50 No DD	30%	$150	30%	$70 No DD	$1,100	$2,200	Embedded	30%	Embedded	Embedded	$5,200	$10,400	$1,400	$2,800	Separate	$12/$55/50% $100/$200 Brand Ded
FRVT-HMO-GA2-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	$20 No DD	$40 No DD	20%	$250	20%	$50	$700	$1,400	Embedded	20%	Embedded	Embedded	$6,500	$13,000	$1,400	$2,800	Separate	$10 / $40 / 50%, $250 / $500 Brand Ded, VBID = $1 #
FRVT-HMOH-GA2-003-N (2021)	HDHMO	Gold	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$3,000	$6,000	Aggregate	0%	Aggregate	Aggregate	$3,000	$6,000	$1,400	$2,800	Integrated	$10 / $15 / 5%, Subject to Med Deductible
FRVT-HMO-SA2-003-S (2021)	HyHMO	Silver	Standard	On Exchange	$35 No DD	$80 No DD	40%	$250	50%	$100 No DD	$3,200	$6,400	Embedded	50%	Embedded	Embedded	$8,150	$16,300	$1,400	$2,800	Integrated	$15 / $60 / 50%, $350/$700 Brand Ded
FRVT-HMOH-SA2-004-S (2021)	HDHMO	Silver	Standard	On Exchange	10%	30%	30%	30%	30%	30%	$1,750	$3,500	Aggregate	30%	Stacked	Aggregate	$6,900	$13,800	$1,400	$2,800	Integrated	$10/$40/50%
FRVT-HMOH-SA2-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$5,075	$10,150	Embedded	0%	Embedded	Aggregate	$5,075	$10,150	$1,400	$2,800	Integrated	0%/0%/0%
FRVT-HMO-SA2-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$30**	$60	50%	$400	$1,400 (Fac) $300 (Phys)	$100	$1,500	$3,000	Embedded	50%	Embedded	Embedded	$6,700	$13,400	$1,400	$2,800	Separate	$500/$1000 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-BA2-002-S (2021)	HyHMO	Bronze	Standard	On Exchange	$35	$90	50%	50%	50%	$100	$6,250	$12,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	$1,400	$2,800	Integrated	$1000/$1200 Ded then $15/$85/60%
FRVT-HMOH-BA2-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	50%	50%	50%	50%	50%	50%	$5,500	$11,000	Aggregate	50%	Stacked	Aggregate	$6,900	$13,800	$1,400	$2,800	Integrated	$12/40%/60%
FRVT-HMO-BA2-004-S (2021)	HyHMO	Bronze	Standard	On Exchange	$40 No DD	$100 No DD	0%	0%	0%	$0	$8,400	$16,800	Embedded	0%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$30 No DD/0%/0%
FRVT-HMO-BA2-005-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	0%**	0%	0%	0%	0%	0%	$7,850	$15,700	Embedded	0%	Embedded	Embedded	$7,850	$15,700	N/A	N/A	N/A	$30 / $0 / $0, Tiers 2 & 3 Subject to Med Deductible, VBID = $3 #
FRVT-HMO-BA2-001-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	$40	$100	50%	50%	50%	$100	$7,250	$14,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$25/$100/60%, $700/$1400 Ded, VBID = $3 #

American Indian and Alaskan Native (AI/AN) Benefits (Subsidized)					In-Network Benefits																	
Coplan	Product Type	Metal Level	Standard/Non-Standard	On/Off Exchange	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-PA1-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-GA1-001-S (2021)	HyHMO	Gold	Standard	On Exchange	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-GA1-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMOH-GA1-003-N (2021)	HDHMO	Gold	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-SA1-003-S (2021)	HyHMO	Silver	Standard	On Exchange	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMOH-SA1-004-S (2021)	HDHMO	Silver	Standard	On Exchange	0%	0%	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMOH-SA1-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	0%	0%	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-SA1-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	$0	$0	0%	$0	$0	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-002-S (2021)	HyHMO	Bronze	Standard	On Exchange	$0	$0	0%	0%	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMOH-BA1-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	0%	0%	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-004-S (2021)	HyHMO	Bronze	Standard	On Exchange	$0	$0	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-005-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	$0	0%	0%	0%	0%	0%	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-001-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	$0	$0	0%	0%	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0

Services subject to deductible (DD) unless otherwise stated.
***First 3 PCP Office Visits are not subject to deductible*
^ 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.
 # Generic Drugs are Covered in full up to age 10, after Pharmacy deductible is met
** Family structure is $8,550 for each member up to family limit*
Note: MVP's Non-Standard Plan Designs also have a Member Wellness Rider (Form: FRVT366) attached which provides up to $600 per contract per year.

Exhibit 1a -- Comparison of 2020 to 2021 Benefits by Plan

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

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				In-Network Benefits																	
Form ID	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-P-001-S (2020)	HyHMO	Platinum	Standard	$15 No DD	$40 No DD	10%	$100	10%	$60 No DD	$350	$700	Embedded	10%	Embedded	Embedded	$1,350	$2,700	$1,350	$2,700	Separate	$10/$50/50%
FRVT-HMO-P-001-S (2021)	HyHMO	Platinum	Standard	$15 No DD	$40 No DD	10%	$100	10%	$60 No DD	$350	$700	Embedded	10%	Embedded	Embedded	$1,400	$2,800	$1,400	$2,800	Separate	$10/$50/50%
FRVT-HMO-G-001-S (2020)	HyHMO	Gold	Standard	$20 No DD	$50 No DD	30%	$150	30%	$70 No DD	$900	$1,800	Embedded	30%	Embedded	Embedded	$5,000	$10,000	$1,350	$2,700	Separate	$10/$50/50% $100/$200 Brand Ded
FRVT-HMO-G-001-S (2021)	HyHMO	Gold	Standard	$20 No DD	$50 No DD	30%	$150	30%	$70 No DD	$1,100	$2,200	Embedded	30%	Embedded	Embedded	$5,200	$10,400	$1,400	$2,800	Separate	$12/$55/50% $100/$200 Brand Ded
FRVT-HMO-G-002-N (2020)	HyHMO	Gold	Non-Standard	$20 No DD	$40 No DD	20%	$250	20%	$50	$600	$1,200	Embedded	20%	Embedded	Embedded	$6,500	$13,000	$1,350	$2,700	Separate	$10 / $40 / 50%, $200 / $400 Brand Ded, VBID = $1 #
FRVT-HMO-G-002-N (2021)	HyHMO	Gold	Non-Standard	$20 No DD	$40 No DD	20%	$250	20%	$50	$700	$1,400	Embedded	20%	Embedded	Embedded	$6,500	$13,000	$1,400	$2,800	Separate	$10 / $40 / 50%, $250 / $500 Brand Ded, VBID = $1 #
FRVT-HMOH-G-003-N (2020)	HDHMO	Gold	Non-Standard	0%	0%	0%	0%	0%	0%	$2,700	$5,400	Aggregate	0%	Aggregate	Aggregate	$2,700	$5,400	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-G-003-N (2021)	HDHMO	Gold	Non-Standard	0%	0%	0%	0%	0%	0%	$3,000	$6,000	Aggregate	0%	Aggregate	Aggregate	$3,000	$6,000	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S-003-S (2020)	HyHMO	Silver	Standard	$35 No DD	$80 No DD	40%	$250	50%	$100 No DD	$3,200	$6,400	Embedded	40%	Embedded	Embedded	$7,900	$15,800	$1,350	$2,700	Integrated	$15 / $60 / 50%, $350/$700 Brand Ded
FRVT-HMO-S-003-S (2021)	HyHMO	Silver	Standard	$35 No DD	$80 No DD	50%	$250	50%	$100 No DD	$3,200	$6,400	Embedded	50%	Embedded	Embedded	$8,150	$16,300	$1,400	$2,800	Integrated	$15 / $60 / 50%, $350/$700 Brand Ded
FRVT-HMOH-S-004-S (2020)	HDHMO	Silver	Standard	10%	30%	30%	30%	30%	30%	$1,700	$3,400	Aggregate	30%	Stacked	Aggregate	$6,750	$13,500"	$1,350	$2,700	Integrated	$10/$40/50%, Subject to Med Deductible
FRVT-HMOH-S-004-S (2021)	HDHMO	Silver	Standard	10%	30%	30%	30%	30%	30%	$1,750	$3,500	Aggregate	30%	Stacked	Aggregate	$6,900	$13,800"	$1,400	$2,800	Integrated	$10/$40/50%, Subject to Med Deductible
FRVT-HMOH-S-002-N (2020)	HDHMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$4,750	$9,500	Embedded	0%	Embedded	Aggregate	$4,750	$9,500	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S-002-N (2021)	HDHMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$5,075	$10,150	Embedded	0%	Embedded	Aggregate	$5,075	$10,150	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S-001-N (2020)	HyHMO	Silver	Non-Standard	$30**	$60	50%	$400	$1,400 (Fac) $300 (Phys)	$100	$1,500	$3,000	Embedded	50%	Embedded	Embedded	$6,500	$13,000	$1,350	$2,700	Separate	$500/$1000 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-S-001-N (2021)	HyHMO	Silver	Non-Standard	$30**	$60	50%	$400	$1,400 (Fac) $300 (Phys)	$100	$1,500	$3,000	Embedded	50%	Embedded	Embedded	$6,700	$13,400	$1,400	$2,800	Separate	$500/$1000 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-B-002-S (2020)	HMO	Bronze	Standard	$35	$90	50%	50%	50%	$100	$6,000	$12,000	Embedded	50%	Embedded	Embedded	$8,200	$16,400	$1,350	$2,700	Integrated	$1000/$1200 Ded then $20/$85/60%
FRVT-HMO-B-002-S (2021)	HMO	Bronze	Standard	$35	$90	50%	50%	50%	$100	$6,250	$12,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	$1,400	$2,800	Integrated	$1000/$1200 Ded then $15/$85/60%
FRVT-HMOH-B-003-S (2020)	HDHMO	Bronze	Standard	50%	50%	50%	50%	50%	50%	$5,500	$11,000	Aggregate	50%	Stacked	Aggregate	$6,750	$13,500"	$1,350	$2,700	Integrated	$12/40%/60%, Subject to Med Deductible
FRVT-HMOH-B-003-S (2021)	HDHMO	Bronze	Standard	50%	50%	50%	50%	50%	50%	$5,500	$11,000	Aggregate	50%	Stacked	Aggregate	$6,900	$13,800"	$1,400	$2,800	Integrated	$12/40%/60%, Subject to Med Deductible
FRVT-HMO-B-004-S (2020)	HMO	Bronze	Standard	$40 No DD	$100 No DD	0%	0%	0%	0%	$7,900	$15,800	Embedded	0%	Embedded	Embedded	$7,900	$15,800	N/A	N/A	N/A	$25 No DD/0%/0%, Subject to Med Deductible
FRVT-HMO-B-004-S (2021)	HMO	Bronze	Standard	$40 No DD	$100 No DD	0%	0%	0%	0%	$8,400	$16,800	Embedded	0%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$30 No DD/0%/0%, Subject to Med Deductible
FRVT-HMO-B-005-N (2020)	HMO	Bronze	Non-Standard	0%**	0%	0%	0%	0%	0%	$7,600	$15,200	Embedded	0%	Embedded	Embedded	$7,600	$15,200	N/A	N/A	N/A	$30 No DD / $0 / $0, Subject to Med Deductible, VBID = $3 #
FRVT-HMO-B-005-N (2021)	HMO	Bronze	Non-Standard	0%**	0%	0%	0%	0%	0%	$7,850	$15,700	Embedded	0%	Embedded	Embedded	$7,850	$15,700	N/A	N/A	N/A	$30 No DD / $0 / $0, Subject to Med Deductible, VBID = $3 #
FRVT-HMO-B-001-N (2020)	HMO	Bronze	Non-Standard	$40	$100	50%	50%	50%	$100	$7,250	$14,500	Embedded	50%	Embedded	Embedded	$8,000	$16,000	N/A	N/A	N/A	$25/$100/60%, $700/$1400 Ded, VBID = $3 #
FRVT-HMO-B-001-N (2021)	HMO	Bronze	Non-Standard	$40	$100	50%	50%	50%	$100	$7,250	$14,500	Embedded	50%	Embedded	Embedded	$8,400	$16,800	N/A	N/A	N/A	$25/$100/60%, $700/$1400 Ded, VBID = $3 #
FRVT-HMO-C-001-N (2020)	HMO	Catastrophic	Standard	$0**	$0	0%	$0	0%	$0	$8,000	$16,000	Embedded	0%	Embedded	Embedded	$8,000	$16,000	$1,350	$2,700	Integrated	$0 / $0 / $0 Subject to Med Deductible
FRVT-HMO-C-001-N (2021)	HMO	Catastrophic	Standard	$0**	$0	0%	$0	0%	$0	$8,550	$17,100	Embedded	0%	Embedded	Embedded	$8,550	$17,100	$1,400	$2,800	Integrated	$0 / $0 / $0 Subject to Med Deductible

Subsidized Cost-Sharing Benefits (Non AI/AN)				In-Network Benefits																	
Coplan	Product Type	Metal Level	Standard/Non-Standard	PCP	SCP	IP (Med/Surg)	ER	OP Surg	Amb	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-S3-001-S (2020)	HyHMO	Silver	Standard	$35 No DD	$70 No DD	50%	$250	50%	$100 No DD	$3,000	$6,000	Embedded	50%	Embedded	Embedded	$6,550	$13,100	$1,200	$2,400	Integrated	$12 / $60 / 50%, $350 / $700 Brand Ded
FRVT-HMO-S3-001-S (2021)	HyHMO	Silver	Standard	$35 No DD	$70 No DD	50%	$250	50%	$100 No DD	$3,100	$6,200	Embedded	50%	Embedded	Embedded	$6,750	$13,500	$1,250	$2,500	Integrated	$12 / $60 / 50%, $350 / $700 Brand Ded
FRVT-HMO-S3-002-S (2020)	HyHMO	Silver	Standard	$10 No DD	$30 No DD	40%	$250	40%	$100 No DD	$900	$1,800	Embedded	40%	Embedded	Embedded	$1,900	$3,800	$400	$800	Integrated	$10 / $50 / 50%, $150 / $300 Brand Ded
FRVT-HMO-S3-002-S (2021)	HyHMO	Silver	Standard	$10 No DD	$30 No DD	40%	$250	40%	$100 No DD	$1,100	$2,200	Embedded	40%	Embedded	Embedded	$2,200	$4,400	$450	$900	Integrated	$10 / $50 / 50%, $200 / $400 Brand Ded
FRVT-HMO-S3-003-S (2020)	HyHMO	Silver	Standard	$5 No DD	$15 No DD	10%	$75	10%	$50 No DD	$200	$400	Embedded	10%	Embedded	Embedded	$900	$1,800	$200	$400	Integrated	$5 / $20 / 30%
FRVT-HMO-S3-003-S (2021)	HyHMO	Silver	Standard	$5 No DD	$15 No DD	10%	$75	10%	$50 No DD	$200	$400	Embedded	10%	Embedded	Embedded	$900	$1,800	$200	$400	Integrated	$5 / $20 / 30%
FRVT-HMO-S3-004-S (2020)	HyHMO	Silver	Standard	$25 No DD	$45 No DD	50%	$250	50%	$100 No DD	$2,300	$4,600	Embedded	50%	Embedded	Embedded	$5,000	$10,000	$1,000	$2,000	Integrated	$12 / $60 / 50%, $250 / $500 Brand Ded
FRVT-HMO-S3-004-S (2021)	HyHMO	Silver	Standard	$25 No DD	$50 No DD	50%	$250	50%	$100 No DD	$2,600	$5,200	Embedded	50%	Embedded	Embedded	$6,000	$12,000	$1,100	$2,200	Integrated	$12 / $60 / 50%, $300 / $600 Brand Ded
FRVT-HMOH-S4-001-S (2020)	HDHMO	Silver	Standard	Ded then 10%	25%	25%	25%	25%	25%	$1,700	$3,400	Aggregate	25%	Stacked	Aggregate	$5,000	$10,000"	$1,350	$2,700	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S4-001-S (2021)	HDHMO	Silver	Standard	Ded then 10%	25%	25%	25%	25%	25%	$1,750	$3,500	Aggregate	25%	Stacked	Aggregate	$5,200	$10,400	$1,400	$2,800	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S4-002-S (2020)	HMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$1,250	$2,500	Aggregate	0%	Aggregate	Aggregate	$1,250	$2,500	N/A	N/A	N/A	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-002-S (2021)	HMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$1,400	$2,800	Aggregate	0%	Aggregate	Aggregate	$1,400	$2,800	$1,400	$2,800	Integrated	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-003-S (2020)	HMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$550	$1,100	Aggregate	0%	Aggregate	Aggregate	$550	$1,100	N/A	N/A	N/A	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-003-S (2021)	HMO	Silver	Standard	0%	0%	0%	0%	0%	0%	$550	$1,100	Aggregate	0%	Aggregate	Aggregate	$550	$1,100	$550	$1,100	Integrated	$0 / $0 / 0% Subject to Med Deductible
FRVT-HMOH-S4-004-S (2020)	HDHMO	Silver	Standard	Ded then 10%	25%	25%	25%	25%	25%	$1,450	$2,900	Aggregate	25%	Aggregate	Aggregate	$3,400	$6,800	$1,350	$2,700	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S4-004-S (2021)	HDHMO	Silver	Standard	Ded then 10%	25%	25%	25%	25%	25%	$1,600	$3,200	Aggregate	25%	Stacked	Aggregate	$4,400	$8,800	$1,400	$2,800	Integrated	$10 / $40 / 50% Subject to Med Deductible
FRVT-HMOH-S2-001-N (2020)	HDHMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$4,100	$8,200	Embedded	0%	Embedded	Aggregate	$4,100	$8,200	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-001-N (2021)	HDHMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$4,250	$8,500	Embedded	0%	Embedded	Aggregate	$4,250	$8,500	$1,400	$2,800	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-002-N (2020)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$1,400	$2,800	Embedded	0%	Embedded	Embedded	$1,400	$2,800	N/A	N/A	N/A	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-002-N (2021)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$1,500	$3,000	Embedded	0%	Embedded	Embedded	$1,500	$3,000	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-003-N (2020)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$600	$1,200	Embedded	0%	Embedded	Embedded	$600	$1,200	N/A	N/A	N/A	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-003-N (2021)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$550	$1,100	Embedded	0%	Embedded	Embedded	$550	$1,100	$550	$1,100	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-004-N (2020)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$3,250	$6,500	Embedded	0%	Embedded	Aggregate	$3,250	$6,500	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMOH-S2-004-N (2021)	HMO	Silver	Non-Standard	0%	0%	0%	0%	0%	0%	$3,250	$6,500	Embedded	0%	Embedded	Aggregate	$3,250	$6,500	$1,350	$2,700	Integrated	0% / 0% / 0%, Subject to Med Deductible
FRVT-HMO-S1-001-N (2020)	HyHMO	Silver	Non-Standard	$30**	$60	50%	$350	$1400 (Fac) $300 (Phys)	$100	$1,300	$2,600	Embedded	50%	Embedded	Embedded	$5,400	$10,800	$1,350	$2,700	Separate	$450 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-S1-001-N (2021)	HyHMO	Silver	Non-Standard	$30**	$60	50%	$350	$1400 (Fac) $300 (Phys)	$100	$1,300	$2,600	Embedded	50%	Embedded	Embedded	$5,500	$11,000	$1,400	$2,800	Separate	$450 Ded then $5/50%/50%, VBID = $1 #
FRVT-HMO-S1-002-N (2020)	HyHMO	Silver	Non-Standard	$5 No DD	$30	10%	$50	$200 (Fac) $100 (Phys)	$50	$0	$0	Embedded	10%	Embedded	Embedded	$2,450	$4,900	$600	$1,200	Separate	$5 / 20% / 40%, VBID = $1 #
FRVT-HMO-S1-002-N (2021)	HyHMO	Silver	Non-Standard	$10 No DD	$30	10%	$50	$200 (Fac) $100 (Phys)	$50	$0	$0	Embedded	10%	Embedded	Embedded	$2,600	$5,200	$700	$1,400	Separate	$5 / 20% / 40%, VBID = $1 #
FRVT-HMO-S1-003-N (2020)	HyHMO	Silver	Non-Standard	$5 No DD	$10	5%	$25	$40 (Fac) $20 (Phys)	$25	$0	$0	Embedded	5%	Embedded	Embedded	$1,450	$2,900	$350	$700	Separate	$5 / 5% / 5%, VBID = $1 #
FRVT-HMO-S1-003-N (2021)	HyHMO	Silver	Non-Standard	$5 No DD	$10	5%	$25	$40 (Fac) $20 (Phys)	$25	$0	$0	Embedded	5%	Embedded	Embedded	$1,450	$2,900	$350	$700	Separate	$5 / 5% / 5%, VBID = $1 #
FRVT-HMO-S1-004-N (2020)	HyHMO	Silver	Non-Standard	$10**	$40	30%	$100	$800 (Fac) $200 (Phys)	$100	$500	$1,000	Embedded	30%	Embedded	Embedded	$5,400	$10,800	$1,350	$2,700	Separate	$5 / 40% / 40%, $200 / $400 Ded, VBID = $1 #
FRVT-HMO-S1-004-N (2021)	HyHMO	Silver	Non-Standard	$10**	$40	30%	$100	$800 (Fac) $200 (Phys)	$100	$500	$1,000	Embedded	30%	Embedded	Embedded	$5,400	$10,800	$1,350	$2,700	Separate	$5 / 40% / 40%, $200 / $400 Ded, VBID = $1 #

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	Med Ded Single	Med Ded Family	Deductible Type	Coins.	Med OOP Type	Rx OOP Type	Med OOP Max Single	Med OOP Max Family	Rx OOP Max Single	Rx OOP Max Family	OOP Max Type	Pharmacy
FRVT-HMO-BA1-001-S (2020)	HMO	Bronze	Standard	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-001-S (2021)	HMO	Bronze	Standard	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-001-N (2020)	HyHMO	Bronze	Non-Standard	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0
FRVT-HMO-BA1-001-N (2021)	HMO	Bronze	Non-Standard	$0	$0	0%	$0	0%	$0	$0	$0	$0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0

Changes in benefits from 2020 to 2021 are shown in gray shading.

Exhibit 2 -- Pricing Trend Assumptions

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Experience Period:	January 1, 2019 - December 31, 2019
Rating Period:	January 1, 2021 - December 31, 2021

	2020	2021	Total
Months of Trend	12	12	**24**

Medical Trend Summary

2020 Annual Trend

	% of Allowed Claims	Unit Cost	Utilization	Total
IP	22.0%	5.1%	1.0%	6.1%
OP	48.9%	4.4%	1.0%	5.4%
PHY	27.1%	1.3%	1.0%	2.3%
OTR	1.9%	2.0%	1.0%	3.0%
Medical Total		3.7%	1.0%	**4.7%**

2021 Annual Trend

	% of Allowed Claims	Unit Cost	Utilization	Total
IP	22.3%	7.0%	1.0%	8.1%
OP	49.3%	6.5%	1.0%	7.5%
PHY	26.5%	4.6%	1.0%	5.6%
OTR	1.8%	5.0%	1.0%	6.1%
Medical Total		6.0%	1.0%	**7.1%**

Annual Allowed Medical Trend **5.9%**

Leveraging Impact - Fee-For-Service Medical Claims

	Allowed-COB	Coinsurance	Copay	Deductible	Paid*
Rating Period:	$423.97	$11.14	$7.79	$58.33	$346.70
24 Months of Trend:	1.121	1.121	1.020	1.041	**1.137**
Projection Period:	$475.46	$12.50	$7.95	$60.73	$394.28
Allowed Trend (Annual)	5.9%				
Paid Trend (Annual)	6.6%				
Leveraging (Annual)	**0.7%**				

Rx Trend Summary

	2020 Trend		2021 Trend		Annualized Trend	
	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Generic	-16.6%	2.8%	-8.9%	2.3%	-12.8%	2.6%
Brand	11.9%	-6.8%	4.6%	1.5%	8.2%	-2.7%
Specialty	6.4%	8.4%	6.0%	9.1%	6.2%	8.7%

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Exhibit 2b -- Rx Trend Development

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Rx Claim Information	Generic	Brand	Specialty	Total
Experience Period Scripts / 1000	11,455	681	103	12,239
Experience Period Allowed Cost per Script	$17.42	$412.53	$4,420.08	$76.33
Experience Period Deductible Per Script	$3.38	$21.73	$74.53	$5.00
Experience Period Copay Per Script	$2.88	$13.32	$12.02	$3.54
Experience Period Coinsurance Per Script	$1.10	$19.66	$30.18	$2.38
Experience Period Paid Cost Per Script	$10.06	$357.82	$4,303.40	$65.41
Experience Period Allowed PMPM	$16.63	$23.42	$37.79	$77.85
Experience Period Deductible PMPM	$3.23	$1.23	$0.64	$5.10
Experience Period Copay PMPM	$2.75	$0.76	$0.10	$3.61
Experience Period Coinsurance PMPM	$1.05	$1.12	$0.26	$2.43
Experience Period Paid PMPM	$9.60	$20.32	$36.80	$66.71
Experience Period Rx Rebates PMPM				($16.06)
Annual Util Trend	1.026	0.973	1.087	1.023
Annual Unit Cost Trend	0.872	1.082	1.062	1.048
Annual Allowed Trend	0.894	1.052	1.155	1.073
Annual Deductible Trend	1.020	1.020	1.020	1.016
Annual Paid Trend	0.792	1.059	1.155	1.081
Annual Paid Trend Net of Rebates	n/a	n/a	n/a	1.083
Months of Trend	24	24	24	24
Projected Scripts / 1000	12,049	644	121	12,815
Projected Allowed Cost per Script	$13.24	$482.85	$4,984.38	$83.90
Projected Deductible Per Script	$3.52	$22.62	$77.60	$5.18
Projected Copay Per Script	$2.88	$13.32	$12.02	$3.49
Projected Coinsurance Per Script	$0.84	$23.01	$34.03	$2.27
Projected Paid Cost Per Script	$6.00	$423.89	$4,860.74	$72.96
Projected Allowed PMPM	$13.29	$25.93	$50.38	$89.60
Projected Deductible PMPM	$3.54	$1.22	$0.78	$5.53
Projected Copay PMPM	$2.89	$0.72	$0.12	$3.73
Projected Coinsurance PMPM	$0.84	$1.24	$0.34	$2.42
Projected Paid PMPM	$6.02	$22.76	$49.13	$77.92
Projected Rx Rebates				($18.49)
Net Projected Paid PMPM				$59.43

Exhibit 2b -- Rx Trend Development (Small ACA)

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Rx Claim Information	Generic	Brand	Specialty	Total
Experience Period Scripts / 1000	11,462	686	103	12,251
Experience Period Allowed Cost per Script	$17.80	$407.09	$4,606.80	$78.07
Experience Period Deductible Per Script	$4.26	$24.28	$93.34	$6.13
Experience Period Copay Per Script	$2.96	$14.97	$13.90	$3.73
Experience Period Coinsurance Per Script	$1.15	$14.72	$21.86	$2.09
Experience Period Paid Cost Per Script	$9.42	$353.11	$4,477.79	$66.12
Experience Period Allowed PMPM	$17.00	$23.28	$39.41	$79.70
Experience Period Deductible PMPM	$4.07	$1.39	$0.80	$6.26
Experience Period Copay PMPM	$2.83	$0.86	$0.12	$3.81
Experience Period Coinsurance PMPM	$1.10	$0.84	$0.19	$2.13
Experience Period Paid PMPM	$9.00	$20.20	$38.31	$67.50
Experience Period Rx Rebates PMPM				($15.98)
Annual Util Trend	1.026	0.973	1.087	1.023
Annual Unit Cost Trend	0.872	1.082	1.062	1.049
Annual Allowed Trend	0.894	1.052	1.155	1.074
Annual Deductible Trend	1.020	1.020	1.020	1.016
Annual Paid Trend	0.766	1.059	1.156	1.083
Annual Paid Trend Net of Rebates	n/a	n/a	n/a	1.085
Months of Trend	24	24	24	24
Projected Scripts / 1000	12,056	649	121	12,827
Projected Allowed Cost per Script	$13.53	$476.48	$5,194.94	$85.98
Projected Deductible Per Script	$4.43	$25.25	$97.07	$6.36
Projected Copay Per Script	$2.96	$14.97	$13.90	$3.68
Projected Coinsurance Per Script	$0.88	$17.23	$24.65	$1.93
Projected Paid Cost Per Script	$5.26	$419.02	$5,059.31	$74.01
Projected Allowed PMPM	$13.59	$25.78	$52.53	$91.90
Projected Deductible PMPM	$4.46	$1.37	$0.98	$6.80
Projected Copay PMPM	$2.98	$0.81	$0.14	$3.93
Projected Coinsurance PMPM	$0.88	$0.93	$0.25	$2.06
Projected Paid PMPM	$5.28	$22.67	$51.16	$79.11
Projected Rx Rebates				($18.43)
Net Projected Paid PMPM				$60.68

Exhibit 2b -- Rx Trend Development (Individual ACA)

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Rx Claim Information	Generic	Brand	Specialty	Total
Experience Period Scripts / 1000	11,447	676	103	12,225
Experience Period Allowed Cost per Script	$16.99	$418.77	$4,209.04	$74.36
Experience Period Deductible Per Script	$2.39	$18.81	$53.28	$3.72
Experience Period Copay Per Script	$2.78	$11.43	$9.89	$3.32
Experience Period Coinsurance Per Script	$1.05	$25.31	$39.58	$2.71
Experience Period Paid Cost Per Script	$10.77	$363.21	$4,106.29	$64.61
Experience Period Allowed PMPM	$16.20	$23.58	$35.97	$75.75
Experience Period Deductible PMPM	$2.28	$1.06	$0.46	$3.79
Experience Period Copay PMPM	$2.66	$0.64	$0.08	$3.38
Experience Period Coinsurance PMPM	$1.00	$1.43	$0.34	$2.76
Experience Period Paid PMPM	$10.27	$20.45	$35.09	$65.82
Experience Period Rx Rebates PMPM				($16.15)
Annual Util Trend	1.026	0.973	1.087	1.023
Annual Unit Cost Trend	0.872	1.082	1.062	1.047
Annual Allowed Trend	0.894	1.052	1.155	1.072
Annual Deductible Trend	1.021	1.021	1.021	1.017
Annual Paid Trend	0.818	1.058	1.155	1.079
Annual Paid Trend Net of Rebates	n/a	n/a	n/a	1.081
Months of Trend	24	24	24	24
Projected Scripts / 1000	12,041	639	121	12,801
Projected Allowed Cost per Script	$12.91	$490.15	$4,746.39	$81.56
Projected Deductible Per Script	$2.49	$19.61	$55.53	$3.84
Projected Copay Per Script	$2.78	$11.43	$9.89	$3.28
Projected Coinsurance Per Script	$0.80	$29.63	$44.64	$2.65
Projected Paid Cost Per Script	$6.84	$429.48	$4,636.34	$71.78
Projected Allowed PMPM	$12.95	$26.11	$47.94	$87.00
Projected Deductible PMPM	$2.49	$1.04	$0.56	$4.10
Projected Copay PMPM	$2.79	$0.61	$0.10	$3.50
Projected Coinsurance PMPM	$0.80	$1.58	$0.45	$2.83
Projected Paid PMPM	$6.87	$22.87	$46.83	$76.57
Projected Rx Rebates				($18.55)
Net Projected Paid PMPM				$58.02

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Development of Index PMPM Claim Rate
Experience Period Incurred DOS: 1/1/19 - 12/31/19
Completed Through: 3/31/20

		ACA Compliant Small Group	ACA Compliant Individual	Small Group + Individual Single Risk Pool
1	Member Months	190,655	168,861	359,516
2	FFS Paid Medical Claims	$318.63	$380.24	$347.56
3	FFS Paid Pediatric Dental Claims	$0.84	$0.84	$0.84
4a	Federal CSR Payments	$0.00	($32.00)	($15.03)
4b	State CSR Payments	$0.00	($2.68)	($1.26)
5	IBNR Factor	1.024	1.024	1.024
6	FFS Incurred Paid Medical Claims	$327.11	$354.68	$340.06
7	FFS Incurred Rx Claims	$67.50	$65.82	$66.71
8	Experience Period Rx Rebates	($15.98)	($16.15)	($16.06)
9	FFS Incurred Rx Claims (Net of Rebates)	$51.52	$49.66	$50.65
10	FFS Medical & Rx Claims in Excess of $100,000 Pooling Point	($41.77)	($51.26)	($46.23)
11	Pooling Charge	$41.62	$43.63	$42.56
12	FFS Experience Period Claim Expense After Pooling Adjustment	$378.48	$396.72	$387.04
13	Experience Period Capitation and Non-FFS Medical Costs	$8.90	$9.11	$9.00
14	**Adjusted Experience Period Claim Expense**	**$387.38**	**$405.83**	**$396.05**
	Market-Wide Adjustments to Experience Period Claims			
15	Adjustment for pharmacy benefit carve-in	$0.35	$0.12	$0.24
16	Adjustment for Safe Harbor Coverage on QHDHP's	$0.23	$0.09	$0.16
17	Adjustment for COVID-19 Immunization Cost	$5.00	$5.00	$5.00
18	Adjustment for COVID-19 Pent-up Demand	$1.50	$1.50	$1.50
19	Adjustment for National High Cost Reinsurance Pool	$1.06	$1.11	$1.08
20	**Experience Period Claim Expense After All Adjustments**	**$395.52**	**$413.65**	**$404.04**
21	Annual FFS Medical projection factor	1.066	1.066	1.066
22	Annual FFS Rx projection factor	1.085	1.081	1.083
23	Annual FFS Claim trend projection factor	1.069	1.068	1.069
24	Months of Trend	24	24	24
25	Projection Period FFS Claim Expense PMPM Prior to Adjustments for Federal Programs	$441.08	$460.88	$450.38
26	Projection Period VT Paid Claim Surcharge + NYS HCRA	$5.07	$5.30	$5.17
27	Projection Period Capitation and Non-FFS Medical Costs	$4.90	$4.90	$4.90
28	**Paid Index Rate PMPM Prior to Adjustments for Federal Programs**	**$451.05**	**$471.07**	**$460.45**
	Federal Reinsurance and Risk Adjustment Programs			
29	Federal Risk Adjustment Program Impact	$71.25	$74.41	$72.74
30	**Paid Index Rate PMPM After Adjustments for Federal Programs**	**$522.30**	**$545.49**	**$533.18**

Exhibit 4 -- Conversion Factor and Tier Ratios

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Tier	Contract Type	Subscribers	Members	Avg Contract Size	Load Factor
4	Single	16,111	16,111	1.000	1.000
4	Double	4,188	8,376	2.000	2.000
4	Parent/Child(ren)	914	2,244	2.455	1.930
4	Family	2,659	10,249	3.854	2.810

Single Conversion Factor **1.097**

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

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

% of Premium Retention Components	
Broker Load	0.00%
Bad Debt	0.40%
Contribution to Reserves	1.50%
Total % of Premium Retention Components	1.90%

PMPM Retention Components	
General Administrative Load	$43.75

% of Premium Taxes and Assessments	
Premium Tax	0.00%
VT Vaccine Pilot	0.34%
ACA Insurer Tax	0.00%
Total % of Premium Taxes/Assessments	0.34%

% of Paid Claim Taxes and Assessments	
Vermont Paid Claim Surcharge	0.999%
New York State HCRA Surcharge	0.150%
Total % of Paid Claim Taxes/Assessments	1.149%

PMPM Taxes and Assessments	
HHS Risk Adjustment User Fee	$0.18
18 VSA 9374(h) Billback	$1.84
Total PMPM Taxes/Assessments	$2.02

Exhibit 6 -- Calculation of Load for On-Exchange Silver Plans

MVP Health Plan, Inc. 2021 Vermont Exchange Rate Filing
For Effective Dates Beginning Between January 1, 2021 - December 31, 2021

Derivation of Projected CSR Load

1)	Projection Period Federal CSR Dollars	$5,720,172	
2)	Projection Period Member Months, CSR Plans	72,744	
3)	Projection Period Federal CSR PMPM	$78.63	= 1) / 2)
4)	IBNR Factor	1.024	
5)	Federal CSR PMPM with IBNR	$80.52	= 3) * 4)
6)	Annual Trend Factor	1.012	
7)	Months of Trend	24	
8)	Trended Federal CSR PMPM	$82.54	= 5) * 6) ^ [7) / 12]

Exhibit 7 – 2021 Exchange Premium Rates

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2021 Adjusted Paid Claim Cost (Exhibit 3, Line 30)	$533.18
Benefit Relativity * Induced Demand Reflected in Index Rate	0.7963
Adjusted Claim Cost for Pricing	$669.54

Coplan	Product Type	Metal Level	Standard/Non-Standard	On/Off Exchange	Federal and State Combined Subsidy	Benefit Actuarial Value	Induced Utilization Factor*	Net Claim Cost PMPM	Bad Debt / CTR (% of Premium)	Administrative Expense (PMPM)	% of Premium Taxes and Assessments	PMPM Taxes and Assessments	Benefits in Excess of EHB's**	CSR Loading	Gross Claim Cost PMPM	Single***	Double	Parent/Child (ren)	Family	Increase over 2020 Single Rate	Increase over 2020 Double Rate	Increase over 2020 P/C Rate	Increase over 2020 Family Rate
FRVT-HMO-P-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	Non-Subsidized	0.907	1.150	$698.37	$14.46	$43.75	$2.59	$2.02	$0.00	$0.00	$761.19	$835.03	$1,670.06	$1,611.61	$2,346.43	6.4%	6.4%	6.4%	6.4%
FRVT-HMO-G-001-S (2021)	HyHMO	Gold	Standard	On Exchange	Non-Subsidized	0.803	1.083	$582.35	$12.21	$43.75	$2.18	$2.02	$0.00	$0.00	$642.52	$704.84	$1,409.68	$1,360.34	$1,980.60	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-G-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	Non-Subsidized	0.823	1.098	$605.07	$12.67	$43.75	$2.27	$2.02	$0.88	$0.00	$666.65	$731.32	$1,462.64	$1,411.45	$2,055.01	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-G-003-N (2021)	HDHMO	Gold	Non-Standard	On Exchange	Non-Subsidized	0.809	1.089	$589.68	$12.37	$43.75	$2.21	$2.02	$0.88	$0.00	$650.91	$714.05	$1,428.10	$1,378.12	$2,006.48	9.5%	9.5%	9.5%	9.5%
FRVT-HMO-S-003-S (2021)	HyHMO	Silver	Standard	On Exchange	Non-Subsidized	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-S-004-S (2021)	HDHMO	Silver	Standard	On Exchange	Non-Subsidized	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-S-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	Non-Subsidized	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMO-S-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	Non-Subsidized	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
VT-HMO-S-003-S II (2021)	HyHMO	Silver	Standard	Off Exchange	Non-Subsidized	0.722	1.043	$504.14	$10.69	$43.75	$1.91	$2.02	$0.00	$0.00	$562.52	$617.08	$1,234.16	$1,190.96	$1,733.99	5.5%	5.5%	5.5%	5.5%
VT-HMOH-S-004-S II (2021)	HDHMO	Silver	Standard	Off Exchange	Non-Subsidized	0.712	1.034	$492.89	$10.47	$43.75	$1.87	$2.02	$0.00	$0.00	$551.00	$604.45	$1,208.90	$1,166.59	$1,698.50	5.8%	5.8%	5.8%	5.8%
VT-HMOH-S-002-N II (2021)	HDHMO	Silver	Non-Standard	Off Exchange	Non-Subsidized	0.718	1.037	$498.74	$10.60	$43.75	$1.90	$2.02	$0.88	$0.00	$557.88	$611.99	$1,223.98	$1,181.14	$1,719.69	5.6%	5.6%	5.6%	5.6%
VT-HMO-S-001-N II (2021)	HyHMO	Silver	Non-Standard	Off Exchange	Non-Subsidized	0.707	1.032	$488.57	$10.40	$43.75	$1.86	$2.02	$0.88	$0.00	$547.48	$600.59	$1,201.18	$1,159.14	$1,687.66	8.3%	8.3%	8.3%	8.3%
FRVT-HMO-B-002-S (2021)	HMO	Bronze	Standard	On Exchange	Non-Subsidized	0.621	1.005	$417.82	$9.01	$43.75	$1.61	$2.02	$0.00	$0.00	$474.21	$520.21	$1,040.42	$1,004.01	$1,461.79	9.2%	9.2%	9.2%	9.2%
FRVT-HMOH-B-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	Non-Subsidized	0.628	1.007	$423.06	$9.11	$43.75	$1.63	$2.02	$0.00	$0.00	$479.57	$526.09	$1,052.18	$1,015.35	$1,478.31	7.4%	7.4%	7.4%	7.4%
FRVT-HMO-B-004-S (2021)	HMO	Bronze	Standard	On Exchange	Non-Subsidized	0.649	1.013	$440.54	$9.45	$43.75	$1.69	$2.02	$0.00	$0.00	$497.45	$545.70	$1,091.40	$1,053.20	$1,533.42	0.5%	0.5%	0.5%	0.5%
FRVT-HMO-B-005-N (2021)	HMO	Bronze	Non-Standard	On Exchange	Non-Subsidized	0.634	1.008	$427.56	$9.22	$43.75	$1.65	$2.02	$0.88	$0.00	$485.07	$532.12	$1,064.24	$1,026.99	$1,495.26	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-B-001-N (2021)	HMO	Bronze	Non-Standard	On Exchange	Non-Subsidized	0.609	1.001	$408.08	$8.84	$43.75	$1.58	$2.02	$0.88	$0.00	$465.16	$510.28	$1,020.56	$984.84	$1,433.89	7.2%	7.2%	7.2%	7.2%
FRVT-HMO-C-001-N (2021)	HMO	Catastrophic	Standard	On Exchange	Non-Subsidized	0.634	0.637	$270.44	$6.15	$43.75	$1.10	$2.02	$0.00	$0.00	$323.46	$354.84	$709.68	$684.84	$997.10	5.5%	5.5%	5.5%	5.5%
FRVT-HMO-S3-001-S (2021)	HyHMO	Silver	Standard	On Exchange	Subsidized (73%)	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMO-S3-002-S (2021)	HyHMO	Silver	Standard	On Exchange	Subsidized (87%)	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMO-S3-003-S (2021)	HyHMO	Silver	Standard	On Exchange	Subsidized (94%)	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMO-S3-004-S (2021)	HyHMO	Silver	Standard	On Exchange	Subsidized (77%)	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-S4-001-S (2021)	HDHMO	Silver	Standard	On Exchange	Subsidized (73%)	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-S4-002-S (2021)	HMO	Silver	Standard	On Exchange	Subsidized (87%)	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-S4-003-S (2021)	HMO	Silver	Standard	On Exchange	Subsidized (94%)	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-S4-004-S (2021)	HDHMO	Silver	Standard	On Exchange	Subsidized (77%)	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-S2-001-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	Subsidized (73%)	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMOH-S2-002-N (2021)	HMO	Silver	Non-Standard	On Exchange	Subsidized (87%)	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMOH-S2-003-N (2021)	HMO	Silver	Non-Standard	On Exchange	Subsidized (94%)	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMOH-S2-004-N (2021)	HMO	Silver	Non-Standard	On Exchange	Subsidized (77%)	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMO-S1-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	Subsidized (73%)	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-S1-002-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	Subsidized (87%)	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-S1-003-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	Subsidized (94%)	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-S1-004-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	Subsidized (77%)	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-PA2-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	AI/AN	0.907	1.150	$698.37	$14.46	$43.75	$2.59	$2.02	$0.00	$0.00	$761.19	$835.03	$1,670.06	$1,611.61	$2,346.43	6.4%	6.4%	6.4%	6.4%
FRVT-HMO-GA2-001-S (2021)	HyHMO	Gold	Standard	On Exchange	AI/AN	0.803	1.083	$582.35	$12.21	$43.75	$2.18	$2.02	$0.00	$0.00	$642.52	$704.84	$1,409.68	$1,360.34	$1,980.60	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-GA2-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	AI/AN	0.823	1.098	$605.07	$12.67	$43.75	$2.27	$2.02	$0.88	$0.00	$666.65	$731.32	$1,462.64	$1,411.45	$2,055.01	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-GA2-003-N (2021	HDHMO	Gold	Non-Standard	On Exchange	AI/AN	0.809	1.089	$589.68	$12.37	$43.75	$2.21	$2.02	$0.88	$0.00	$650.91	$714.05	$1,428.10	$1,378.12	$2,006.48	9.5%	9.5%	9.5%	9.5%
FRVT-HMO-SA2-003-S (2021)	HyHMO	Silver	Standard	On Exchange	AI/AN	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-SA2-004-S (2021)	HDHMO	Silver	Standard	On Exchange	AI/AN	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-SA2-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	AI/AN	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMO-SA2-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	AI/AN	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-BA2-002-S (2021)	HyHMO	Bronze	Standard	On Exchange	AI/AN	0.621	1.005	$417.82	$9.01	$43.75	$1.61	$2.02	$0.00	$0.00	$474.21	$520.21	$1,040.42	$1,004.01	$1,461.79	9.2%	9.2%	9.2%	9.2%
FRVT-HMOH-BA2-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	AI/AN	0.628	1.007	$423.06	$9.11	$43.75	$1.63	$2.02	$0.00	$0.00	$479.57	$526.09	$1,052.18	$1,015.35	$1,478.31	7.4%	7.4%	7.4%	7.4%
FRVT-HMO-BA2-004-S (2021)	HyHMO	Bronze	Standard	On Exchange	AI/AN	0.649	1.013	$440.54	$9.45	$43.75	$1.69	$2.02	$0.00	$0.00	$497.45	$545.70	$1,091.40	$1,053.20	$1,533.42	0.5%	0.5%	0.5%	0.5%
FRVT-HMO-BA2-005-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	AI/AN	0.634	1.008	$427.56	$9.22	$43.75	$1.65	$2.02	$0.88	$0.00	$485.07	$532.12	$1,064.24	$1,026.99	$1,495.26	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-BA2-001-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	AI/AN	0.609	1.001	$408.08	$8.84	$43.75	$1.58	$2.02	$0.88	$0.00	$465.16	$510.28	$1,020.56	$984.84	$1,433.89	7.2%	7.2%	7.2%	7.2%
FRVT-HMO-PA1-001-S (2021)	HyHMO	Platinum	Standard	On Exchange	AI/AN	0.907	1.150	$698.37	$14.46	$43.75	$2.59	$2.02	$0.00	$0.00	$761.19	$835.03	$1,670.06	$1,611.61	$2,346.43	6.4%	6.4%	6.4%	6.4%
FRVT-HMO-GA1-001-S (2021)	HyHMO	Gold	Standard	On Exchange	AI/AN	0.803	1.083	$582.35	$12.21	$43.75	$2.18	$2.02	$0.00	$0.00	$642.52	$704.84	$1,409.68	$1,360.34	$1,980.60	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-GA1-002-N (2021)	HyHMO	Gold	Non-Standard	On Exchange	AI/AN	0.823	1.098	$605.07	$12.67	$43.75	$2.27	$2.02	$0.88	$0.00	$666.65	$731.32	$1,462.64	$1,411.45	$2,055.01	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-GA1-003-N (2021	HDHMO	Gold	Non-Standard	On Exchange	AI/AN	0.809	1.089	$589.68	$12.37	$43.75	$2.21	$2.02	$0.88	$0.00	$650.91	$714.05	$1,428.10	$1,378.12	$2,006.48	9.5%	9.5%	9.5%	9.5%
FRVT-HMO-SA1-003-S (2021)	HyHMO	Silver	Standard	On Exchange	AI/AN	0.722	1.043	$504.14	$12.29	$43.75	$2.20	$2.02	$0.00	$82.54	$646.95	$709.70	$1,419.40	$1,369.72	$1,994.26	5.1%	5.1%	5.1%	5.1%
FRVT-HMOH-SA1-004-S (2021)	HDHMO	Silver	Standard	On Exchange	AI/AN	0.712	1.034	$492.89	$12.07	$43.75	$2.16	$2.02	$0.00	$82.54	$635.43	$697.07	$1,394.14	$1,345.35	$1,958.77	5.3%	5.3%	5.3%	5.3%
FRVT-HMOH-SA1-002-N (2021)	HDHMO	Silver	Non-Standard	On Exchange	AI/AN	0.719	1.040	$500.68	$12.24	$43.75	$2.19	$2.02	$0.88	$82.54	$644.31	$706.81	$1,413.62	$1,364.14	$1,986.14	5.2%	5.2%	5.2%	5.2%
FRVT-HMO-SA1-001-N (2021)	HyHMO	Silver	Non-Standard	On Exchange	AI/AN	0.707	1.032	$488.57	$12.01	$43.75	$2.15	$2.02	$0.88	$82.54	$631.91	$693.21	$1,386.42	$1,337.90	$1,947.92	7.5%	7.5%	7.5%	7.5%
FRVT-HMO-BA1-002-S (2021)	HyHMO	Bronze	Standard	On Exchange	AI/AN	0.621	1.005	$417.82	$9.01	$43.75	$1.61	$2.02	$0.00	$0.00	$474.21	$520.21	$1,040.42	$1,004.01	$1,461.79	9.2%	9.2%	9.2%	9.2%
FRVT-HMOH-BA1-003-S (2021)	HDHMO	Bronze	Standard	On Exchange	AI/AN	0.628	1.007	$423.06	$9.11	$43.75	$1.63	$2.02	$0.00	$0.00	$479.57	$526.09	$1,052.18	$1,015.35	$1,478.31	7.4%	7.4%	7.4%	7.4%
FRVT-HMO-BA1-004-S (2021)	HyHMO	Bronze	Standard	On Exchange	AI/AN	0.649	1.013	$440.54	$9.45	$43.75	$1.69	$2.02	$0.00	$0.00	$497.45	$545.70	$1,091.40	$1,053.20	$1,533.42	0.5%	0.5%	0.5%	0.5%
FRVT-HMO-BA1-005-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	AI/AN	0.634	1.008	$427.56	$9.22	$43.75	$1.65	$2.02	$0.88	$0.00	$485.07	$532.12	$1,064.24	$1,026.99	$1,495.26	6.2%	6.2%	6.2%	6.2%
FRVT-HMO-BA1-001-N (2021)	HyHMO	Bronze	Non-Standard	On Exchange	AI/AN	0.609	1.001	$408.08	$8.84	$43.75	$1.58	$2.02	$0.88	$0.00	$465.16	$510.28	$1,020.56	$984.84	$1,433.89	7.2%	7.2%	7.2%	7.2%

*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 FRVT366
***Child Only Rate = Single Rate per Child

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 Plan, Inc.
HIOS ID	77566
SERFF Filing Number	MVPH-13237 1260
Date of Submission	5/8/2020
Proposed Effective Date	1/1/2021

	Average Annual Premium
Before Rate Change	$6,732
After Rate Change	$7,226

		Amount in SERFF's Rate Review Detail Section	Explanation for differences
Proposed Overall Rate Change	7.34%		N/A
Proposed Minimum Rate Change	0.54%		N/A
Proposed Maximum Rate Change	9.55%		N/A

If the difference between the maximum and minimum rate increase is greater than 10%, Provide a statement and clear delineation of contributing factors explaining why certain individual will receive a rate decrease as low as the minimum while others will face rate increases as high as the maximum

N/A

Relationship of Proposed Rate Scale to Current Rate Scale:
Provide a detailed breakdown of the average rate change from the previous approved filing by using the chart below to itemize the drivers of the average rate change. The table should include the previous assumption, current assumption, and the resulting change. Include additional lines as necessary.

Source of Change	Previous filing Assumption	Current Filing Assumption	Relativity Current Filing / Previous filing	
Base Period Experience	1.000	1.075	1.075	e.g. previous filing experience period index rate compared to the current filing experience index rate
Impact of Leap Year on Experience	1.003	1.000	0.997	If applicable, the change in this factor is based on the average copay impact difference between previous filing and current filing.
Impact of Rx Benefit Carve-In	1.001	1.001	1.000	The change in this factor is based on the change the trend assumption in previous filing and current filing (e.g.. 1.075^2 / 1.08^2)
Adjustment for Safe Harbor Coverage on QHDHP's	1.000	1.000	1.000	The change in this factor is based on the change in the morbidity assumptions between previous filing and current filing.
Adjustment for COVID-19 Immunization Cost	1.000	1.013	1.013	The change in this factor is based on the change in the risk adjustment recoveries assumptions between previous filing and current filing.
Adjustment for pediatric dental carve-in to Small Group Grandfathered	1.000	1.000	1.000	
Adjustment for COVID-19 Pent-up Demand	1.000	1.004	1.004	
Adjustment for National Reinsurance	1.002	1.003	1.000	
Pricing Trend	1.132	1.140	1.007	
Risk Adjustment Recoveries	1.160	1.158	0.999	
Experience Period Benefit and AV Change	1.013	1.000	0.987	
SG&A	1.064	1.065	1.001	
Taxes and Fees (PMPM Basis)	1.003	1.003	1.000	
Taxes and Fees (% of Premium Basis)	1.013	1.003	0.990	
Margin	1.014	1.020	1.005	
Single Conversion Factor	1.091	1.097	1.005	
CSR Defunding	1.034	1.025	0.992	
Benefit Mix Impact	1.001	1.000	0.999	
Total Rate Change			1.073	
If applicable, Provide an explanation for difference between the Calculated Rate change and the average rate change in cell B17			1.073	

N/A

Annual Rate Change Distribution

	Impacted # of Contracts	Impacted # of Members	Impacted # of Groups, If applicable
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%	314	416	31
Increase of 5.01% to 10.00%	23,558	36,564	3,251
Increase of 10.01% to 14.99%	0	0	0
Increase of 15.00% or more	0	0	0
Total	23,872	36,980	3,282

History of Rate Changes

For Year	Average Annual Proposed Rate Change	Average Annual Approved Rate Change
2017	8.93%	3.89%
2018	6.74%	3.42%
2019	10.88%	6.63%
2020	8.45%	10.08%

Retention

	PMPM in effect during the experience period	PMPM from Most Recent Approved Rate Filing	Proposed PMPM for Effective Date	Proposed Change in PMPM Compared to Prior 12 months	Proposed Change in PMPM Compared to Most Recently Approved Filing
Dates	1/1/2019 - 12/31/2019	1/1/2020 - 12/31/2020	1/1/2021 - 12/31/2021		
Commissions & Brokers Fees	$0.00	$0.00	$0.00		
Taxes, Licenses & Fees	$1.06	$9.39	$4.07	283.75%	-56.66%
Exchange Fee	$0.00	$0.00	$0.00		
Reinsurance	$0.00	$0.00	$0.00		
All Other Admin Expense	$39.80	$42.00	$43.75	9.93%	4.17%
Profit/Risk Margin	$9.68	$7.85	$11.44	18.20%	45.83%
Total	$50.54	$59.23	$59.26	17.26%	0.05%
Variable	$25.38	$27.60	$29.82	17.48%	8.06%
Non-Variable	$25.16	$31.64	$29.44	17.03%	-6.94%
Total	$50.54	$59.23	$59.26	17.26%	0.05%
Check	TRUE	TRUE	TRUE		

	As % of Premium during the experience period	As % of Premium from Most Recent Approved Rate Filing	Proposed As % of Premium for Effective Date	Proposed Change in % of Premium Compared to Prior 12 months	Proposed Change in % of Premium Compared to Most Recently Approved Filing
Commissions & Brokers Fees	0.00%	0.00%	0.00%		
Taxes, Licenses & Fees	0.21%	1.68%	0.68%	224.66%	-59.67%
Exchange Fee	0.00%	0.00%	0.00%		
Reinsurance	0.00%	0.00%	0.00%		
All Other Admin Expense	7.81%	7.50%	7.27%	-7.00%	-3.06%
Profit/Risk Margin	1.90%	1.40%	1.90%	0.00%	35.71%
Total	9.92%	10.57%	9.84%	-0.80%	-6.89%
Variable	4.98%	4.92%	4.95%	-0.61%	0.57%
Non-Variable	4.94%	5.65%	4.89%	-0.99%	-13.40%
Total	9.92%	10.57%	9.84%	-0.80%	-6.89%
Check	TRUE	TRUE	TRUE		

Trend & Projection Assumptions

Historical Experience (ACA Only): Incurred or Allowed Basis[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "Allowed").*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Normalized Monthly Incurred Claims $ PMPM*	Normalized Rolling 12 Mo Trend	Normalized Annualized Rolling 6 Mo Trend	Normalized Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$285.33				1.00	1.00	1.00	$285.33			
	Feb-2017	10,301	$243.57				1.00	1.00	1.00	$242.46			
	Mar-2017	11,249	$348.85				1.01	1.01	1.00	$343.65			
	Apr-2017	11,326	$280.47				1.00	1.01	1.00	$276.70			
	May-2017	11,395	$330.56				1.00	1.01	1.00	$326.60			
	Jun-2017	11,437	$335.77			32.21%	1.00	1.01	1.00	$331.65			29.60%
	Jul-2017	11,594	$310.48			53.81%	1.00	1.01	1.00	$306.53			53.44%
	Aug-2017	11,706	$338.73			10.93%	1.00	1.01	1.00	$334.06			11.17%
	Sep-2017	11,726	$340.03			19.13%	1.00	1.01	1.00	$336.57			19.27%
	Oct-2017	11,764	$351.66			23.96%	1.00	1.01	1.00	$348.33			24.56%
	Nov-2017	11,675	$415.90			59.74%	1.00	1.00	1.00	$413.69			62.87%
	Dec-2017	11,600	$367.03		34.25%	72.82%	1.00	1.00	1.00	$366.65		34.73%	77.76%
	Jan-2018	25,006	$274.48		18.16%	-13.86%	0.98	1.02	1.00	$272.68		19.26%	-11.60%
	Feb-2018	25,014	$296.58		0.93%	-55.85%	0.98	1.02	1.00	$295.23		2.41%	-55.20%
	Mar-2018	25,117	$316.04		-0.56%	-62.60%	0.98	1.02	1.00	$314.94		0.94%	-62.53%
	Apr-2018	25,025	$351.53		-5.60%	-11.04%	0.98	1.02	1.00	$351.04		-4.06%	-10.44%
	May-2018	25,098	$386.25		-11.28%	85.78%	0.98	1.02	1.00	$386.12		-9.92%	87.92%
	Jun-2018	25,199	$359.97		-12.63%	134.42%	0.98	1.02	1.00	$360.60		-11.51%	138.96%
	Jul-2018	25,331	$359.15		5.28%	72.71%	0.98	1.01	1.00	$359.88		6.69%	75.60%
	Aug-2018	25,418	$411.40		25.03%	32.57%	0.98	1.01	1.00	$412.50		26.63%	34.59%
	Sep-2018	25,557	$355.33		32.53%	10.62%	0.98	1.01	1.00	$356.32		34.20%	11.73%
	Oct-2018	25,520	$453.17		42.15%	48.36%	0.98	1.01	1.00	$455.43		43.90%	49.82%
	Nov-2018	25,523	$461.23		48.32%	58.96%	0.98	1.01	1.00	$463.99		50.21%	60.59%
	Dec-2018	25,498	$420.53	12.18%	53.69%	97.68%	0.98	1.01	1.00	$424.07	13.42%	55.78%	100.80%
	Jan-2019	30,160	$380.90	17.10%	43.18%	12.34%	0.97	1.01	1.00	$389.13	18.69%	45.71%	16.18%
	Feb-2019	30,197	$331.50	17.41%	19.39%	-38.16%	0.97	1.01	1.00	$338.94	19.20%	21.97%	-34.96%
	Mar-2019	30,247	$409.95	20.85%	20.34%	-50.03%	0.97	1.01	1.00	$420.05	22.85%	23.58%	-46.66%
	Apr-2019	30,257	$406.76	19.94%	6.33%	-30.09%	0.97	1.01	1.00	$417.58	22.07%	9.76%	-26.53%
	May-2019	30,224	$434.32	18.75%	-1.71%	52.43%	0.97	1.01	1.00	$445.90	21.01%	1.96%	57.59%
	Jun-2019	30,021	$378.96	18.11%	-9.40%	39.69%	0.97	1.01	1.00	$389.19	20.44%	-5.70%	41.76%
	Jul-2019	29,960	$406.40	17.92%	-8.59%	27.35%	0.97	1.00	1.00	$418.36	20.36%	-5.25%	28.85%
	Aug-2019	29,866	$397.74	15.15%	3.98%	-20.02%	0.97	1.00	1.00	$409.93	17.66%	7.38%	-19.06%
	Sep-2019	29,794	$399.42	15.73%	-1.27%	-5.34%	0.97	1.00	1.00	$412.25	18.41%	1.48%	-3.87%
	Oct-2019	29,723	$446.36	12.68%	5.49%	7.95%	0.97	1.00	1.00	$461.02	15.43%	7.86%	9.73%
	Nov-2019	29,629	$436.54	10.24%	7.23%	37.99%	0.97	1.00	1.00	$451.52	13.09%	9.14%	40.18%
Last Month in Experience Period	Dec-2019	29,438	$447.67	9.54%	16.97%	49.35%	0.96	1.00	1.00	$463.47	12.52%	18.70%	51.35%

If applicable, please provide an explanation for the Other normalization factor.

N/A

The Department is requesting each carrier provide additional trend exhibits, in excel with working formulas, that are similar to the aggregate information provided above. These exhibits should provide the data by Service Category, Metal Tier, etc. that are used by the Company in the trend development. Please state where in the filing it is located.

Please see the tabs "Med Trends by Category" and "Rx Trend by Category" for the historical incurred claims by Med category (IP/OP/PHY/OTR) and Rx category (Generic/Brand/Specialty).

Solvency

	Most Recent Quarterly Financial Statement	Most Recent Annual Financial Statement
Total Adjusted Capital	403,986,260	403,986,260
Authorized Control Level	93,171,951	93,171,951
RBC Ratio	433.59%	433.59%

Loss Ratio

Time Period	Period Beginning Date	Period Ending Date	Member Months	Incurred Claims	Earned Premium	Loss Ratio	Expected Incurred Claims	A-to-E Claims Ratio	Quality Improvement Expenses	Adjustments to Earned Premium	Adj Medical Loss Ratio
Historical Year -4	1/1/2015	12/31/2015	63,884	22,841,257	26,703,077	85.5%	22,944,918	99.5%	320,437	857,959	89.6%
Historical Year -3	1/1/2016	12/31/2016	82,627	31,173,390	35,126,637	88.7%	30,777,242	101.3%	261,019	1,125,644	92.5%
Historical Year -2	1/1/2017	12/31/2017	135,548	53,704,172	60,178,693	89.2%	54,138,008	99.2%	475,773	412,043	90.7%
Historical Year -1	1/1/2018	12/31/2018	303,306	132,029,885	141,715,771	93.2%	124,831,896	105.8%	1,155,596	2,231,894	95.5%
Historical Year 0	1/1/2019	12/31/2019	359,516	166,195,023	181,982,319	91.3%	164,715,313	100.9%	1,430,874	381,087	92.3%
Historical Totals			944,881	405,943,727	445,706,497	91.1%	397,407,377	102.1%	3,643,699	5,008,627	92.9%
Interim Time Period	1/1/2020	2/29/2020	73,836	33,595,069	41,395,022	81.2%	36,929,926	91.0%	186,067	693,301	83.0%
Future Year 1	1/1/2021	12/31/2021	443,760	240,567,192	267,204,764	90.0%	240,567,192	100.0%	1,151,823	1,805,123	91.1%

Anticipated Pricing Loss Ratio (no adjustments)	90.0%
Anticipated LR using Federally-prescribed MLR methodology	91.1%

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.
The interim time period the time periods available in the current year.
The future year should represent the 12 months immediately following the rate effective date.

Consumer Adjusted Premium Rate Development

Section III of WS2 of the 2021 URRT requires that the Issuer provide the Actuarial Value and cost-sharing design of the plan. The Department requires that the issuer provide the breakdown of this value between Cost Sharing Only and Induced Utilization for every plan in the URRT.
Please see the example below.

Actuarial value and cost-sharing design of the plan

Actuarial value and cost-sharing design of the plan (From the URRT)	0.900
Paid/Allowed Ratio (Cost-Sharing only)	0.783
Used Induced utilization factors	1.150
Calculated	0.900

In the text box, please state where in the filing it is located.

Please see the columns "Benefit Actuarial Value" and "Induced Utilization Factor" on Exhibit 7 of the rate filing. In addition, note that this value in the URRT also includes the value of the CSR load on the On Exchange Silver plans.

Risk Adjustment

	Actual Risk Adjustment Received(2019 interim RA results)	Assumed in Most Recent Approved Rate Filing	Assumed in Current Rate Filing	Proposed Change in PMPM Compared to Prior 12 months	Proposed Change in PMPM Compared to Most Recently Approved Filing
Time Period	1/1/2019	1/1/2020	1/1/2021		
Total Risk adjustment (Dollar amount)	($22,492,428)	($24,716,866)	($32,277,910)		
Membership Member Months	359,516	370,644	443,760	23.43%	19.73%
PMPM	($62.56)	($66.69)	($72.74)	16.26%	9.07%
Premium	$181,982,319	$207,693,975	$267,204,764	46.83%	28.65%
As a % of Premium	-12%	-12%	-12%	-2.26%	1.51%

If the actual risk adjustment payable/receivable was more than 20% different than what was estimated in the previous filing, please provide details on how the current risk adjustment estimate has addressed prior results.

N/A

Trend & Projection Assumptions For Inpatient Claims

Historical Experience (ACA Only): Incurred or Allowed Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "Allowed").*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Monthly Incurred Claims $ PMPM*	ed Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$76.42				1.00	1.00	1.00	$76.42			
	Feb-2017	10,301	$63.51				1.00	1.00	1.00	$63.22			
	Mar-2017	11,249	$103.30				1.01	1.01	1.00	$101.76			
	Apr-2017	11,326	$48.03				1.00	1.01	1.00	$47.39			
	May-2017	11,395	$67.44				1.00	1.01	1.00	$66.63			
	Jun-2017	11,437	$65.58			-70.35%	1.00	1.01	1.00	$64.77			-70.89%
	Jul-2017	11,594	$58.20			-37.98%	1.00	1.01	1.00	$57.46			-38.14%
	Aug-2017	11,706	$58.73			-51.45%	1.00	1.01	1.00	$57.92			-51.29%
	Sep-2017	11,726	$60.88			-7.12%	1.00	1.01	1.00	$60.26			-7.02%
	Oct-2017	11,764	$50.47			-37.33%	1.00	1.01	1.00	$49.99			-37.05%
	Nov-2017	11,675	$99.71			78.54%	1.00	1.00	1.00	$99.18			82.33%
	Dec-2017	11,600	$70.45		-11.69%	136.25%	1.00	1.00	1.00	$70.37		-11.37%	143.32%
	Jan-2018	25,006	$60.09		-5.89%	162.62%	0.98	1.02	1.00	$59.70		-4.97%	169.46%
	Feb-2018	25,014	$70.73		3.11%	-20.56%	0.98	1.02	1.00	$70.40		4.69%	-19.55%
	Mar-2018	25,117	$57.06		22.01%	-47.28%	0.98	1.02	1.00	$56.87		23.86%	-47.27%
	Apr-2018	25,025	$66.55		26.49%	-35.10%	0.98	1.02	1.00	$66.45		28.53%	-34.66%
	May-2018	25,098	$62.73		-4.69%	-23.27%	0.98	1.02	1.00	$62.71		-3.32%	-22.36%
	Jun-2018	25,199	$72.99		-4.04%	34.44%	0.98	1.02	1.00	$73.11		-2.91%	37.12%
	Jul-2018	25,331	$70.04		3.23%	25.81%	0.98	1.01	1.00	$70.18		4.53%	28.02%
	Aug-2018	25,418	$83.73		3.27%	119.52%	0.98	1.01	1.00	$83.96		4.56%	122.92%
	Sep-2018	25,557	$59.46		9.85%	23.31%	0.98	1.01	1.00	$59.62		11.22%	24.50%
	Oct-2018	25,520	$82.44		12.96%	44.38%	0.98	1.01	1.00	$82.85		14.39%	45.73%
	Nov-2018	25,523	$104.58		51.83%	39.43%	0.98	1.01	1.00	$105.21		53.86%	40.94%
	Dec-2018	25,498	$67.90	4.59%	43.98%	104.58%	0.98	1.01	1.00	$68.47	5.70%	45.97%	107.72%
	Jan-2019	30,160	$115.10	15.37%	67.87%	176.58%	0.97	1.01	1.00	$117.58	17.03%	71.29%	187.63%
	Feb-2019	30,197	$62.74	12.67%	43.16%	2.53%	0.97	1.01	1.00	$64.15	14.48%	46.53%	8.25%
	Mar-2019	30,247	$89.28	23.54%	58.45%	20.48%	0.97	1.01	1.00	$91.48	25.67%	62.95%	28.58%
	Apr-2019	30,257	$79.08	22.59%	44.53%	-60.15%	0.97	1.01	1.00	$81.18	24.85%	49.27%	-58.34%
	May-2019	30,224	$80.56	25.49%	10.22%	1.50%	0.97	1.01	1.00	$82.71	27.93%	14.39%	4.44%
	Jun-2019	30,021	$66.99	22.74%	11.25%	-48.11%	0.97	1.01	1.00	$68.80	25.19%	15.73%	-47.31%
	Jul-2019	29,960	$71.02	21.08%	-24.72%	-19.94%	0.97	1.00	1.00	$73.11	23.60%	-22.18%	-19.02%
	Aug-2019	29,866	$68.64	15.43%	-15.06%	-52.50%	0.97	1.00	1.00	$70.74	17.95%	-12.50%	-51.92%
	Sep-2019	29,794	$74.94	17.95%	-28.80%	-19.69%	0.97	1.00	1.00	$77.35	20.67%	-26.94%	-18.42%
	Oct-2019	29,723	$72.68	13.29%	-29.71%	-4.27%	0.97	1.00	1.00	$75.06	16.03%	-28.18%	-2.69%
	Nov-2019	29,629	$78.15	7.72%	-24.31%	42.46%	0.97	1.00	1.00	$80.83	10.48%	-23.01%	44.72%
Last Month in Experience Period	Dec-2019	29,438	$57.14	6.76%	-26.73%	-11.63%	0.96	1.00	1.00	$59.16	9.61%	-25.61%	-10.49%

Trend & Projection Assumptions For Outpatient Claims

Historical Experience (ACA Only): Incurred or Allowed Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "Allowed").*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Monthly Incurred Claims $ PMPM*	ed Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$121.51				1.00	1.00	1.00	$121.51			
	Feb-2017	10,301	$101.47				1.00	1.00	1.00	$101.01			
	Mar-2017	11,249	$136.08				1.01	1.01	1.00	$134.05			
	Apr-2017	11,326	$132.01				1.00	1.01	1.00	$130.23			
	May-2017	11,395	$143.39				1.00	1.01	1.00	$141.67			
	Jun-2017	11,437	$139.78			76.10%	1.00	1.01	1.00	$138.06			72.43%
	Jul-2017	11,594	$132.48			56.57%	1.00	1.01	1.00	$130.80			56.19%
	Aug-2017	11,706	$150.00			10.96%	1.00	1.01	1.00	$147.93			11.17%
	Sep-2017	11,726	$142.75			10.09%	1.00	1.01	1.00	$141.29			10.22%
	Oct-2017	11,764	$159.41			40.20%	1.00	1.01	1.00	$157.90			40.87%
	Nov-2017	11,675	$166.39			51.41%	1.00	1.00	1.00	$165.51			54.34%
	Dec-2017	11,600	$156.16		35.99%	64.92%	1.00	1.00	1.00	$156.00		36.45%	69.60%
	Jan-2018	25,006	$111.47		16.74%	-34.72%	0.98	1.02	1.00	$110.73		17.80%	-32.99%
	Feb-2018	25,014	$124.08		-3.81%	-58.96%	0.98	1.02	1.00	$123.52		-2.41%	-58.33%
	Mar-2018	25,117	$137.28		-5.98%	-64.18%	0.98	1.02	1.00	$136.80		-4.56%	-64.10%
	Apr-2018	25,025	$146.32		-11.99%	1.22%	0.98	1.02	1.00	$146.11		-10.56%	1.87%
	May-2018	25,098	$174.25		-10.92%	122.21%	0.98	1.02	1.00	$174.19		-9.53%	124.76%
	Jun-2018	25,199	$142.73		-15.05%	138.27%	0.98	1.02	1.00	$142.98		-13.94%	142.82%
	Jul-2018	25,331	$139.87		3.09%	57.48%	0.98	1.01	1.00	$140.15		4.48%	60.08%
	Aug-2018	25,418	$166.16		22.87%	-7.64%	0.98	1.01	1.00	$166.60		24.42%	-6.23%
	Sep-2018	25,557	$144.36		25.61%	-10.67%	0.98	1.01	1.00	$144.76		27.17%	-9.76%
	Oct-2018	25,520	$183.97		36.46%	37.39%	0.98	1.01	1.00	$184.88		38.12%	38.78%
	Nov-2018	25,523	$182.29		30.19%	67.45%	0.98	1.01	1.00	$183.39		31.83%	69.15%
	Dec-2018	25,498	$179.40	8.52%	41.91%	115.44%	0.98	1.01	1.00	$180.91	9.72%	43.85%	118.86%
	Jan-2019	30,160	$146.72	13.39%	33.59%	8.39%	0.97	1.01	1.00	$149.89	14.92%	35.95%	12.02%
	Feb-2019	30,197	$145.49	14.31%	15.91%	-29.43%	0.97	1.01	1.00	$148.75	16.06%	18.44%	-25.81%
	Mar-2019	30,247	$172.65	16.47%	20.72%	-47.31%	0.97	1.01	1.00	$176.91	18.41%	24.00%	-43.76%
	Apr-2019	30,257	$168.06	16.54%	8.23%	-13.72%	0.97	1.01	1.00	$172.53	18.63%	11.74%	-9.28%
	May-2019	30,224	$188.01	14.27%	8.22%	62.93%	0.97	1.01	1.00	$193.02	16.46%	12.25%	68.51%
	Jun-2019	30,021	$168.54	15.57%	-1.34%	62.20%	0.97	1.01	1.00	$173.10	17.89%	2.69%	64.60%
	Jul-2019	29,960	$175.10	17.36%	3.75%	43.02%	0.97	1.00	1.00	$180.25	19.84%	7.57%	44.71%
	Aug-2019	29,866	$171.05	16.00%	14.27%	-10.19%	0.97	1.00	1.00	$176.29	18.56%	18.00%	-9.12%
	Sep-2019	29,794	$162.62	16.86%	6.02%	-11.54%	0.97	1.00	1.00	$167.85	19.58%	8.95%	-10.18%
	Oct-2019	29,723	$191.06	15.03%	13.94%	-5.19%	0.97	1.00	1.00	$197.33	17.86%	16.47%	-3.63%
	Nov-2019	29,629	$178.18	13.16%	9.86%	13.99%	0.97	1.00	1.00	$184.29	16.10%	11.82%	15.81%
Last Month in Experience Period	Dec-2019	29,438	$169.32	11.05%	12.03%	25.61%	0.96	1.00	1.00	$175.30	14.07%	13.66%	27.28%

Trend & Projection Assumptions For Physician Claims

Historical Experience (ACA Only): Incurred or Allowed Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "Allowed").*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Monthly Incurred Claims $ PMPM*	ed Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$71.36				1.00	1.00	1.00	$71.36			
	Feb-2017	10,301	$62.94				1.00	1.00	1.00	$62.66			
	Mar-2017	11,249	$76.57				1.01	1.01	1.00	$75.42			
	Apr-2017	11,326	$73.55				1.00	1.01	1.00	$72.57			
	May-2017	11,395	$84.93				1.00	1.01	1.00	$83.91			
	Jun-2017	11,437	$79.86			61.73%	1.00	1.01	1.00	$78.88			58.26%
	Jul-2017	11,594	$76.18			61.22%	1.00	1.01	1.00	$75.21			60.70%
	Aug-2017	11,706	$87.08			14.50%	1.00	1.01	1.00	$85.88			14.70%
	Sep-2017	11,726	$86.47			20.58%	1.00	1.01	1.00	$85.59			20.74%
	Oct-2017	11,764	$95.86			56.50%	1.00	1.01	1.00	$94.95			57.27%
	Nov-2017	11,675	$107.13			100.56%	1.00	1.00	1.00	$106.56			104.50%
	Dec-2017	11,600	$96.21		48.22%	105.78%	1.00	1.00	1.00	$96.11		48.73%	111.62%
	Jan-2018	25,006	$70.72		32.67%	-17.30%	0.98	1.02	1.00	$70.25		33.87%	-15.13%
	Feb-2018	25,014	$71.20		9.03%	-62.06%	0.98	1.02	1.00	$70.88		10.62%	-61.50%
	Mar-2018	25,117	$79.84		1.84%	-69.81%	0.98	1.02	1.00	$79.56		3.37%	-69.75%
	Apr-2018	25,025	$87.04		-7.58%	-26.28%	0.98	1.02	1.00	$86.91		-6.08%	-25.79%
	May-2018	25,098	$96.57		-14.00%	80.95%	0.98	1.02	1.00	$96.53		-12.69%	83.02%
	Jun-2018	25,199	$93.85		-17.28%	145.04%	0.98	1.02	1.00	$94.02		-16.22%	149.84%
	Jul-2018	25,331	$90.17		-2.14%	92.85%	0.98	1.01	1.00	$90.35		-0.82%	96.09%
	Aug-2018	25,418	$97.88		19.23%	31.16%	0.98	1.01	1.00	$98.14		20.76%	33.16%
	Sep-2018	25,557	$93.66		28.78%	6.26%	0.98	1.01	1.00	$93.92		30.40%	7.30%
	Oct-2018	25,520	$117.36		44.26%	46.96%	0.98	1.01	1.00	$117.95		46.04%	48.41%
	Nov-2018	25,523	$108.42		48.15%	64.81%	0.98	1.01	1.00	$109.07		50.03%	66.47%
	Dec-2018	25,498	$103.51	10.77%	49.78%	86.69%	0.98	1.01	1.00	$104.39	11.97%	51.80%	89.61%
	Jan-2019	30,160	$82.26	13.51%	33.71%	-20.73%	0.97	1.01	1.00	$84.04	15.01%	35.98%	-18.12%
	Feb-2019	30,197	$78.99	14.63%	12.46%	-54.55%	0.97	1.01	1.00	$80.76	16.33%	14.80%	-52.24%
	Mar-2019	30,247	$94.04	15.92%	6.97%	-63.87%	0.97	1.01	1.00	$96.36	17.80%	9.78%	-61.43%
	Apr-2019	30,257	$95.59	15.11%	-10.17%	-27.86%	0.97	1.01	1.00	$98.13	17.12%	-7.30%	-24.09%
	May-2019	30,224	$102.75	13.71%	-14.72%	54.44%	0.97	1.01	1.00	$105.49	15.82%	-11.55%	59.83%
	Jun-2019	30,021	$88.62	11.39%	-21.25%	59.68%	0.97	1.01	1.00	$91.01	13.55%	-18.03%	62.05%
	Jul-2019	29,960	$93.97	10.48%	-14.72%	27.38%	0.97	1.00	1.00	$96.73	12.74%	-11.55%	28.87%
	Aug-2019	29,866	$97.17	9.03%	-2.16%	-16.20%	0.97	1.00	1.00	$100.14	11.37%	1.12%	-15.19%
	Sep-2019	29,794	$97.06	8.56%	-1.10%	1.67%	0.97	1.00	1.00	$100.18	11.05%	1.72%	3.26%
	Oct-2019	29,723	$109.16	5.26%	10.96%	27.68%	0.97	1.00	1.00	$112.75	7.83%	13.49%	29.79%
	Nov-2019	29,629	$94.99	3.18%	9.36%	34.46%	0.97	1.00	1.00	$98.25	5.84%	11.33%	36.55%
Last Month in Experience Period	Dec-2019	29,438	$94.84	1.60%	17.24%	15.94%	0.96	1.00	1.00	$98.18	4.37%	18.96%	17.45%

Trend & Projection Assumptions For Other Claims

Historical Experience (ACA Only): Incurred or Allowed Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "Allowed").*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Monthly Incurred Claims $ PMPM*	ed Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$7.61				1.00	1.00	1.00	$7.61			
	Feb-2017	10,301	$5.77				1.00	1.00	1.00	$5.74			
	Mar-2017	11,249	$4.67				1.01	1.01	1.00	$4.61			
	Apr-2017	11,326	$5.71				1.00	1.01	1.00	$5.63			
	May-2017	11,395	$5.25				1.00	1.01	1.00	$5.19			
	Jun-2017	11,437	$11.48			151.20%	1.00	1.01	1.00	$11.34			144.36%
	Jul-2017	11,594	$5.70			274.35%	1.00	1.01	1.00	$5.63			272.19%
	Aug-2017	11,706	$5.20			314.73%	1.00	1.01	1.00	$5.13			315.82%
	Sep-2017	11,726	$9.99			-24.82%	1.00	1.01	1.00	$9.89			-24.60%
	Oct-2017	11,764	$5.22			-31.25%	1.00	1.01	1.00	$5.17			-30.86%
	Nov-2017	11,675	$6.58			-9.02%	1.00	1.00	1.00	$6.55			-7.47%
	Dec-2017	11,600	$6.04		-8.46%	-47.10%	1.00	1.00	1.00	$6.04		-8.29%	-45.65%
	Jan-2018	25,006	$6.54		4.48%	-20.14%	0.98	1.02	1.00	$6.50		5.36%	-18.21%
	Feb-2018	25,014	$4.37		-4.81%	-65.52%	0.98	1.02	1.00	$4.35		-3.53%	-65.00%
	Mar-2018	25,117	$5.59		-39.04%	-26.76%	0.98	1.02	1.00	$5.57		-38.16%	-26.73%
	Apr-2018	25,025	$8.07		-25.10%	-23.83%	0.98	1.02	1.00	$8.06		-23.89%	-23.15%
	May-2018	25,098	$5.43		-33.28%	70.73%	0.98	1.02	1.00	$5.43		-32.24%	72.87%
	Jun-2018	25,199	$7.88		-4.41%	181.91%	0.98	1.02	1.00	$7.90		-3.14%	187.63%
	Jul-2018	25,331	$6.79		-6.93%	54.72%	0.98	1.01	1.00	$6.80		-5.63%	57.27%
	Aug-2018	25,418	$7.44		23.37%	79.83%	0.98	1.01	1.00	$7.45		25.06%	82.61%
	Sep-2018	25,557	$5.17		44.92%	-32.47%	0.98	1.01	1.00	$5.18		46.73%	-31.81%
	Oct-2018	25,520	$6.50		11.91%	-18.70%	0.98	1.01	1.00	$6.53		13.27%	-17.98%
	Nov-2018	25,523	$7.39		30.44%	-44.80%	0.98	1.01	1.00	$7.43		32.11%	-44.22%
	Dec-2018	25,498	$7.73	-0.36%	17.08%	54.52%	0.98	1.01	1.00	$7.80	0.70%	18.67%	57.05%
	Jan-2019	30,160	$4.77	-1.88%	2.84%	10.44%	0.97	1.01	1.00	$4.88	-0.60%	4.52%	13.86%
	Feb-2019	30,197	$5.91	4.33%	-18.71%	-17.63%	0.97	1.01	1.00	$6.04	5.89%	-16.97%	-13.59%
	Mar-2019	30,247	$7.40	6.72%	-6.56%	-51.01%	0.97	1.01	1.00	$7.58	8.48%	-4.00%	-47.70%
	Apr-2019	30,257	$7.42	1.76%	6.06%	25.76%	0.97	1.01	1.00	$7.62	3.59%	9.50%	32.64%
	May-2019	30,224	$10.96	10.31%	15.09%	306.80%	0.97	1.01	1.00	$11.25	12.51%	19.49%	321.68%
	Jun-2019	30,021	$6.39	10.06%	9.26%	252.71%	0.97	1.01	1.00	$6.56	12.30%	13.78%	257.71%
	Jul-2019	29,960	$10.35	13.57%	56.67%	219.30%	0.97	1.00	1.00	$10.66	16.06%	62.63%	223.13%
	Aug-2019	29,866	$6.22	9.23%	72.17%	-37.09%	0.97	1.00	1.00	$6.41	11.73%	77.81%	-36.35%
	Sep-2019	29,794	$8.99	19.07%	63.24%	13.22%	0.97	1.00	1.00	$9.28	21.93%	67.75%	14.97%
	Oct-2019	29,723	$7.12	18.53%	53.79%	-57.85%	0.97	1.00	1.00	$7.36	21.49%	57.17%	-57.16%
	Nov-2019	29,629	$5.78	14.93%	3.30%	-17.19%	0.97	1.00	1.00	$5.98	17.93%	5.04%	-15.95%
Last Month in Experience Period	Dec-2019	29,438	$6.63	11.46%	10.84%	-65.91%	0.96	1.00	1.00	$6.86	14.50%	12.34%	-65.46%

Trend & Projection Assumptions For RX Generic Claims

Historical Experience (ACA Only): 1 Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	d Monthly Incurred Claims $ PMPM*	Normalized Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$4.88				1.00	1.00	1.00	$4.88			
	Feb-2017	10,301	$5.23				1.00	1.00	1.00	$5.20			
	Mar-2017	11,249	$6.35				1.01	1.01	1.00	$6.25			
	Apr-2017	11,326	$6.71				1.00	1.01	1.00	$6.62			
	May-2017	11,395	$7.50				1.00	1.01	1.00	$7.41			
	Jun-2017	11,437	$8.33			244.00%	1.00	1.01	1.00	$8.23			237.19%
	Jul-2017	11,594	$8.37			202.13%	1.00	1.01	1.00	$8.26			201.22%
	Aug-2017	11,706	$8.61			129.52%	1.00	1.01	1.00	$8.50			129.91%
	Sep-2017	11,726	$7.63			41.97%	1.00	1.01	1.00	$7.56			42.09%
	Oct-2017	11,764	$9.12			20.67%	1.00	1.01	1.00	$9.03			21.25%
	Nov-2017	11,675	$8.96			6.43%	1.00	1.00	1.00	$8.91			8.47%
	Dec-2017	11,600	$10.25		80.80%	75.19%	1.00	1.00	1.00	$10.24		81.56%	80.35%
	Jan-2018	25,006	$5.10		19.18%	-45.44%	0.98	1.02	1.00	$5.06		20.28%	-43.91%
	Feb-2018	25,014	$5.48		-14.57%	-72.21%	0.98	1.02	1.00	$5.46		-13.32%	-71.74%
	Mar-2018	25,117	$6.68		-22.44%	-86.19%	0.98	1.02	1.00	$6.66		-21.26%	-86.17%
	Apr-2018	25,025	$7.61		-31.19%	-32.38%	0.98	1.02	1.00	$7.60		-30.05%	-32.02%
	May-2018	25,098	$8.15		-33.90%	108.79%	0.98	1.02	1.00	$8.15		-32.84%	110.90%
	Jun-2018	25,199	$8.01		-39.88%	259.50%	0.98	1.02	1.00	$8.02		-39.09%	266.41%
	Jul-2018	25,331	$7.59		-12.78%	108.19%	0.98	1.01	1.00	$7.61		-11.59%	111.63%
	Aug-2018	25,418	$8.69		21.20%	37.27%	0.98	1.01	1.00	$8.71		22.74%	39.36%
	Sep-2018	25,557	$9.39		41.65%	36.14%	0.98	1.01	1.00	$9.41		43.42%	37.50%
	Oct-2018	25,520	$12.09		72.05%	160.29%	0.98	1.01	1.00	$12.15		74.15%	162.91%
	Nov-2018	25,523	$11.88		93.31%	255.35%	0.98	1.01	1.00	$11.95		95.76%	259.00%
	Dec-2018	25,498	$13.46	12.48%	136.53%	351.34%	0.98	1.01	1.00	$13.57	13.79%	139.79%	358.63%
	Jan-2019	30,160	$7.38	18.45%	105.00%	28.32%	0.97	1.01	1.00	$7.54	20.07%	108.39%	32.11%
	Feb-2019	30,197	$7.95	23.55%	71.53%	-49.17%	0.97	1.01	1.00	$8.13	25.45%	74.96%	-46.80%
	Mar-2019	30,247	$9.69	27.43%	54.17%	-80.00%	0.97	1.01	1.00	$9.93	29.56%	58.04%	-78.65%
	Apr-2019	30,257	$9.64	28.33%	20.10%	-47.82%	0.97	1.01	1.00	$9.90	30.62%	23.75%	-44.93%
	May-2019	30,224	$10.77	29.77%	2.22%	30.60%	0.97	1.01	1.00	$11.06	32.24%	5.87%	35.69%
	Jun-2019	30,021	$9.14	30.50%	-25.22%	94.46%	0.97	1.01	1.00	$9.39	33.06%	-22.19%	97.29%
	Jul-2019	29,960	$9.70	33.16%	-16.66%	38.82%	0.97	1.00	1.00	$9.99	35.87%	-13.54%	40.44%
	Aug-2019	29,866	$10.99	34.33%	-4.14%	-3.59%	0.97	1.00	1.00	$11.33	37.19%	-0.84%	-2.41%
	Sep-2019	29,794	$9.16	30.87%	-6.39%	4.18%	0.97	1.00	1.00	$9.46	33.81%	-3.62%	5.79%
	Oct-2019	29,723	$9.03	22.31%	-1.07%	-5.68%	0.97	1.00	1.00	$9.33	25.19%	1.29%	-4.17%
	Nov-2019	29,629	$8.39	14.68%	-6.37%	-36.89%	0.97	1.00	1.00	$8.68	17.54%	-4.61%	-35.92%
Last Month in Experience Period	Dec-2019	29,438	$13.40	10.40%	23.46%	13.09%	0.96	1.00	1.00	$13.87	13.35%	25.27%	14.68%

Trend & Projection Assumptions For RX Brand Claims

Historical Experience (ACA Only): 1 Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	d Monthly Incurred Claims $ PMPM*	Normalized Rolling 12 Mo Trend	d Annualized Rolling 6 Mo Trend	d Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$12.31				1.00	1.00	1.00	$12.31			
	Feb-2017	10,301	$9.64				1.00	1.00	1.00	$9.59			
	Mar-2017	11,249	$17.20				1.01	1.01	1.00	$16.94			
	Apr-2017	11,326	$16.14				1.00	1.01	1.00	$15.92			
	May-2017	11,395	$16.50				1.00	1.01	1.00	$16.30			
	Jun-2017	11,437	$19.36			198.77%	1.00	1.01	1.00	$19.12			193.43%
	Jul-2017	11,594	$19.03			156.11%	1.00	1.01	1.00	$18.78			155.95%
	Aug-2017	11,706	$21.05			102.60%	1.00	1.01	1.00	$20.76			103.01%
	Sep-2017	11,726	$20.71			86.71%	1.00	1.01	1.00	$20.50			86.94%
	Oct-2017	11,764	$21.41			75.34%	1.00	1.01	1.00	$21.21			76.19%
	Nov-2017	11,675	$24.62			58.66%	1.00	1.00	1.00	$24.48			61.77%
	Dec-2017	11,600	$23.33		99.63%	69.22%	1.00	1.00	1.00	$23.30		100.53%	74.11%
	Jan-2018	25,006	$11.92		35.68%	-49.72%	0.98	1.02	1.00	$11.84		36.99%	-48.34%
	Feb-2018	25,014	$12.86		-10.16%	-82.18%	0.98	1.02	1.00	$12.80		-8.85%	-81.89%
	Mar-2018	25,117	$17.09		-19.62%	-86.68%	0.98	1.02	1.00	$17.03		-18.39%	-86.66%
	Apr-2018	25,025	$19.29		-26.09%	-26.54%	0.98	1.02	1.00	$19.27		-24.87%	-26.11%
	May-2018	25,098	$19.40		-36.77%	174.06%	0.98	1.02	1.00	$19.39		-35.78%	176.82%
	Jun-2018	25,199	$20.05		-40.18%	286.89%	0.98	1.02	1.00	$20.09		-39.39%	294.26%
	Jul-2018	25,331	$20.51		-9.45%	119.75%	0.98	1.01	1.00	$20.55		-8.20%	123.39%
	Aug-2018	25,418	$21.90		30.12%	57.29%	0.98	1.01	1.00	$21.96		31.80%	59.71%
	Sep-2018	25,557	$21.51		46.89%	40.14%	0.98	1.01	1.00	$21.57		48.73%	41.52%
	Oct-2018	25,520	$25.06		59.97%	70.06%	0.98	1.01	1.00	$25.19		61.90%	71.69%
	Nov-2018	25,523	$23.65		74.86%	59.68%	0.98	1.01	1.00	$23.79		77.00%	61.27%
	Dec-2018	25,498	$26.44	7.39%	90.94%	91.11%	0.98	1.01	1.00	$26.67	8.61%	93.47%	94.19%
	Jan-2019	30,160	$15.68	12.89%	48.36%	-20.29%	0.97	1.01	1.00	$16.02	14.41%	50.76%	-17.84%
	Feb-2019	30,197	$16.51	15.79%	15.31%	-55.00%	0.97	1.01	1.00	$16.88	17.51%	17.61%	-52.85%
	Mar-2019	30,247	$17.27	15.91%	-0.39%	-81.23%	0.97	1.01	1.00	$17.69	17.76%	2.08%	-79.98%
	Apr-2019	30,257	$19.96	14.20%	-15.89%	-52.41%	0.97	1.01	1.00	$20.49	16.15%	-13.32%	-49.81%
	May-2019	30,224	$20.64	13.11%	-24.42%	2.44%	0.97	1.01	1.00	$21.19	15.18%	-21.70%	6.35%
	Jun-2019	30,021	$20.36	12.28%	-36.99%	130.49%	0.97	1.01	1.00	$20.91	14.41%	-34.41%	133.94%
	Jul-2019	29,960	$21.20	11.39%	-24.12%	79.38%	0.97	1.00	1.00	$21.82	13.63%	-21.24%	81.51%
	Aug-2019	29,866	$22.08	10.22%	-8.54%	46.31%	0.97	1.00	1.00	$22.76	12.56%	-5.37%	48.04%
	Sep-2019	29,794	$21.27	9.11%	4.99%	25.79%	0.97	1.00	1.00	$21.95	11.58%	8.14%	27.74%
	Oct-2019	29,723	$22.85	5.82%	18.68%	28.33%	0.97	1.00	1.00	$23.60	8.37%	21.53%	30.41%
	Nov-2019	29,629	$21.71	4.30%	25.88%	14.52%	0.97	1.00	1.00	$22.46	6.96%	28.28%	16.31%
Last Month in Experience Period	Dec-2019	29,438	$24.50	1.57%	46.36%	30.94%	0.96	1.00	1.00	$25.36	4.32%	48.50%	32.70%

Trend & Projection Assumptions For RX Specialty Claims

Historical Experience (ACA Only): 1 Basis?[1]: Incurred *(1) Choose the option based on how pricing is developed (i.e., if allowed trends are used in projections, select "*

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development (ACA Only)	Month	Member Months	Monthly Incurred Claims $ PMPM*	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend	Average Benefit Factor	Average Age/Gender Factor	Other Factor	Monthly Incurred Claims $ PMPM*	Normalized Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend
	Jan-2017	9,775	$20.86				1.00	1.00	1.00	$20.86			
	Feb-2017	10,301	$24.62				1.00	1.00	1.00	$24.51			
	Mar-2017	11,249	$34.29				1.01	1.01	1.00	$33.78			
	Apr-2017	11,326	$27.92				1.00	1.01	1.00	$27.54			
	May-2017	11,395	$35.15				1.00	1.01	1.00	$34.73			
	Jun-2017	11,437	$40.98			176.23%	1.00	1.01	1.00	$40.48			171.48%
	Jul-2017	11,594	$40.12			216.25%	1.00	1.01	1.00	$39.61			215.40%
	Aug-2017	11,706	$37.66			121.03%	1.00	1.01	1.00	$37.14			121.50%
	Sep-2017	11,726	$41.20			70.49%	1.00	1.01	1.00	$40.78			70.70%
	Oct-2017	11,764	$39.77			8.32%	1.00	1.01	1.00	$39.39			8.87%
	Nov-2017	11,675	$32.11			-17.60%	1.00	1.00	1.00	$31.94			-16.14%
	Dec-2017	11,600	$34.20		46.63%	-36.69%	1.00	1.00	1.00	$34.16		47.12%	-34.97%
	Jan-2018	25,006	$25.61		-2.55%	-70.07%	0.98	1.02	1.00	$25.45		-1.72%	-69.28%
	Feb-2018	25,014	$24.83		-26.87%	-74.05%	0.98	1.02	1.00	$24.72		-25.85%	-73.62%
	Mar-2018	25,117	$29.32		-37.64%	-68.06%	0.98	1.02	1.00	$29.22		-36.72%	-67.97%
	Apr-2018	25,025	$33.62		-44.18%	0.13%	0.98	1.02	1.00	$33.57		-43.27%	0.82%
	May-2018	25,098	$36.70		-38.18%	131.96%	0.98	1.02	1.00	$36.68		-37.18%	134.65%
	Jun-2018	25,199	$31.44		-34.95%	164.57%	0.98	1.02	1.00	$31.49		-34.04%	169.66%
	Jul-2018	25,331	$41.18		-4.27%	140.80%	0.98	1.01	1.00	$41.27		-2.88%	144.81%
	Aug-2018	25,418	$42.36		34.74%	77.65%	0.98	1.01	1.00	$42.47		36.57%	80.37%
	Sep-2018	25,557	$38.76		61.66%	108.70%	0.98	1.01	1.00	$38.87		63.75%	110.82%
	Oct-2018	25,520	$42.73		76.61%	64.58%	0.98	1.01	1.00	$42.95		78.76%	66.12%
	Nov-2018	25,523	$39.91		68.33%	24.06%	0.98	1.01	1.00	$40.15		70.43%	25.27%
	Dec-2018	25,498	$38.93	3.30%	80.43%	-2.32%	0.98	1.01	1.00	$39.26	4.49%	82.82%	-0.78%
	Jan-2019	30,160	$25.22	4.45%	30.95%	-53.20%	0.97	1.01	1.00	$25.76	5.86%	32.99%	-51.75%
	Feb-2019	30,197	$30.38	8.03%	-1.50%	-65.08%	0.97	1.01	1.00	$31.06	9.66%	0.46%	-63.33%
	Mar-2019	30,247	$35.37	11.47%	-12.25%	-68.63%	0.97	1.01	1.00	$36.24	13.29%	-9.98%	-66.51%
	Apr-2019	30,257	$42.82	12.54%	-17.90%	26.25%	0.97	1.01	1.00	$43.96	14.54%	-15.24%	33.21%
	May-2019	30,224	$36.40	11.29%	-22.24%	127.43%	0.97	1.01	1.00	$37.38	13.39%	-19.33%	135.61%
	Jun-2019	30,021	$34.44	13.93%	-29.57%	143.81%	0.97	1.01	1.00	$35.37	16.15%	-26.64%	147.33%
	Jul-2019	29,960	$39.96	11.85%	-5.48%	8.41%	0.97	1.00	1.00	$41.14	14.15%	-1.84%	9.67%
	Aug-2019	29,866	$35.45	7.86%	10.94%	-15.58%	0.97	1.00	1.00	$36.54	10.19%	14.74%	-14.57%
	Sep-2019	29,794	$37.49	7.15%	16.46%	-2.70%	0.97	1.00	1.00	$38.70	9.61%	19.81%	-1.19%
	Oct-2019	29,723	$37.30	4.29%	9.37%	-2.00%	0.97	1.00	1.00	$38.52	6.83%	11.80%	-0.42%
	Nov-2019	29,629	$41.18	3.03%	17.26%	24.18%	0.97	1.00	1.00	$42.59	5.69%	19.35%	26.15%
Last Month in Experience Period	Dec-2019	29,438	$45.84	3.67%	34.25%	46.71%	0.96	1.00	1.00	$47.45	6.51%	36.20%	48.74%

625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

ACTUARIAL CERTIFICATION
FEDERAL ACTUARIAL VALUE ADJUSTMENT
VERMONT EXCHANGE
Gold 3 HDHP Plus
Silver 2 HDHP Plus
Silver 2 HDHP Plus II

MVP Health Plan, Inc., a fully owned subsidiary of MVP Health Care, offers a range of products on the Vermont Exchange as well as Silver metal plans off the Exchange. One standard plan is offered at the Platinum and Catastrophic metal levels, while standard and non-standard plans are offered at the remaining levels. Standard plans are prescribed by the State of Vermont and are separately certified where necessary. Non-standard plans are filed at the discretion of MVP. MVP offers three non-standard benefit plans, Gold 3 HDHP Plus, Silver 2 HDHP Plus, and Silver 2 HDHP Plus II, with benefit features that don't fit into the parameters of the Federal Actuarial Value Calculator and therefore are being certified herein. The purpose of this memorandum is to document the actuarial analysis and adjusted actuarial values output from the 2021 Federal Actuarial Value calculator exhibiting compliance with the metal level requirements outlined in 45 CFR 156.140(b).

MVP's benefit pricing model is populated with allowed claim utilization from approximately 211,000 covered MVP commercial members. The data reflects claims paid for 2017 incurred dates, paid as of January 31, 2019. MVP combines data from all its commercial products and states to increase the credibility in the data set. This data set is considered fully credible and appropriate for use as a benefit pricing tool for MVP's fully insured commercial members. The underlying data is appropriate relative to the Vermont Essential Health Benefit Package.

The model uses traditional continuance table logic to value plan deductibles and OOP maximums as well as average utilization per 1,000 and average unit cost per service data for all the significant services that drive member cost sharing. Specific factor adjustments are included in the methodology to account for family deductible and OOP limits, aggregate deductible types, and the State of Vermont maximum Rx OOP regulation. While reduced copays for 90-day supplies of mail order prescriptions also does not fit into the Federal Actuarial Value calculator, the impact on the Actuarial Value is negligible for all plans and is not reflected in the factors presented. The factor adjustments were derived based on modeling the Net Plan liabilities from this subscriber/member based historical allowed claim data set both with and without these benefit features.

The methodology of MVP's benefit pricing tool is consistent with the methodology underlying the Federal calculator with regard to the following factors: continuance tables that reflect membership enrolled for a full 12 months, out of network costs are not considered in the actuarial values, and the model reflects the anticipated utilization of the standard population buying products at these metal levels without consideration for induced demand.

Pursuant to 45 CFR 156.135(b) one of two permitted alternative methods must be used to determine any final adjusted Federal AV. MVP used the AV Calculator to determine the Federal AV for the plan provisions that fit within the calculator parameters and then calculated an actuarial adjustment factor to apply to the calculator produced AV to account for the plan features that materially deviate from the calculator parameters. The product of the Federal Calculator produced AV times the actuarial adjustment factor is the final Federal AV for the benefit plan. I certify that the adjustments made are appropriate and in accordance with generally accepted actuarial principles and methodologies.

The following 3 benefit features for the Gold 3 HDHP Plus were determined to not fit the Federal Calculator:

VT secondary Rx OOP max
Aggregate Family Deductible
Safe harbor prescription drug benefits excluded from the plan deductible

The following 2 benefit features for the Silver 2 HDHP Plus and Silver 2 HDHP II Plus were determined to not fit the Federal Calculator:

VT secondary Rx OOP max
Safe harbor prescription drug benefits excluded from the plan deductible

The following 2 benefit features for the Silver 2 HDHP Plus 73%, 77% and 87% cost-sharing reduction plans were determined to not fit the Federal Calculator:

VT secondary Rx OOP max
Safe harbor prescription drug benefits excluded from the plan deductible

The following benefit feature for the Silver 2 HDHP Plus 94% cost-sharing reduction plan was determined to not fit the Federal Calculator:

Safe harbor prescription drug benefits excluded from the plan deductible

To determine the adjustment factors, I used MVP's proprietary benefit pricing tool to value the AV for these plans first excluding the above features that don't fit the calculator and a second time with the above benefit changes. The ratio of the two AVs is the actuarial adjustment factor used to modify the Federal Calculator computed AV.

Plan Description	MVP determined AV	Federal AV before/after adjustment
Gold 3 HDHP Plus with no secondary Rx OOP max, with embedded single deductibles and with no safe harbor drug benefit	75.65%	79.59%
Gold 3 HDHP Plus including the secondary Rx OOP max, the aggregate family deductible and the safe harbor drug benefit	75.32%	79.24%

Silver 2 HDHP Plus with no secondary Rx OOP max and with no safe harbor drug benefit	66.66%	69.09%
Silver 2 HDHP Plus including the secondary Rx OOP max and the safe harbor drug benefit	69.38%	71.91%

Silver 2 HDHP Plus 73% CSR with no secondary Rx OOP max and with no safe harbor drug benefit	69.80%	71.85%
Silver 2 HDHP Plus 73% CSR including the secondary Rx OOP max and the safe harbor drug benefit	71.82%	73.93%

Silver 2 HDHP Plus 77% CSR with no secondary Rx OOP max and with no safe harbor drug benefit	74.26%	75.78%
Silver 2 HDHP Plus 77% CSR including the secondary Rx OOP max and the safe harbor drug benefit	75.54%	77.09%

Silver 2 HDHP Plus 87% CSR with no safe harbor drug benefit	84.66%	87.34%
Silver 2 HDHP Plus 87% CSR including the safe harbor drug benefit	84.96%	87.65%

Silver 2 HDHP Plus 94% CSR with no safe harbor drug benefit	92.64%	93.76%
Silver 2 HDHP Plus 94% CSR including the safe harbor drug benefit	92.65%	93.77%

Silver 2 HDHP Plus II with no secondary Rx OOP max and with no safe harbor drug benefit	66.58%	69.01%
Silver 2 HDHP Plus II including the secondary Rx OOP max and the safe harbor drug benefit	69.30%	71.83%

Actuarial Adjustment factor for Gold 3 Plan: 0.9956 = 75.32% / 75.65%
Final Federal AV for Gold 3 Plan: 79.59% x 0.9956 = 79.24%

Actuarial Adjustment factor for Silver 2 Plan: 1.0408 = 69.38% / 66.66%
Final Federal AV for Silver 2 Plan: 69.09% x 1.0408 = 71.91%

Actuarial Adjustment factor for Silver 2 73% Plan: 1.0289 = 71.82% / 69.80%
Final Federal AV for Silver 2 73% Plan: 71.85% x 1.0289 = 73.93%

Actuarial Adjustment factor for Silver 2 77% Plan: 1.0172 = 75.54% / 74.26%
Final Federal AV for Silver 2 77% Plan: 75.78% x 1.0172 = 77.09%

Actuarial Adjustment factor for Silver 2 87% Plan: 1.0035 = 84.96% / 84.66%
Final Federal AV for Silver 2 87% Plan: 87.34% x 1.0035 = 87.65%

Actuarial Adjustment factor for Silver 2 94% Plan: 1.0001 = 92.65% / 92.64%
Final Federal AV for Silver 2 94% Plan: 93.76% x 1.0001 = 93.77%

Actuarial Adjustment factor for Silver 2 II Plan: 1.0409 = 69.30% / 66.58%
Final Federal AV for Silver 2 II Plan: 69.01% x 1.0409 = 71.83%

CERTIFICATION

I, Matthew Lombardo, Senior Leader, Actuarial Services for MVP Health Care, am a member of the Academy of Actuaries and a Fellow of the Society of Actuaries, and I meet its qualification standards to provide this certification. I have used the 2021 Actuarial Value Calculator to determine the actuarial value for the plan provisions that fit within the calculator and have determined the actuarially appropriate adjustment factors to apply where necessary for the identified plan features that, in my opinion, deviates substantially from the allowable inputs of the Federal calculator. The development of the actuarial value adjustment factor was determined in accordance with generally accepted actuarial principles and practices and conforms with the exception methodology outlined in 45 CFR 156.135 (b)(3).

The final actuarial values reported for each of these benefit plans, those from the Federal Calculator alone, and the adjusted plans, meet the required actuarial values for each respective metal level as outlined in 45 CFR 156.140(b).

_____ 3/26/2020

Matthew Lombardo, FSA, MAAA Date
Senior Leader, Actuarial Services
MVP Health Care

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

[MVP VT Plus] Gold 2

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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	$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	50.00%				
MOOP ($)						
MOOP if Separate ($)	$6,500.00	$1,400.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$20.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$400.00	☑	☑			☑	☐
Speech Therapy	☑	☐		$40.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$25.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$80.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$11.25	☑	☑			☐	☐
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):	

Plan Description:

Name:	**[MVP VT Plus] Gold 2**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$15
VBID	$1

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.87%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.1641 seconds

Final 2021 AV Calculator

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

[MVP VT Plus] Gold 3 HDHP

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$3,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$3,000.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description: [MVP VT Plus] Gold 3 HDHP

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Calculate

Status/Error Messages:	Calculation Successful.		
Actuarial Value:	79.59%	0.998	79.43%
Metal Tier:	Gold	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.1953 seconds

Final 2021 AV Calculator

031

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

[MVP VT Plus] Silver 1

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)	$1,500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%				
MOOP ($)						
MOOP if Separate ($)	$6,700.00	$1,400.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$60.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$30.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,400.00	☑	☑			☑	☐
Speech Therapy	☑	☐		$60.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$35.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$150.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$1,400.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$300.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$4.00	☑	☑			☑	☐
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

Plan Description:

Name:	**[MVP VT Plus] Silver 1**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.80%
Metal Tier:	Silver
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.1758 seconds

Final 2021 AV Calculator

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

[MVP VT Plus] Reflective Silver 1 II

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)	$1,500.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%				
MOOP ($)						
MOOP if Separate ($)	$6,700.00	$1,400.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$60.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$30.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,400.00	☑	☑			☑	☐
Speech Therapy	☑	☐		$60.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$35.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$150.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$1,400.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$300.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$4.00	☑	☑			☑	☐
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

Plan Description:

Name:	**[MVP VT Plus] Reflective Silver 1 II**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.80%
Metal Tier:	Silver
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.3047 seconds

Final 2021 AV Calculator

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

[MVP VT Plus] Silver 1 CSR 73

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)	$1,300.00	$450.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%				
MOOP ($)						
MOOP if Separate ($)	$5,500.00	$1,400.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$350.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$60.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$30.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,400.00	☑	☑			☑	☐
Speech Therapy	☑	☐		$60.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$35.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$60.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$150.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$1,400.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$300.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$4.00	☑	☑			☑	☐
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

Plan Description:

Name:	**[MVP VT Plus] Silver 1 CSR 73**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.86%
Metal Tier:	Silver
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.1875 seconds

Final 2021 AV Calculator

034

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

[MVP VT Plus] Silver 1 CSR 77

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)	$500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	60.00%				
MOOP ($)						
MOOP if Separate ($)	$5,500.00	$1,400.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$350.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$10.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$40.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$10.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$500.00	☑	☑			☑	☐
Speech Therapy	☑	☐		$40.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$12.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$800.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☑	☑			☑	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$4.00	☑	☑			☑	☐
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

Plan Description:

Name:	**[MVP VT Plus] Silver 1 CSR 77**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	78.19%
Metal Tier:	
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.1836 seconds

Final 2021 AV Calculator

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

[MVP VT Plus] Silver 1 CSR 87

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	60.00%				
MOOP ($)						
MOOP if Separate ($)	$2,600.00	$700.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☐	☐		$50.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☐		$100.00	☑	☑			☐	☐
Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$12.00	☑	☑			☐	☐
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)	☐	☐		$200.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☐		$100.00	☑	☑			☐	☐
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$4.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☑	20%		☑	☑			☐	☐
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):	

Plan Description:

Name:	**[MVP VT Plus] Silver 1 CSR 87**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.78%
Metal Tier:	Gold
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.1406 seconds

Final 2021 AV Calculator

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☑
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

[MVP VT Plus] Silver 1 CSR 94

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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	$0.00				
Coinsurance (%, Insurer's Cost Share)	95.00%	95.00%				
MOOP ($)						
MOOP if Separate ($)	$1,450.00	$350.00				

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☑ All	☑ All			☐ All	☑ All
Emergency Room Services	☐	☐		$25.00	☑	☑			☐	☑
All Inpatient Hospital Services (inc. MH/SUD)	☐	☑			☑	☑			☐	☑
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 Use Disorder Outpatient Services	☐	☐		$5.00	☑	☑			☐	☑
Imaging (CT/PET Scans, MRIs)	☐	☐		$25.00	☑	☑			☐	☑
Speech Therapy	☐	☐		$10.00	☑	☑			☐	☑
Occupational and Physical Therapy	☐	☐		$6.00	☑	☑			☐	☑
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)	☐	☐		$40.00	☑	☑			☐	☑
Outpatient Surgery Physician/Surgical Services	☐	☐		$20.00	☑	☑			☐	☑
Drugs	☐ All	☐ All			☑ All	☑ All			☐ All	☑ All
Generics	☐	☐		$4.00	☑	☑			☐	☑
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):	☐

Plan Description:

Name:	**[MVP VT Plus] Silver 1 CSR 94**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$5
VBID	$1

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.96%
Metal Tier:	Platinum
	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Additional Notes:	
Calculation Time:	0.2031 seconds

Final 2021 AV Calculator

037

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

[MVP VT Plus] Silver 2 HDHP

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$5,075.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$5,075.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description:

Name:	[Input Plan Name]
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j

Output

Calculate

Status/Error Messages:	Calculation Successful.		
Actuarial Value:	69.09%	1.0416	71.96%
Metal Tier:	Silver	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.3398 seconds

Final 2021 AV Calculator

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

[MVP VT Plus] Ref Silver 2 HDHP

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$5,100.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$5,100.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description:

Name: **[MVP VT Plus] Ref Silver 2 HDHP**
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Status/Error Messages:	Calculation Successful.		
Actuarial Value:	69.01%	1.0416	71.88%
Metal Tier:	Silver	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.3984 seconds

Final 2021 AV Calculator

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

[MVP VT Plus] Silver 2 HDHP CSR 73

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$4,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$4,300.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	☐

Plan Description:

Name: **[MVP VT Plus] Silver 2 HDHP CSR 73**
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Status/Error Messages:	Calculation Successful.		
Actuarial Value:	71.67%	1.0286	73.72%
Metal Tier:	Silver	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.2773 seconds

Final 2021 AV Calculator

040

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

[MVP VT Plus] Silver 2 HDHP CSR 77

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$3,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$3,250.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description:

Name: **[MVP VT Plus] Silver 2 HDHP CSR 77**
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.		
Actuarial Value:	75.78%	1.017	77.07%
Metal Tier:		AV Adj	Final AV

Additional Notes:

Calculation Time: 0.2148 seconds

Final 2021 AV Calculator

041

Classified as Confidential

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

[MVP VT Plus] Silver 2 HDHP 87

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$1,500.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description:

Name:	[Input Plan Name]
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.		
Actuarial Value:	87.34%	1.003	87.61%
Metal Tier:	Gold	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.2344 seconds

Final 2021 AV Calculator

Classified as Confidential

042

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

[MVP VT Plus] Silver 2 HDHP CSR 94

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$550.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$550.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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):	

Plan Description:

Name: **[MVP VT Plus] Silver 2 HDHP CSR 94**
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.		
Actuarial Value:	93.76%	1	93.76%
Metal Tier:	Platinum	AV Adj	Final AV

Additional Notes:

Calculation Time: 0.2852 seconds

Final 2021 AV Calculator

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

[MVP VT Plus] Bronze 1

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)	$7,250.00	$700.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
MOOP ($)	$8,400.00					
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$35.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$100.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$35.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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	☑	☐		$19.50	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$100.00	☑	☑			☑	☐
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):	

Plan Description:

Name: **[MVP VT Plus] Bronze 1**
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]
2021_1j

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	62.61%
Metal Tier:	Bronze
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1211 seconds

Final 2021 AV Calculator

044

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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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

[MVP VT Plus] Bronze 5

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network 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 ($)			$7,850.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$7,850.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and 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	☐	☐		$23.00	☑	☑			☐	☐
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

Plan Description:

Name:	**[MVP VT Plus] Bronze 5**
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]
	2021_1j
Generic	$30
VBID	$3

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	64.81%
Metal Tier:	
Additional Notes:	
Calculation Time:	0.3242 seconds

Final 2021 AV Calculator

045

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Wakely

March 9, 2020

Mr. Dana Houlihan
Director, Plan Management & Enrollment Policy
VT Health Connect
Department of Vermont Health Access
Via Email Only

RE: STATE OF VERMONT ACTUARIAL VALUE CERTIFICATION FOR 2021 STANDARD PLAN DESIGNS

Dear Dana:

The Affordable Care Act (ACA) requires that health care coverage provided by issuers to non-grandfathered individual and small groups must cover all Essential Health Benefits (EHBs) and have plan designs that have Actuarial Values (AVs) that fall under the Platinum (90% AV), Gold (80% AV), Silver (70% AV), or Bronze (60% AV) tiers.

The State of Vermont (State) is standardizing several plan designs that all issuers offering plans in the Exchange, Vermont Health Connect, must offer. Issuers must offer the standard plan designs in the individual and small group merged market. In 2020, one Platinum, one Gold, two Silver, and three Bronze standard plan designs were developed for Vermont Health Connect. There is a traditional deductible plan at each of the Platinum, Gold, and Silver metal levels, with two at the Bronze level, and a High Deductible Health Plan (HDHP) at each of the Silver and Bronze levels. The 2020 standard plan designs are all continuing in 2021.

For each of the Silver standard plan designs, the cost sharing reduction plan designs are also standard. Cost sharing reduction (CSR) plan designs were developed at each of the 73% (Federal), 77% (Vermont specific), 87% (Federal), and 94% (Federal) AV levels.

The State contracted with Wakely Consulting Group, LLC (Wakely) to assist in the development of the 2021 standard plan designs and to provide an actuarial certification of the actuarial values of the state's standard plan designs that do not fit within the parameters of the Federal calculator and require adjustment. This memo documents the approved 2021 standard plan designs as well as the process for developing the corresponding actuarial values. The actuarial certification is provided in Appendix A. The 2021 Notice of Benefit and Payment Parameters (NBPP) is still in draft form. Should there be changes between the draft and final versions, the plan designs reflected here may require changes.

A list of the changes from the 2020 standard plan designs is in Appendix B. At a high level the changes for each base standard plan are:

1. Platinum – The medical deductible and medical Maximum Out of Pocket (MOOP) were increased.
2. Gold – The medical deductible, medical Maximum Out of Pocket (MOOP), pharmacy MOOP, generic pharmacy copay, and preferred brand pharmacy copay were all increased.
3. Silver Deductible – The combined medical/pharmacy MOOP and separate pharmacy MOOP were increased. Chiropractic services copays and physical therapy copays were decreased.
4. Bronze Deductible with Pharmacy Limit – The medical deductible, combined medical/pharmacy MOOP, and separate pharmacy MOOP were all increased. The generic pharmacy, chiropractic services, and physical therapy copays were all decreased. The deductible was also waived for generic scripts.
5. Bronze Deductible without Pharmacy Limit – The medical deductible, combined medical/pharmacy MOOP, and generic pharmacy copays were increased.
6. Silver HDHP – The medical deductible, medical MOOP, and the embedded individual combined medical/pharmacy MOOP were increased.
7. Bronze HDHP – The medical MOOP and the embedded individual combined medical/pharmacy MOOP were increased.

In addition to the standard plans, starting in 2016 the State of Vermont requests that issuers offer a Gold plan where the deductible and MOOP are set at the same amount. This means that once the deductible is met, the plan pays 100% of all services. Unlike the standard plans, it is not required that issuers offer this plan, but it is highly recommended. The issuer may determine the amount at which to set the deductible and MOOP, as long as they are equal and the resulting plan falls in the Gold tier. Since the amounts are to be determined by the issuers, these plans are not included within this memo.

Regulatory Background

The ACA allows for a -4% to +2% de minimis range around the target AVs for each metal level. For example, any plan design that has an AV from 66% to 72% is considered a Silver plan. Bronze plan designs meeting certain criteria are eligible for an expanded range of +5% on the higher end, allowing an AV up to 65% compared to a high end at 62%. Applicable plans include High Deductible Health Plans and plans that cover at least one major service, other than preventive, prior to the deductible. Of the Vermont standard plan designs, all three Bronze plans qualify for the expanded range. This is a change for 2021. In 2020 and prior, the Bronze Deductible plan with Pharmacy Limit did not qualify.

The Center for Consumer Information and Insurance Oversight (CCIIO) has released the final 2021 Actuarial Value Calculator (AVC)[1] that issuers must use to determine the AV of a plan. The final AVC has not yet been released. While CCIIO anticipates that most plans will be able to use the AVC without modification, some plan designs have features which are not supported by the AVC. In these instances, an actuary can either modify the inputs to most closely represent the plan design or an actuary can modify the results of the AVC to account for the features not supported by the AVC. An actuarial certification documenting the development of the AV for these designs is required.

The federal HDHP minimum deductible and MOOP limits are not yet released for 2021. The 2020 minimum deductible and MOOP were $1,400 and $6,900, respectively. Historically, the deductible has increased $50 every two to three years and the MOOP increases around $100 a year, on average. Should the federal HDHP minimum deductible for 2021 increase from $1,400, both the Silver and Bronze HDHPs and associated CSR plan designs will require changes to meet this requirement.

Additionally, the 2021 Notice of Benefits and Payment Parameters (NBPP)[2] is still in draft form. Based on the draft regulations, the single annual limit, or MOOP, is expected to be $8,550, up from $8,150 in 2020. Should the single annual limit not be finalized as proposed and the regulations finalize a limit below $8,550, both the Silver and Bronze HDHPs shown in this report will require changes in order to meet this requirement. Additionally, if the final limit is finalized below $8,400 both Bronze Deductible Plans (with and without drug limit) will also require changes in order to meet this requirement.

CSR Loading

As of 2020, Act No. 88 (Bill S.19) requires the premiums of the Silver on-Exchange plans to reflect the cost of funding for CSR subsidies, following the announcement that federal funding would cease. This resulted in a “CSR load” to these plans such that the Silver premiums are higher than they would have been without the CSR load. For individuals who are not eligible for premium subsidies (and are therefore not protected from the CSR load), issuers offer “reflective” off-Exchange Silver plans whose premiums have not been increased for the CSR load and have only a minor difference in plan design compared to their on-Exchange counterparts. These plans will continue in 2021.

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[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-guidance/index.html

[2] https://www.federalregister.gov/documents/2020/01/24/2020-00077/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021

The off-Exchange "reflective" plans will have a $5 copay or 5% coinsurance increase on ambulance services compared to the on-Exchange plans. These differentials apply to both standard and non-standard Silver plans. A comparison of the standard Silver on and off-Exchange plan designs are shown in Appendix C. As ambulance services are not explicitly included in the AVC and the differences in cost sharing are minimal, there is no difference in the calculation of the federal AV for these plans. Unless otherwise noted, in the Appendices the cost sharing for ambulance services represents the on-Exchange plan design.

In the event there is a Silver plan approved with 100% coinsurance, the off-Exchange "reflective" plan will have a $25 deductible and MOOP increase compared to the on-Exchange plan. Unlike the ambulance cost sharing above, this difference will impact the AV. The issuer submitting such a plan will need to ensure that both the on and off-Exchange plan designs fit within the AV requirements. Since this is for non-standard plans only, these plans are not included within this memo.

Chiropractic and Physical Therapy Copays

Act No. 7 (Bill S.1), relating to copayment limits for chiropractic care and physical therapy, was signed into law June 25, 2018. Act No. 7 requires that the copay for chiropractic and physical therapy services for Silver and Bronze metal level plans be between 125%-150% of the copay applicable to services provided by a primary care provider (PCP) in 2020. For 2021, S.202 was introduced which would require the copay for chiropractic services for Silver and Bronze metal level plans to be less than or equal to 125% of the PCP copay. The plan designs shown here have been updated assuming that S.202 is passed as introduced and sets the chiropractic and physical therapy copays equal to 125% of the PCP copay, rounded down to the nearest $5 increment. This change impacts only the Silver and Bronze metal level plans with a copay. Plans with coinsurance are not impacted.

The Federal actuarial value calculator does not account for all service categories and chiropractic services is one of those that is not explicitly included in the calculator. As noted in the "Actuarial Value Considerations" section below, CCIIO has stated and regulations dictate that modifications should be made only for substantial differences. We have not previously made adjustments to the results of the AVC to reflect chiropractic services cost sharing and do not feel that this regulation would warrant a change to that methodology. Therefore, no adjustments have been made to the actuarial value calculations and certification included in this memo for chiropractic services.

S.202 does not specifically require changes to the physical therapy copays. Based on issuer feedback, it is preferable to continue to set physical therapy and chiropractic copays equal to each other. The AVC does account for physical therapy services. The changes to the copays for chiropractic and physical therapy services are reflected in the 2021 standard plan designs.

Actuarial Value Considerations

A summary of Vermont's standard plan designs is in Appendix E. Four of the standard plan designs (and the cost sharing reduction plan designs) have features not supported by the AVC and thus an actuarial certification is required. The remaining standard plan designs have features that may warrant an AV adjustment but no explicit adjustment or actuarial certification has been done for these plans. In developing these standard plan designs and the resulting actuarial certification, Wakely also followed applicable Actuarial Standards of Practice (ASOP) as detailed in Appendix D and including:

- ASOP No. 23 Data Quality;
- ASOP No. 25 Credibility Procedures;
- ASOP No. 41 Actuarial Communications; and
- ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act.

Both Silver plans and two of the three Bronze plans have design features that are both significant and not supported by the AVC. The Silver cost sharing reduction plan designs have similar features. While most plans have some subtleties in their design that are not supported by the AVC, CCIIO has stated and regulations dictate that modifications should be made only for substantial differences. The three potential substantial differences that Wakely considered include:

1. Family deductible and MOOPs. There are two common types of applications for deductibles and MOOPs, commonly referred to in Vermont as stacked and aggregate[3]. The data supporting the AVC is only at the member level, and thus most closely resembles the stacked application of deductibles and MOOPs although the family stacked AV will be higher in most instances. Most HDHP plans use the aggregate application of deductible

[3] Stacked deductibles and MOOPs are typical in traditional deductible plans where the individual deductible and MOOP apply to each member of a contract and the family deductible and MOOP is used as a protection for contracts where multiple members have claims. For example, if the family MOOP is two times the individual MOOP but three members of a contract all would have reached their individual MOOP, it limits the family's liability to two times the individual MOOP.

Aggregate deductible and MOOPs are typical in HDHPs where all claims for all members of a non-single contract accumulate to the family deductible and MOOP. For two person or family contracts where only one member has significant claims, the member still must reach the higher deductible and MOOP amounts which makes the average member liability higher under an aggregate deductible.

and MOOPs which can significantly lower the AV since a family of two would need to accumulate to a deductible that is twice that of a single contract. Note that if the family MOOP is more than the proposed single limit of $8,550, the MOOP must either be stacked or there must be an embedded individual MOOP of $8,550. Wakely developed a model to account for aggregate family deductibles and has modified this model to account for stacked and embedded MOOPs for HDHPs. Thus, a specific adjustment has been made to the appropriate AVs for HDHPs.

2. Vermont implemented a statute (H.559 Sec. 32. 8 V.S.A. § 4089) for prescription drug deductibles and MOOPs. The requirement mandates, in part, that the MOOP for prescription drug costs in any plan design shall not exceed the minimum deductible amount for HDHPs per Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 ($1,400 and $2,800 for individual and family coverage in 2020, 2021 amounts are not yet known). The requirement also states that for HDHPs the cost sharing benefit for prescription drugs must start after the minimum deductible amount for HDHPs (same $1,400 and $2,800 for individual and family coverage in 2020) is met, but the amount may be met with either medical or prescription drug claims. This means that for all HDHPs, for purposes of prescription drug coverage, the deductible is considered met when accumulated medical and drug claims reach $1,400 for individual or $2,800 for family, regardless of what the medical deductible amount is. Similarly, the MOOP for only drug claims (including amounts used to accumulate to the deductible) is $1,400 or $2,800, regardless of the amount of the overall MOOP which will include both drug and medical claims.

   Since for an integrated deductible and MOOP, only one amount is able to be input in the AVC, the value of the lower drug deductible and MOOP cannot be modeled in the AVC. This statute has a significant impact on AV, particularly at the lower AV tiers where the difference between the medical and prescription drug deductible and MOOP is greater. Wakely has developed a model to account for Vermont's prescription drug regulation and thus, where appropriate, a specific adjustment has been made to the AVs using this model.

3. In the current market, most Vermont HDHPs waive the deductible for preventive prescription drugs. This is another plan feature not currently supported by the AVC. Wakely has not analyzed the exact portion of drugs this represents and this may vary by issuer. The impact to AV would only apply to drug costs that would normally be incurred prior to the member reaching the deductible. Any costs after the deductible is met and after the MOOP is met would be similar to the AVC. It is possible that this design feature could have a significant impact on the AV. Based on some high level estimates, Wakely believes the impact to AV for this design feature is likely around 0.5%. Since Wakely did not quantify the exact adjustment of the preventive drug difference for HDHPs, Wakely did not make a specific adjustment but did make sure that any AVs developed for HDHPs were at least 0.5% below the high end of the de minimis range in order to account for this

increased benefit. It is expected that the impact for these drugs would be highest for the Bronze plan where the deductible is highest and the impact would decrease as deductibles decrease (and AVs increase). Given the issuers now have credible data on the portion of claims that are preventive prescription drugs, it is recommended that the appropriateness of this adjustment is analyzed for the 2022 plan designs.

There are other potential design features for which adjustments could be made. However, given the expectation that adjustments be made for only the most substantive deviations, Wakely does not believe additional adjustments are warranted. It is also important to note that the bucketing of claims and the methodology used to calculate the AVC are not always clearly defined. Thus, at times it is difficult to ascertain whether an adjustment is warranted and how that adjustment would be estimated.

As stated, Wakely made explicit adjustments to account for the stacked and aggregate family deductible/MOOP and Vermont's prescription drug regulation. These adjustments are described in detail in the Methodology section. For the preventive prescription drug benefits, Wakely did not make an explicit adjustment but did allow cushion in the AV such that an increase of up to 0.5% would not result in the AV falling outside of the required range. The table below shows the acceptable range for each standard plan design after accounting for this cushion where an explicit adjustment was not made.

Table 1: Adjusted Acceptable Federal Actuarial Values

	Plan	Adjusted Acceptable Range
Deductible Plans	Platinum	86.0%-92.0%
	Gold	76.0%-82.0%
	Silver	66.0%-72.0%
	Bronze (with drug limit)	56.0%-65.0%[4]
	Bronze (without drug limit)	56.0%-65.0%
HDHPs	Silver - Embedded MOOP	66.0%-71.5%
	Bronze - Embedded MOOP	56.0%-64.5%
Cost Sharing Reduction Plan Designs - Deductible Plans	250-300% FPL (73% AV)	72.0%-74.0%
	200-250% FPL (77% AV)	76.0%-78.0%
	150-200% FPL (87% AV)	86.0%-88.0%
	133-150% FPL (94% AV)	93.0%-95.0%
Cost Sharing Reduction Plan Designs - HDHPs	250-300% FPL (73% AV)	72.0%-73.5%
	200-250% FPL (77% AV)	76.0%-77.5%
	150-200% FPL (87% AV)	86.0%-87.5%
	133-150% FPL (94% AV)	93.0%-94.5%

The table in Appendix F shows all plan designs for which adjustments were made, the adjustments considered, the original AV from the AVC, and the final adjusted AV.

Methodology

Since several of the standard plan designs have features not supported by the AVC, Wakely developed a model to capture the impact of these features on the AV. It was anticipated that the AVC would not accommodate all of the Vermont plan design features.

If a plan has substantive differences from what the AVC allows, there are two allowed approaches defined in the federal regulations. The first allows the actuary to adjust the inputs of the plan design to “fit” it into the AVC. The second allows the actuary to put in as many of the design features as possible into the AVC and then adjust the resulting AV to account for the unique design features. Wakely determined the second approach was most appropriate for the Vermont

[4] In 2020 and prior, the Bronze Deductible (with drug limit) plan was not eligible for the expanded de minimis range and would had an upper AV limit of 62.0%. Due to changes in the 2021 plan design, this plan now qualifies for the expanded range.

plan design differences. Thus for the plan designs where adjustments were made, Wakely first input as much of the plan design as possible into the AVC and then modified the resulting AV to account for the unique features.

The following discusses the model that Wakely developed and the process used to adjust the actuarial values from the AVC.

Vermont-Specific Adjustment Model

Anticipating the need to quantify some of Vermont's unique plan design features, Wakely developed a model that would account for both aggregate deductibles and MOOPs as well as quantify the impact of Vermont's prescription drug regulation. This model is updated every few years to capture recent Vermont-specific data. The current model was updated for the 2020 plan designs and includes Vermont-specific ACA data incurred in 2017.

In developing the model, Wakely was provided with membership and medical and pharmacy claims data extracts from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Filters were then applied to the data to target the most appropriate population for the model and reduce the amount of records included. The data used included:

- Small group and individual ACA markets
- Allowed medical and prescription drug data that was incurred in 2017
- Products types HMO (non-Medicare risk), PPO, POS and EPO
- Excluded claims marked as denied, out-of-state, and duplicates

After all filters were applied, the remaining data included allowed claims and membership for approximately 825,000 member months.

The methodology developed for the model does not use the traditional approach of continuance tables. When determining the paid claims and resulting actuarial value of the plan designs where the prescription drug regulation is a factor, the order in which the claims occur is important. Continuance tables fail to recognize the impact of the order of the claims on actuarial values. Thus, the model re-prices the claims based on the inputs provided in the model rather than rely on continuance tables.

The model allows a user to enter the following:

- Medical and Prescription drug deductible amounts for both individual and family contracts. These amounts can differ but the model assumes the amounts are always integrated, or

that both medical and drug claims will accumulate to both deductibles, even if different amounts.

- Medical and prescription drug maximum out of pocket amounts for both individual and family contracts. These amounts can differ and the model allows for different treatment of the MOOPs as noted below.
- Medical and prescription drug coinsurance amounts. If the plan design includes copays, an effective coinsurance needs to be input.
- The structure of the deductibles and MOOPs. As can be seen in the table below, the model can distinguish between aggregate and stacked deductibles and MOOPs. It also allows for different accumulations of claims to the medical and prescription drug MOOPs. There are six structural selections available in the model, described in the table below. Option 5 is most closely aligned to the federal AVC. Option 6 represents the design of the Vermont HDHPs.

	Costs that Accumulate			
Options	Deductible	Maximum Out-of-Pocket (MOOP)		**Deductible / MOOP Type**
		Medical	Rx	
1	Medical & Rx	Medical & Rx	Rx Only	Aggregate
2	Medical & Rx	Medical & Rx	Rx Only	Stacked
3	Medical & Rx	Medical Only	Rx Only	Aggregate
4	Medical & Rx	Medical Only	Rx Only	Stacked
5	Medical & Rx	Medical & Rx	Medical & Rx	Stacked
6	Medical & Rx	Medical & Rx	Rx Only	Aggregate Deductible /Aggregate MOOP with Embedded Ind MOOP (can also be used for Stacked MOOP)

Adjusted AV Calculations

Using the federal AV calculator and the model as outlined above, the following methodology was used to develop the adjusted AV calculations for the HDHPs:

1. The plan designs were entered into the AVC ignoring the separate prescription drug deductible and MOOP thresholds. The resulting AV is the unadjusted value, which does not account for the prescription drug regulations or the aggregate family deductible and MOOP levels.
2. The model was used to determine the revised AV.

a. The same plan design input into the AVC was input into the model. The model only allows for coinsurance. Since the HDHP designs include copays, an effective coinsurance was developed for each plan design. The effective coinsurance amounts were developed separately for medical and prescription drug services using the allowed weights and average cost per service from the federal AVC continuance tables for the relevant metal tier.

b. The model was normalized to the AVC for each plan design. This means the same plan design, ignoring the prescription drug thresholds and assuming a stacked family deductible and MOOP, was input into the model and the underlying data was adjusted to arrive at the same AV as the AVC. This was done to ensure the same starting AV in both models and to try to mirror the induced utilization in the AVC. The normalization factors were reviewed for reasonability and deemed reasonable given they are accounting for trend, regional differences in cost and utilization and induced utilization.

c. The plan design in the model was adjusted to lower the prescription drug deductible and MOOP inputs (if applicable) to the appropriate plan design amounts and also to adjust the prescription drug MOOP to only consider prescription drug claims (the medical MOOP amount continues to use both medical and prescription drug claims). The application of deductible and MOOP was also changed to use an aggregate family deductible and family MOOP with an embedded individual MOOP equal to $8,550.

3. The resulting AV from the model is used as the final AV for tier placement.

The model was intended only for HDHPs where medical and drug claims both accumulate to the deductible. The Bronze plan with the pharmacy limit[5] and Silver deductible plans (and associated CSR plans) need to be adjusted to account for the lower prescription drug MOOP, but the deductible plan has separate medical and drug deductibles. Thus, the model was used but with a slight variation in methodology. The following highlight the differences in methodology used only for the Bronze and Silver Deductible plans.

1. Same as for HDHPs, as much of the plan design as possible was entered into the AVC. This is the unadjusted AV. The Bronze and Silver Deductible plans then need to be adjusted for the lower and separate prescription drug MOOP.

[5] Only the Bronze plan with the pharmacy limit needs to be adjusted. The Bronze plan without the pharmacy limit is not subject to the lower prescription drug MOOP and as such does not require an explicit adjustment to the AVC results.

2. The model was used to develop the AV adjustments in a slightly different process than for the HDHPs.

    a. Instead of normalizing the model to the AVC, the normalization factor for the Bronze or Silver HDHP was used.

    b. The model cannot accommodate plan designs where both medical and drug claims do not accumulate to the deductible. Thus, the same plan design was entered into the model as in the AVC but the model selection indicated that both medical and drug claims accumulated to the deductible amounts.

    c. The model was then re-run with the lower drug MOOP and to adjust the prescription drug MOOP to only consider prescription drug claims (the medical MOOP amount continues to use both medical and prescription drug claims). The model continued to use a stacked application for deductible and MOOP since it is a traditional deductible plan.

3. The final AV is the ratio of the AV from 2c and 2b applied to the AV from the AVC in 1.

Appendix G includes screen shots from the AVC and the model for each plan design with an adjusted actuarial value. Also included is a summary of the AVs and in the instance of the Bronze and Silver Deductible plans, a calculation of the adjustment.

Disclosures and Limitations

Responsible Actuary. Julie Peper and Brittney Phillips are the actuaries responsible for this communication. Julie is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. Brittney is a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the State of Vermont and issuers within that state that will be submitting standard plan designs. Distribution to such parties should be made in its entirety. This report cannot be distributed to or relied on by any third party without the prior written permission of Wakely.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the model are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that actual experience will tie to the AV estimated for the placement of plan designs into tiers. The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected

actuarial value of a plan or pricing AV used to determine premium rates. Actual AVs will vary based on a plan's specific population, utilization, unit cost, and other variables.

Conflict of Interest. The responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the State of Vermont and any issuer in the state.

Data and Reliance. We have relied on others for data and information used in the actuarial value adjustments. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. Below is a list of data and assumptions provided by others and assumptions required by law.

- Final 2021 Federal AVC Model was relied on for the original AV. While reasonability tests have shown there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and we make no warranties for the accuracy of the AVs that result from the AVC.
- VHCURES data supplied by the state was used in the development of the HDHP model.

Subsequent Events. Subsequent events to the date of this report that could impact the plan designs presented include, but are not limited to:

1. The federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits are not yet released for 2021. The 2020 minimum deductible and MOOP are $1,400 and $6,900, respectively. Historically, the deductible has increased $50 every two to three years and the MOOP increases around $100 a year on average, though neither changed from 2016 to 2017. The plan designs presented are compliant with the 2020 HDHP limits and may need to change once the 2021 HDHP limits are released, primarily if the minimum deductible is increased.
2. The 2021 Notice of Benefits and Payment Parameters (NBPP) are still in draft form. Based on the draft regulations, the single annual limit is expected to be $8,550, up from $8,150 in 2020. The plan designs presented are compliant with the 2021 draft NBPP and may need to change if the final NBPP lowers the annual limit from the draft notice.
3. Other changes to regulations passed subsequent to this report.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. A summary of ASOP compliance is listed in Exhibit D.

Exhibit A contains the formal actuarial certification. If you have any questions regarding this letter or the certification, please contact us.

Sincerely,

Julie A. Peper, FSA, MAAA
Principal and Senior Consulting Actuary

Brittney Phillips, ASA, MAAA
Consulting Actuary

Appendix A

Actuarial Certification
State of Vermont
Actuarial Value of Standard Plan Designs
Effective January 1, 2021

I, Brittney Phillips, am associated with the firm of Wakely Consulting Group, LLC (Wakely), am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by the State of Vermont to provide a certification of the actuarial value of the state's standard plan designs that are effective January 1, 2021 on Vermont Health Connect. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the actuarial values provided with this certification are considered actuarially sound for purposes of § 156.135(b), according to the following criteria:

1. The final 2021 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
2. Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
3. The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
4. The actuarial values meet the requirements of § 156.135(b).

The assumptions and methodology used to develop the actuarial values have been documented in my correspondence with the State of Vermont. The actuarial values associated with this certification are for standard plan designs (Silver HDHP, Bronze HDHP, one Bronze Deductible, Silver Deductible, Silver HDHP CSR 73%, Silver HDHP CSR 77%, Silver HDHP CSR 87%, Silver HDHP CSR 94%, Silver Deductible CSR 73%, Silver Deductible CSR 77%, Silver Deductible CSR 87%, and Silver Deductible CSR 94%) that will be effective as of January 1, 2021 for individual and group coverage sold on Vermont Health Connect.

The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

In developing the actuarial values, I have relied upon the federal Actuarial Value calculator and data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System

(VHCURES). I did not audit the data provided; however, I did review the data for reasonableness and consistency.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Brittney Phillips, ASA, MAAA
March 9, 2020

Appendix B – Summary of Plan Design Changes from 2020 Designs

	Deductible Plans	
Plan	**Platinum**	**Gold**
Changes	Increase medical OOPM from $1,350 to $1,400	Increase medical deductible from $900 to $1,100
	Increase Rx OOPM from $1,350 to $1,400	Increase medical OOPM from $5,000 to $5,200
		Increase Rx OOPM from $1,350 to $1,400
		Increase generic Rx copay from $10 to $12
		Increase preferred brand Rx copay from $50 to $55

	Deductible Plans	
Plan	**Silver**	**Bronze w/ Rx Limit**
Changes	Increase medical OOPM from $7,900 to $8,150	Increase medical deductible from $6,000 to $6,250
	Increase Rx OOPM from $1,350 to $1,400	Increase medical OOPM from $8,150 to $8,400
	Decrease chiro/PT copay from $45 to $40	Increase Rx OOPM from $1,350 to $1,400
		Waive deductible for generic scripts
		Decrease generic Rx copay from $20 to $15
		Decrease chiro/PT copay from $45 to $40

	Deductible Plans
Plan	**Bronze w/o Rx Limit**
Changes	Increase medical deductible from $7,900 to $8,400
	Increase medical OOPM from $7,900 to $8,400
	Increase generic Rx copay from $25 to $30

	HDHPs	
Plan	**Silver - Embedded MOOP**	**Bronze - Embedded MOOP**
Changes	Increase medical deductible from $1,700 to $1,750	Increase medical OOPM from $6,750 to $6,900
	Increase medical OOPM from $6,750 to $6,900	Increase embedded single OOPM from $8,150 to $8,550
	Increase embedded single OOPM from $8,150 to $8,550	

Appendix C – On and Off-Exchange Reflective Silver Standard Plan Designs

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	2021 Plan Designs - Silver Deductible Plans		2021 Plan Designs - Silver HDHP Plans	
Deductible/OOP Max	**On-Exchange**	**Off-Exchange**	**On-Exchange**	**Off- Exchange**
Type of Plan	Deductible	Deductible	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$3,200	$3,200	$1,750	$1,750
Rx Ded	$350	$350	$1,400	$1,400
Integrated Ded	No	No	Yes	Yes
Medical MOOP	$8,150	$8,150	$6,900	$6,900
Rx MOOP	$1,400	$1,400	$1,400	$1,400
Integrated MOOP	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Preventive	Preventive
Drug Deductible waived for:	Generic scripts	Generic scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient	50%	50%	30%	30%
Outpatient	50%	50%	30%	30%
ER	$250	$250	30%	30%
Radiology (MRI, CT, PET)	50%	50%	30%	30%
Preventive	$0	$0	0%	0%
PCP Office Visit	$35	$35	10%	10%
MH/SA Office Visit	$35	$35	10%	10%
Chiropractic	$80	$80	30%	30%
Physical Therapy	$40	$40	30%	30%
Specialist Office Visit	$40	$40	30%	30%
Urgent Care	$90	$90	30%	30%
Ambulance	$100	**$105**	30%	**35%**
Rx Generic	$15	$15	$10	$10
Rx Preferred Brand	$60	$60	$40	$40
Rx Non-Preferred Brand	50%	50%	50%	50%
Rx Specialty	50%	50%	50%	50%
Actuarial Value				
2021 Federal AVC, Adjusted if Necessary	71.8%	71.8%	71.2%	71.2%

Appendix D – Comments Relative to Applicable ASOPs

This appendix includes comments relative to the following applicable Actuarial Standards of Practice (ASOP).

1. ASOP No. 23, Data Quality;
2. ASOP No. 25, Credibility Procedures;
3. ASOP No. 41, Actuarial Communications; and
4. ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act.

ASOP 23: Data Quality

3.1 Overview – VHCURES data was used as the basis for the HDHP model and this data source was deemed reasonable for the analysis discussed in the management report.

3.2 Selection of Data - The data was considered reasonable for our analysis subject to the following considerations -

a. The data sources contained all material data elements.

b. The following considerations were reviewed as part of our analysis:

1. Data was appropriate and sufficiently current.

2. Data was reasonable and comprehensive of the necessary data elements.

3. There were no known, material limitations of the data.

4. No alternative data sets were reasonably available. The reliability of the data underlying our analysis did not require support from alternative data sets.

5. Alternative data sets were not deemed necessary to complete the analysis.

6. Sampling methods were not required.

3.3 Reliance on Data Supplied by Others - Reliance is discussed in the management report to which this appendix is attached.

3.4 Reliance on Other Information Relevant to the Use of Data - We relied on information contained in the report. We did not detect any material errors in the data provided and relied upon the data as part of our analysis.

3.5 Review of Data - We reviewed the data. Data definitions were included as part of the VHCURES data. Ultimately the data was reasonable with the adjustments discussed in our management report.

3.6 Limitation of the Actuary's Responsibility - We did not audit the data.

3.7 Use of Data– Use and adjustments to the data are discussed in this management report. In addition:

a. We deem that the data are of sufficient quality to perform the analysis;

b. The data did not require enhancement before the analysis could be performed

c. The data was reasonable for the analysis and did not require adjustment beyond that discussed in the management report;

d. We did not detect any material defects in any data source;

e. The data were adequate to perform our analysis.

ASOP 25: Credibility Procedures

The HDHP model uses data as its starting point. The experience used is fully credible and therefore no credibility blending or adjustments were necessary.

ASOP 41: Actuarial Communications

This report and the actuarial memorandum submitted are consistent with the guidance in ASOP 41.

3.1 General Requirements for Actuarial Communications

3.1.1 Principal and Scope of Engagement – These results were developed to comply with § 156.135(b) and should not be used for any other purpose. The distribution of this report to other users is limited to the State of Vermont.

3.1.2 Form and Content – The State of Vermont was the principal for this engagement and the scope of the engagement included developing and certifying the actuarial values for the standard plan designs as discussed in the management report.

3.1.3 Timing of Communication – This report is provided in conjunction with the actuarial certification of the submitted actuarial values.

3.1.4 Identification of Responsible Actuary – The responsible actuary is identified in the attestation and this management report.

3.2 Actuarial Report – This management report is an Actuarial Report as defined in this ASOP. Correspondence between Wakely and the State of Vermont as part of this engagement should also be considered part of the Actuarial Report.

3.3 Specific Circumstances – No constraints apply beyond any discussed in the attachment management report.

3.4 Disclosures Within an Actuarial Report - all relevant disclosures have been made in the management report. Consistent with this ASOP, we make specific mention to the following items here:

3.4.1 Uncertainty or Risk – Uncertainty is discussed in the management report.

3.4.2 Conflict of Interest – Wakely is financially, organizationally, and otherwise independent from the State of Vermont and any reliant parties.

3.4.3 Reliance on Other Sources for Data and Other Information - Reliance regarding data and assumptions are discussed in this management report.

3.4.4 Responsibility for Assumptions and Methods - Assumptions and methods are discussed in the management report and the parties associated with the assumptions and methods have been delineated. Therefore, pursuant to this ASOP, no additional disclosure is necessary.

3.4.5 Information Date of Report -The management report lists the applicable dates for the analysis and correspondence.

3.4.6 Subsequent Events - Subsequent events are listed in the Limitations and Disclosures section.

3.5 Explanation of Material Differences - Wakely has issued no other report regarding the development of these actuarial values. No comparison to prior results is necessary.

3.6 Oral Communications - No oral communication is considered part of this actuarial report. Any material assumptions or methods discussed in oral communications have been documented in written form as well.

3.7 Responsibility to Other Users - Intended users of this report have been specifically noted in the document.

ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act

3.1 Use of AVC or MVC – The federal AVC was used.

3.2 Exceptions to the AVC – The federal AV was determined by making adjustments to the results of the federal AVC based on provisions that could not be appropriate modeled in the AVC.

3.3 Exceptions to the MVC – Not applicable.

3.4 Evaluating Non-Standard Plan Designs – The HDHP model was normalized to the federal AVC.

3.5 Reasonableness of Assumptions for Non-Standard Plan Designs – The assumptions used to modify the federal AVs were reviewed for reasonability.

3.6 Unreasonable Results – Not applicable.

3.7 Documentation – See ASOP 41 documentation above.

Appendix E – Standard Plan Designs

Deductible Plan Designs

	2021 Plan Designs - Deductible Plans				
Deductible/OOP Max	**Platinum**	**Gold**	**Silver**	**Bronze w/ Rx Limit**	**Bronze w/o Rx Limit**
Type of Plan	Deductible	Deductible	Deductible	Deductible	Deductible
Medical Ded	$350	$1,100	$3,200	$6,250	$8,400
Rx Ded	$0	$100	$350	$1,000	N/A
Integrated Ded	No	No	No	No	Yes
Medical MOOP	$1,400	$5,200	$8,150	$8,400	$8,400
Rx MOOP	$1,400	$1,400	$1,400	$1,400	N/A
Integrated MOOP	No	No	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes
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	Preventive	Preventive, OV
Drug Deductible waived for:	N/A	Generic scripts	Generic scripts	Generic Scripts	Generic Scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient	10%	30%	50%	50%	0%
Outpatient	10%	30%	50%	50%	0%
ER	$100	$150	$250	50%	0%
Radiology (MRI, CT, PET)	10%	30%	50%	50%	0%
Preventive	$0	$0	$0	$0	0%
PCP Office Visit	$15	$20	$35	$35	$40
MH/SA Office Visit	$15	$20	$35	$35	$40
Specialist Office Visit	$40	$50	$80	$90	$100
Chiropractic	$20	$30	$40	$40	$50
Physical Therapy	$20	$30	$40	$40	$50
Urgent Care	$50	$60	$90	$100	0%
Ambulance	$60	$70	$100	$100	0%
Rx Generic	$10	$12	$15	$15	$30
Rx Preferred Brand	$50	$55	$60	$85	0%
Rx Non-Preferred Brand	50%	50%	50%	60%	0%
Rx Specialty	50%	50%	50%	60%	0%
Actuarial Value					
2021 Federal AVC, Adjusted if Necessary	89.7%	81.9%	71.8%	64.1%	64.8%

Deductible Plan Designs – Cost Sharing Reduction Plans

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	2021 Plan Designs - Deductible Plans				
Deductible/OOP Max	**70% AV Silver**	**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	$3,200	$3,100	$2,600	$1,100	$200
Rx Ded	$350	$350	$300	$200	$0
Integrated Ded	No	No	No	No	No
Medical MOOP	$8,150	$6,750	$6,000	$2,200	$900
Rx MOOP	$1,400	$1,250	$1,100	$450	$200
Integrated MOOP	Rx -No, Medical - Yes	Rx -No, Medical - Yes	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	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	50%	50%	50%	40%	10%
Outpatient	50%	50%	50%	40%	10%
ER	$250	$250	$250	$250	$75
Radiology (MRI, CT, PET)	50%	50%	50%	40%	10%
Preventive	$0	$0	$0	$0	$0
PCP Office Visit	$35	$35	$25	$10	$5
MH/SA Office Visit	$35	$35	$25	$10	$5
Specialist Office Visit	$80	$70	$50	$30	$15
Chiropractic	$40	$40	$30	$12	$6
Physical Therapy	$90	$80	$60	$40	$25
Urgent Care	$100	$100	$100	$100	$50
Ambulance	$15	$12	$12	$10	$5
Rx Generic	$60	$60	$60	$50	$20
Rx Preferred Brand	50%	50%	50%	50%	30%
Rx Non-Preferred Brand	50%	50%	50%	50%	30%
Rx Specialty	50%	50%	50%	40%	10%
Actuarial Value					
2021 Federal AVC, Adjusted if Necessary	71.8%	74.0%	78.0%	88.0%	94.8%

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HDHP Plan Designs

	2021 Plan Designs - HDHP Plans	
Deductible/OOP Max	**Silver**	**Bronze**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$1,750	$5,500
Rx Ded	$1,400	$1,400
Integrated Ded	Yes	Yes
Medical MOOP	$6,900	$6,900
Rx MOOP	$1,400	$1,400
Integrated MOOP	Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual
Medical Deductible waived for:	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient	30%	50%
Outpatient	30%	50%
ER	30%	50%
Radiology (MRI, CT, PET)	30%	50%
Preventive	0%	0%
PCP Office Visit	10%	50%
MH/SA Office Visit	10%	50%
Specialist Office Visit	30%	50%
Chiropractic	30%	50%
Physical Therapy	30%	50%
Urgent Care	30%	50%
Ambulance	30%	50%
Rx Generic	$10	$12
Rx Preferred Brand	$40	40%
Rx Non-Preferred Brand	50%	60%
Rx Specialty	50%	60%
Actuarial Value		
2021 Federal AVC, Adjusted if Necessary	71.2%	63.8%

HDHP Plan Designs – Cost Sharing Reduction Plans

071

	2021 Plan Designs - HDHP Plan CSR Variations				
Deductible/OOP Max	**70% AV Silver**	**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	HSA Q/HDHP	Deductible (NOT HSAQ)
Medical Ded	$1,750	$1,750	$1,600	$1,400	$550
Rx Ded	$1,400	$1,400	$1,400	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes
Medical MOOP	$6,900	$5,200	$4,400	$1,400	$550
Rx MOOP	$1,400	$1,400	$1,400	N/A	N/A
Integrated MOOP	Rx – No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 2x Individual	Aggregate with Combined Medical/Rx embedded $8,550 Single OOPM; 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**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient	30%	25%	25%	0%	0%
Outpatient	30%	25%	25%	0%	0%
ER	30%	25%	25%	0%	0%
Radiology (MRI, CT, PET)	30%	25%	25%	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	30%	25%	25%	0%	0%
Chiropractic	30%	25%	25%	0%	0%
Physical Therapy	30%	25%	25%	0%	0%
Urgent Care	30%	25%	25%	0%	0%
Ambulance	30%	25%	25%	0%	0%
Rx Generic	$10	$10	$10	$0	$0
Rx Preferred Brand	$40	$40	$40	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	0%	0%
Rx Specialty	50%	50%	50%	0%	0%
Actuarial Value					
2021 Federal AVC, Adjusted if Necessary	71.2%	73.5%	77.4%	87.5%	93.7%

Appendix F – Summary of Adjustments Considered and Final Adjusted AVs

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Adjustments Considered	Aggregate Ded	Aggregate MOOP, Embedded $8,550	Stacked MOOP	Drug Regulation	Preventive Drugs	AV from AVC	Final Adjusted AV
Silver HDHP – Embedded $8,550 Individual MOOP	Yes	Yes	No	Yes	Yes	73.4%	71.2%
Bronze HDHP– Embedded $8,550 Individual MOOP	Yes	Yes	No	Yes	Yes	65.2%	63.8%
Silver Deductible	No	No	No	Yes	No	70.8%	71.8%
Bronze Deductible (with pharmacy limit)	No	No	Yes	Yes	No	63.3%	64.1%
Silver HDHP - Embedded $8,550 Individual MOOP CSR 73%	Yes	Yes	No	Yes	Yes	75.7%	73.5%
Silver HDHP - Embedded $8,550 Individual MOOP CSR 77%	Yes	Yes	No	Yes	Yes	79.5%	77.4%
Silver HDHP - Embedded $8,550 Individual MOOP CSR 87%	Yes	Yes	No	No	Yes	88.0%	87.5%
Silver HDHP - Embedded $8,550 Individual MOOP CSR 94%	Yes	Yes	No	No	Yes	93.8%	93.7%
Silver Deductible CSR – 73%	No	No	Yes	Yes	No	73.1%	74.0%
Silver Deductible CSR – 77%	No	No	Yes	Yes	No	77.4%	78.0%
Silver Deductible CSR – 87%	No	No	Yes	Yes	No	87.7%	88.0%
Silver Deductible CSR – 94%	No	No	Yes	Yes	No	94.7%	94.8%

Appendix G – Screen Shots and AV Development

1. Silver HDHP – Embedded MOOP
2. Bronze HDHP – Embedded MOOP
3. Silver Deductible Plan
4. Bronze Deductible Plan (with pharmacy limit)
5. Silver HDHP – Embedded MOOP CSR – 73%
6. Silver HDHP – Embedded MOOP CSR – 77%
7. Silver HDHP – Embedded MOOP CSR – 87%
8. Silver HDHP – Embedded MOOP CSR – 94%
9. Silver Deductible CSR – 73%
10. Silver Deductible CSR – 77%
11. Silver Deductible CSR – 87%
12. Silver Deductible CSR – 94%

1. Silver HDHP – Embedded MOOP

AV from AVC = 73.4%

Adjusted AV = 71.2%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,750.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$6,900.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

Name:	2021 Silver HDHP Plan Option 2
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value:	73.37%
Metal Tier:	
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1445 seconds

Draft 2021 AV Calculator

1. Silver HDHP – Embedded MOOP, Continued

HDHP Model – Normalization:

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	1,750	1,750
Family Deductible	3,500	3,500
Individual Out-of-Pocket	6,900	6,900
Family Out-of-Pocket	13,800	13,800
Coinsurance (50% or Less)	27%	28%
Individual Embedded Moop:	8,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$427.24	$102.44	$529.69
Plan PMPM	$312.51	$76.17	$388.68
Actuarial Value	73.1%	74.4%	73.38%

1. **Silver HDHP – Embedded MOOP, 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	1,750	1,400
Family Deductible	3,500	2,800
Individual Out-of-Pocket	6,900	1,400
Family Out-of-Pocket	13,800	2,800
Coinsurance (50% or Less)	27%	28%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$427.24	$102.44	$529.69
Plan PMPM	$295.84	$81.03	$376.87
Actuarial Value	69.2%	79.1%	71.15%

2. Bronze HDHP – Embedded MOOP

AV from AVC = 65.2%

Adjusted AV = 63.8%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
MOOP ($)			$6,900.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

	2021 Bronze HDHP Plan
Name:	Option 2
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value:	65.16%
Metal Tier:	
Additional Notes:	
Calculation Time:	0.1797 seconds

Draft 2021 AV Calculator

2. Bronze HDHP – Embedded MOOP, 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	5,500	5,500
Family Deductible	11,000	11,000
Individual Out-of-Pocket	6,900	6,900
Family Out-of-Pocket	13,800	13,800
Coinsurance (50% or Less)	48%	48%
Individual Embedded Moop:	8,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$513.61	$123.15	$636.77
Plan PMPM	$331.13	$83.82	$414.95
Actuarial Value	64.5%	68.1%	65.17%

2. **Bronze HDHP – Embedded MOOP, 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	5,500	1,400
Family Deductible	11,000	2,800
Individual Out-of-Pocket	6,900	1,400
Family Out-of-Pocket	13,800	2,800
Coinsurance (50% or Less)	48%	48%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$513.61	$123.15	$636.77
Plan PMPM	$313.37	$92.61	$405.99
Actuarial Value	61.0%	75.2%	63.76%

3. Silver Deductible

AV from AVC = 70.8%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 65.96%/65.04% = 1.01 x .708 = 71.8%

Adjusted AV = 71.8%

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 MOOP for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,200.00	$350.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%				
MOOP ($)	$8,150.00					
MOOP if Separate ($)						

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	☑	☐		$250.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
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 Use Disorder Outpatient Services	☐	☐		$35.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☐	☐		$80.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$45.00	☐	☐			☐	☐
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	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☐	☐			☑	☐
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):	

Plan Description:

2021 Silver Deductible

Name: Plan Option 1
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2021_1j

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.81%
Metal Tier:	Silver
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.082 seconds

Draft 2021 AV Calculator

Silver 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	3,200	350
Family Deductible	6,400	700
Individual Out-of-Pocket	8,150	8,150
Family Out-of-Pocket	16,300	16,300
Coinsurance (50% or Less)	43%	33%
Individual Embedded Moop:	8,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$427.24	$102.44	$529.69
Plan PMPM	$265.35	$79.17	$344.52
Actuarial Value	62.1%	77.3%	65.04%

3. Silver Deductible, Continued

HDHP Model – With Prescription Drug Adjustments:

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	3,200	350
Family Deductible	6,400	700
Individual Out-of-Pocket	8,150	1,400
Family Out-of-Pocket	16,300	2,800
Coinsurance (50% or Less)	43%	33%
Individual Embedded Moop:	8,150	

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked 2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$427.24	$102.44	$529.69
Plan PMPM	$262.56	$86.82	$349.38
Actuarial Value	61.5%	84.7%	65.96%

4. Bronze Deductible (with drug limit)

AV from AVC = 63.3%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 63.62%/62.82% = 1.013 x .633 = 64.1%

Adjusted AV = 64.1%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$6,250.00	$1,000.00	
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%	
MOOP ($)	$8,400.00		
MOOP if Separate ($)			

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$35.00	☐	☐			☑	☐
Specialist Visit	☑	☐		$90.00	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$35.00	☐	☐			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☐		$90.00	☐	☐			☑	☐
Occupational and Physical Therapy	☑	☐		$45.00	☐	☐			☑	☐
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	☐	☐		$15.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$85.00	☐	☐			☑	☐
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):	

Plan Description:

Name:	2021 Bronze Deductible Plan - with Rx Limit - Option 5
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	63.30%
Metal Tier:	Bronze
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.082 seconds

Draft 2021 AV Calculator

4. Bronze Deductible (Continuing, with drug limit), 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	6,250	1,000
Family Deductible	12,500	2,000
Individual Out-of-Pocket	8,400	8,400
Family Out-of-Pocket	16,800	16,800
Coinsurance (50% or Less)	47%	42%
Individual Embedded Moop:	8,400	

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

5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$513.61	$123.15	$636.77
Plan PMPM	$308.05	$91.95	$400.01
Actuarial Value	60.0%	74.7%	62.82%

4. **Bronze Deductible (Continuing, with drug limit), 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	6,250	1,000
Family Deductible	12,500	2,000
Individual Out-of-Pocket	8,400	1,400
Family Out-of-Pocket	16,800	2,800
Coinsurance (50% or Less)	47%	42%
Individual Embedded Moop:	8,400	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$513.61	$123.15	$636.77
Plan PMPM	$303.35	$101.76	$405.11
Actuarial Value	59.1%	82.6%	63.62%

5. Silver HDHP – Embedded MOOP CSR – 73%

AV from AVC = 75.7%

Adjusted AV = 73.5%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,750.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
MOOP ($)			$5,200.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

Name:	2021 HDHP Plan CSR Variations - 250-300% FPL (73% AV)
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	75.69%
Metal Tier:	
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1172 seconds

Draft 2021 AV Calculator

5. Silver HDHP – Embedded MOOP 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	1,750	1,750
Family Deductible	3,500	3,500
Individual Out-of-Pocket	5,200	5,200
Family Out-of-Pocket	10,400	10,400
Coinsurance (50% or Less)	23%	28%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$435.09	$104.33	$539.42
Plan PMPM	$329.44	$78.80	$408.24
Actuarial Value	75.7%	75.5%	75.68%

5. **Silver HDHP – Embedded MOOP 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	1,750	1,400
Family Deductible	3,500	2,800
Individual Out-of-Pocket	5,200	1,400
Family Out-of-Pocket	10,400	2,800
Coinsurance (50% or Less)	23%	28%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$435.09	$104.33	$539.42
Plan PMPM	$313.60	$82.73	$396.33
Actuarial Value	72.1%	79.3%	73.47%

6. Silver HDHP – Embedded MOOP CSR – 77%

AV from AVC = 79.5%

Adjusted AV = 77.4%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,600.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
MOOP ($)			$4,400.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	90%		☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

Name:	2021 HDHP Plan CSR Variations - 200-250% FPL (77% AV)
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	79.48%
Metal Tier:	
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.1055 seconds

Draft 2021 AV Calculator

6. Silver HDHP – Embedded MOOP 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	1,600	1,600
Family Deductible	3,200	3,200
Individual Out-of-Pocket	4,400	4,400
Family Out-of-Pocket	8,800	8,800
Coinsurance (50% or Less)	23%	24%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$511.77	$122.71	$634.48
Plan PMPM	$406.05	$98.31	$504.36
Actuarial Value	79.3%	80.1%	79.49%

6. **Silver HDHP – Embedded MOOP 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	1,600	1,400
Family Deductible	3,200	2,800
Individual Out-of-Pocket	4,400	1,400
Family Out-of-Pocket	8,800	2,800
Coinsurance (50% or Less)	23%	24%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$511.77	$122.71	$634.48
Plan PMPM	$390.18	$100.66	$490.84
Actuarial Value	76.2%	82.0%	77.36%

7. Silver HDHP – Embedded MOOP CSR – 87%

AV from AVC = 88.0%

Adjusted AV = 87.5%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

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

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

	2021 HDHP Plan CSR Variations - 150-200% FPL
Name:	(87% AV)
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.98%
Metal Tier:	Gold
Additional Notes:	
Calculation Time:	0.1367 seconds

Draft 2021 AV Calculator

7. Silver HDHP – Embedded MOOP 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	1,400	1,400
Family Deductible	2,800	2,800
Individual Out-of-Pocket	1,400	1,400
Family Out-of-Pocket	2,800	2,800
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$489.60	$117.40	$606.99
Plan PMPM	$430.02	$103.99	$534.01
Actuarial Value	87.8%	88.6%	87.98%

7. **Silver HDHP – Embedded MOOP 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	1,400	1,400
Family Deductible	2,800	2,800
Individual Out-of-Pocket	1,400	1,400
Family Out-of-Pocket	2,800	2,800
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$489.60	$117.40	$606.99
Plan PMPM	$427.60	$103.45	$531.05
Actuarial Value	87.3%	88.1%	87.49%

8. Silver HDHP – Embedded MOOP CSR – 94%

AV from AVC = 93.8%

Adjusted AV = 93.7%

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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$550.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
MOOP ($)			$550.00			
MOOP if Separate ($)						

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. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐			☐	☐
Specialist Visit	☑	☑			☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and 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):	

Plan Description:

Name:	2021 HDHP Plan CSR Variations - 133-150% FPL (94% AV)
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.76%
Metal Tier:	Platinum
Additional Notes:	
Calculation Time:	0.1289 seconds

Draft 2021 AV Calculator

8. Silver HDHP – Embedded MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$415.23	$99.56	$514.80
Plan PMPM	$389.34	$93.36	$482.70
Actuarial Value	93.8%	93.8%	93.76%

8. **Silver HDHP – Embedded MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$415.23	$99.56	$514.80
Plan PMPM	$389.18	$93.26	$482.45
Actuarial Value	93.7%	93.7%	93.72%

9. Silver Deductible CSR – 73%

AV from AVC = 73.1%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 68.11%/67.35% = 1.011 x 73.1% = 74.0%

Adjusted AV = 74.0% 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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$3,100.00	$350.00	
Coinsurance (%, Insurer's Cost Share)	50.00%	50.00%	
MOOP ($)	$6,750.00		
MOOP if Separate ($)			

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	☑	☐		$250.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$70.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$35.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☐	☐		$70.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☐	☐			☐	☐
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	☐	☐		$12.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☐	☐			☑	☐
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):	

Plan Description:

Name:	2021 Deductible Plan CSR Variations - 250-300% FPL (73% AV)
Plan HIOS ID:	
Issuer HIOS ID:	
AVC Version:	2021_1j

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.14%
Metal Tier:	Silver
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.0625 seconds

Draft 2021 AV Calculator

9. Silver Deductible CSR – 73%, 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	3,100	350
Family Deductible	6,200	700
Individual Out-of-Pocket	6,750	6,750
Family Out-of-Pocket	13,500	13,500
Coinsurance (50% or Less)	42%	31%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$435.09	$104.33	$539.42
Plan PMPM	$280.83	$82.48	$363.31
Actuarial Value	64.5%	79.1%	67.35%

9. **Silver Deductible CSR – 73%, 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	3,100	350
Family Deductible	6,200	700
Individual Out-of-Pocket	6,750	1,250
Family Out-of-Pocket	13,500	2,500
Coinsurance (50% or Less)	42%	31%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$435.09	$104.33	$539.42
Plan PMPM	$277.96	$89.44	$367.40
Actuarial Value	63.9%	85.7%	68.11%

10. Silver Deductible CSR – 77%

AV from AVC = 77.4%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 73.0%/72.46% = 1.007 x .774 = 78.0%

Adjusted AV = 78.0%

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 MOOP for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☑
Desired Metal Tier: Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

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

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	☑	☐		$250.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$50.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$25.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☐	☐		$50.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$30.00	☐	☐			☐	☐
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	☐	☐		$12.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☐	☐			☑	☐
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):

Plan Description:

Name: 2021 Deductible Plan CSR Variations - 200-250% FPL (77% AV)
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2021_1j

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 77.40%
Metal Tier:
Additional Notes: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time: 0.125 seconds
Draft 2021 AV Calculator

10. Silver Deductible CSR – 77%, 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	2,600	300
Family Deductible	5,200	600
Individual Out-of-Pocket	6,100	6,100
Family Out-of-Pocket	12,200	12,200
Coinsurance (50% or Less)	41%	26%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$511.77	$122.71	$634.48
Plan PMPM	$357.42	$102.33	$459.75
Actuarial Value	69.8%	83.4%	72.46%

10. **Silver Deductible CSR – 77%, 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	2,600	300
Family Deductible	5,200	600
Individual Out-of-Pocket	6,100	1,100
Family Out-of-Pocket	12,200	2,200
Coinsurance (50% or Less)	41%	26%
Individual Embedded Moop:	8,550	

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

2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$511.77	$122.71	$634.48
Plan PMPM	$354.49	$108.67	$463.16
Actuarial Value	69.3%	88.6%	73.00%

11. Silver Deductible CSR – 87%

AV from AVC = 87.7%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 85.15%/84.92% = 1.003 x .877= 88.0%

Adjusted AV = 88.0%

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 MOOP for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☑
Desired Metal Tier: Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,100.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
MOOP ($)	$2,200.00					
MOOP if Separate ($)						

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	☑	☐		$250.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$30.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$10.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☐	☐		$30.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$12.00	☐	☐			☐	☐
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	☐	☐		$10.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☐	☐			☑	☐
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):

Plan Description:

Name: 2021 Deductible Plan CSR Variations - 150-200% FPL (87% AV)
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2021_1j

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.73%
Metal Tier: Gold
Additional Notes: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time: 0.0859 seconds

Draft 2021 AV Calculator

11. Silver Deductible CSR – 87%, 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	1,100	200
Family Deductible	2,200	400
Individual Out-of-Pocket	2,200	2,200
Family Out-of-Pocket	4,400	4,400
Coinsurance (50% or Less)	31%	25%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$489.60	$117.40	$606.99
Plan PMPM	$410.23	$105.22	$515.45
Actuarial Value	83.8%	89.6%	84.92%

11. **Silver Deductible CSR – 87%, 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	1,100	200
Family Deductible	2,200	400
Individual Out-of-Pocket	2,200	450
Family Out-of-Pocket	4,400	900
Coinsurance (50% or Less)	31%	25%
Individual Embedded Moop:	8,550	

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked 2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$489.60	$117.40	$606.99
Plan PMPM	$407.76	$109.12	$516.88
Actuarial Value	83.3%	93.0%	85.15%

12. Silver Deductible CSR – 94%

AV from AVC = 94.7%

Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 94.62%/94.47% = 1.002 x .947 = 94.8%

Adjusted AV = 94.8%

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 MOOP for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☑
Desired Metal Tier: Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$200.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	70.00%				
MOOP ($)	$900.00					
MOOP if Separate ($)						

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	☑	☐		$75.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$15.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$5.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☐	☐		$15.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$7.00	☐	☐			☐	☐
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	☐	☐		$5.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$20.00	☐	☐			☐	☐
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):	

Plan Description:

Name: 2020 Deductible Plan CSR Variations - 133-150% FPL (94% AV)
Plan HIOS ID:
Issuer HIOS ID:

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.84%
Metal Tier:	Platinum
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.0938 seconds

Draft 2020 AV Calculator

Silver Deductible CSR – 94%, 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	200	0
Family Deductible	400	0
Individual Out-of-Pocket	900	900
Family Out-of-Pocket	1,800	1,800
Coinsurance (50% or Less)	8%	15%
Individual Embedded Moop:	8,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$415.23	$99.56	$514.80
Plan PMPM	$391.69	$94.63	$486.32
Actuarial Value	94.3%	95.0%	94.47%

12. **Silver Deductible CSR – 94%, 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	200	0			
	Family Deductible	400	0			
	Individual Out-of-Pocket	900	200			
	Family Out-of-Pocket	1,800	400			
	Coinsurance (50% or Less)	8%	15%			
	Individual Embedded Moop:	8,550				
		Costs that Accumulate				
			OOP		Deductible /	
		Deductible	Medical	Rx	OOP Type	
	Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2
		Calculate				
Results						
		Medical	Rx	Total		
	Allowed PMPM	$415.23	$99.56	$514.80		
	Plan PMPM	$390.85	$96.26	$487.11		
	Actuarial Value	94.1%	96.7%	94.62%		

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MVP Health Care Derivation of 2021 VT Exchange Rate Increases by Contract and Benefit Plan for ACA Compliant Members as of Febuary 2020

	NON-STANDARD PLANS								STANDARD PLANS												
	GOLD		SILVER				BRONZE		PLATINUM	GOLD	SILVER				BRONZE			Catastrophic	Total Annual Premium	Average PMPM	Average Annual Premium
	HDHP	Non-HDHP	On Exchange Non-HDHP	Reflective Non-HDHP	On Exchange HDHP	Reflective HDHP	Non-HDHP	No RX OOP			On Exchange Non-HDHP	Reflective Non-HDHP	On Exchange HDHP	Reflective HDHP	HDHP	Non-HDHP	No RX OOP				
2021 Proposed Rates																					
Single Rate	$714.05	$731.32	$693.21	$600.59	$706.81	$611.99	$510.28	$532.12	$835.03	$704.84	$709.70	$617.08	$697.07	$604.45	$526.09	$520.21	$545.70	$354.84			
Couple Rate	$1,428.10	$1,462.64	$1,386.42	$1,201.18	$1,413.62	$1,223.98	$1,020.56	$1,064.24	$1,670.06	$1,409.68	$1,419.40	$1,234.16	$1,394.14	$1,208.90	$1,052.18	$1,040.42	$1,091.40	$709.68			
Adult and Child(ren) Rate	$1,378.12	$1,411.45	$1,337.90	$1,159.14	$1,364.14	$1,181.14	$984.84	$1,026.99	$1,611.61	$1,360.34	$1,369.72	$1,190.96	$1,345.35	$1,166.59	$1,015.35	$1,004.01	$1,053.20	$684.84			
Family Rate	$2,006.48	$2,055.01	$1,947.92	$1,687.66	$1,986.14	$1,719.69	$1,433.89	$1,495.26	$2,346.43	$1,980.60	$1,994.26	$1,733.99	$1,958.77	$1,698.50	$1,478.31	$1,461.79	$1,533.42	$997.10	$267,204,764	$602.14	$7,225.66
2020 Approved Rates																					
Single Rate	$651.82	$695.91	$644.91	$554.40	$671.94	$579.29	$475.96	$501.07	$784.52	$663.63	$675.22	$584.71	$661.70	$571.19	$490.01	$476.22	$542.75	$336.24			
Couple Rate	$1,303.64	$1,391.82	$1,289.82	$1,108.80	$1,343.88	$1,158.58	$951.92	$1,002.14	$1,569.04	$1,327.26	$1,350.44	$1,169.42	$1,323.40	$1,142.38	$980.02	$952.44	$1,085.50	$672.48			
Adult and Child(ren) Rate	$1,258.01	$1,343.11	$1,244.68	$1,069.99	$1,296.84	$1,118.03	$918.60	$967.07	$1,514.12	$1,280.81	$1,303.17	$1,128.49	$1,277.08	$1,102.40	$945.72	$919.10	$1,047.51	$648.94			
Family Rate	$1,831.61	$1,955.51	$1,812.20	$1,557.86	$1,888.15	$1,627.80	$1,337.45	$1,408.01	$2,204.50	$1,864.80	$1,897.37	$1,643.04	$1,859.38	$1,605.04	$1,376.93	$1,338.18	$1,525.13	$944.83	$248,934,672	$560.97	$6,731.60
2021 Proposed Rate Increases																					
Single Rate	9.5%	5.1%	7.5%	8.3%	5.2%	5.6%	7.2%	6.2%	6.4%	6.2%	5.1%	5.5%	5.3%	5.8%	7.4%	9.2%	0.5%	5.5%			
Couple Rate	9.5%	5.1%	7.5%	8.3%	5.2%	5.6%	7.2%	6.2%	6.4%	6.2%	5.1%	5.5%	5.3%	5.8%	7.4%	9.2%	0.5%	5.5%			
Adult and Child(ren) Rate	9.5%	5.1%	7.5%	8.3%	5.2%	5.6%	7.2%	6.2%	6.4%	6.2%	5.1%	5.5%	5.3%	5.8%	7.4%	9.2%	0.5%	5.5%			
Family Rate	9.5%	5.1%	7.5%	8.3%	5.2%	5.6%	7.2%	6.2%	6.4%	6.2%	5.1%	5.5%	5.3%	5.8%	7.4%	9.2%	0.5%	5.5%	**7.34%**	**Total Revenue Change**	
February 2020 Contracts																					
Single Rate	2,331	246	3,026	785	69	228	549	522	1,281	2,091	288	716	175	607	1,390	1,557	243	7			
Couple Rate	776	55	719	152	19	61	97	67	456	631	71	160	50	149	330	349	45	1			
Adult and Child(ren) Rate	184	9	117	30	5	15	19	13	117	161	12	41	6	44	79	52	10	0			
Family Rate	773	34	122	129	6	59	47	39	295	351	9	131	7	150	323	168	16	0			
Total	**4,064**	**344**	**3,984**	**1,096**	**99**	**363**	**712**	**641**	**2,149**	**3,234**	**380**	**1,048**	**238**	**950**	**2,122**	**2,126**	**314**	**8**			
2021 Proposed PMPY Revenue	$7,461.88	$8,068.78	$8,173.38	$6,452.13	$8,031.17	$6,411.06	$5,803.44	$6,032.07	$8,987.49	$7,653.32	$8,315.66	$6,697.15	$8,237.08	$6,288.44	$5,642.04	$5,877.57	$6,253.41	$4,258.08			
2020 Approved PMPY Revenue	$6,811.56	$7,678.10	$7,603.89	$5,955.91	$7,634.95	$6,068.50	$5,413.12	$5,680.09	$8,443.85	$7,205.85	$7,911.65	$6,345.85	$7,819.12	$5,942.42	$5,255.11	$5,380.55	$6,219.60	$4,034.88			

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:	Leader, Actuarial
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
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) = $\frac{\text{Projected Paid Index Rate After Adjustments PMPM (line 30 of Exhibit 3)}}{\text{[Avg Inforce Actuarial Value * Induced Utilization Factor]}}$

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.

Contact Information

Company Identifying 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:	Leader, Actuarial
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

2021 Vermont Exchange Filing

General Information

This memorandum details the methods and assumptions underlying the proposed 2021 premium rates for the State of Vermont's Individual and SHOP Exchange. 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 and no new base plans being offered. MVP made modifications to a number of the benefits being offered, and the updated forms have been submitted in a separate SERFF filing. The proposed rates reflect an average rate adjustment to prior rates of 7.3%, ranging from 0.5% to 9.5%.

Drivers of Rate Increase

The proposed premium rates reflect an increase over the prior rates due to single risk pool experience which is more adverse than assumed in the current rates, medical and pharmacy cost and utilization inflation, the impact of the novel coronavirus (COVID-19) pandemic, and an increase to the administrative expense and contribution to reserve assumptions. Premium rate increases are varying by plan due to benefit modifications of several benefits being offered as well as the impact of fixed PMPM non-claim costs on premiums that vary based on benefit level.

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. 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, and the experience period data reflects 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 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. And MVP Health Insurance Company Small Group and Individual data for Vermont members over the time period 1/1/2019 – 12/31/2019, completed through 3/31/2020. MVP included all data for ACA-compliant small group and individual members, satisfying the single risk pool requirements of 45 CFR Part 156.

MVP does not project to rebate consumers for 2019 dates of service, 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 and individuals over the experience period.

Allowed claim data includes claims from our fee for service (FFS) claim warehouses (medical and pharmacy) 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 (IBNR) was added to the experience period fee-for-service (FFS) medical claims. IBNR files were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates, and Vermont specific data for the experience period was used to develop the factors. The fee-for-service experience period claims were reconciled with the IBNR lag triangles to ensure accuracy.

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 for the claims shown in Worksheet I, Section I of the URRT.

	Allowed	**Incurred**
Claims Processed Through Claim System	$175,137,911	$143,467,810
Experience Period Costs Not Processed Through Claims System	$3,686,381	$3,236,663
IBNR	$3,652,704	$2,994,440
Total	$182,476,996	$149,698,913

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, ICD-10, Diagnosis Code, or HCPCS). The "Other" category includes pediatric dental claims. The "Capitation" category includes capitated payments as well as all other claims not processed through MVP's claim warehouses.

Medical Trend Factors

The assumed unit cost trends reflect known and assumed price increases from MVP's provider network, weighted by benefit category. The Capitation unit cost trend reflects the expected change between the capitated and non-FFS claim expense between the experience period and the projection period.

MVP analyzed historical utilization patterns for the ACA-compliant business to determine whether there has been a utilization trend pattern in the recent past. Because of the rapid membership growth in this block in the past several years, the utilization trends produced by the model were not considered reliable. However, the reviewing actuary in the previous year's filing performed an analysis that found that "a reasonable range for market wide utilization trend to be 1% to 4%". Therefore, MVP is building in 1% annual medical utilization trend in this filing.

Rx Trend Factors

Annual allowed Rx trend factors split by generic, brand, and specialty drugs are provided by MVP's PBM and were determined using MVP specific data over the experience period by drug class. The forecast 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.

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

MVP is assuming that the single risk pool membership base of 359,516 member months in the experience period is fully credible for rating purposes. Therefore, the applied credibility percentage is 100.00% (0.00% weight on credibility manual).

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

Morbidity Adjustment- Impact of Pooling High Cost Claimants

As part of its rate filing process, MVP removes the claim expense (net of reinsurance) above $100,000 for members who reach that threshold on an annual basis. Those claims have been replaced by the average of the annual cost of claims exceeding $100,000 relative to claims less than $100,000 for the eligible population for the previous three calendar years (2019, 2018 and 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%

The net impact of this factor is an decrease to the experience period allowed claim cost of -0.7%.

Morbidity Adjustment- Impact of 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 factor is increasing the experience period allowed claim cost by 1.0%.

Morbidity Adjustment- Impact of 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. This factor is increasing the experience period allowed claim cost by 0.3%.

Plan Design Changes- Paid to Allowed Ratio Normalization
The actual paid to allowed ratio during the experience period and the assumed paid to allowed ratio used for pricing differ for two reasons. First, the federal cost sharing reduction (CSR) subsidies are no longer being paid to MVP, which artificially inflates MVP's claim expense relative to the total allowed claim cost. Second, the actual paid to allowed ratio (including assumed payments for cost sharing reductions) for the experience period is different than the pricing paid to allowed ratio produced by MVP's internal benefit relativity model. Because MVP prices using net claim expense instead of allowed claims, the allowed claims in the URRT need to be adjusted for the difference in the paid to allowed ratios to develop an equivalent Market Adjusted Index Rate. The total of this two-part adjustment is 0.6%.

Other- Impact of National High Cost Reinsurance Pool (HCRP)
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 a 0.28% increase to the allowed claim cost.

Reinsurance (Worksheet 1, Section 2)
MVP is reflecting $0.00 PMPM in reinsurance recoveries during the projection period. MVP did not have any members hit the MVP corporate or national HCRP thresholds in 2019, and does not expect to have any hit them in 2021.

Federal Risk Adjustment Program (Worksheet 1, Section 2)
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.

The URRT instructions state that the projected risk adjustment PMPM on Worksheet 1 is to be calculated on an allowed basis. Therefore, MVP has taken the projected risk adjustment PMPM on a net basis and divided by the projection period paid to allowed ratio to come up with the value shown ($91.34 PMPM).

Exchange User Fees (Worksheet 1, Section 2)
Vermont's Exchange is not a Federally-Facilitated Exchange, therefore 0.00% of premium is built in to account for user fees during the projection period.

Market-Wide Adjusted Index Rate
The experience period index rate of $507.56 is equal to the single risk pool allowed claim data for the time period, 1/1/2019 – 12/31/2019, completed through 3/31/2020. The single risk pool projection period index rate is $578.73. These amounts reflect the cost of EHBs over the applicable time periods. The projection period index rate reflects the market-wide adjustments discussed above in the section labeled, "Projection Factors".

The actual market adjusted index rate for the projection period equals $669.54. However, due to the rounding of factors present in the URRT, the value in the file reflects $670.07. This value was computed by adjusting the projection period index rate for the federal risk adjustment program, reinsurance and marketplace user fees. Please see above for details on the computation of the projected value of the risk adjustment program. The market adjusted index rate reflects the average demographic characteristics of the single risk pool.

Actuarial Values and Cost Sharing Design of Plan (Worksheet 2, Section 3)
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 Gold 3, and non-Standard Silver 2 plans. The actuarial certification of these adjustments has been included.

The Benefit Actuarial Value for each plan was determined using MVP's in-house benefit pricing tools. 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. MVP did not reflect any induced utilization in the projection of the net paid amounts for each unique benefit plan.

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.

This field also includes the adjustment for Silver loading made to on-Exchange Silver plans. The load of $82.54 PMPM has been converted to a percentage of the net claim cost and the total adjustment made is the product of the three values (AV, induced demand, and silver loading).

Provider Network Adjustment (Worksheet 2, Section 3)
MVP only offers one provider network for its Vermont plans; therefore, no plan-level adjustment is necessary.

Benefits in Addition to EHB (Worksheet 2, Section 3)
Members purchasing a non-standard plan will receive MVP's Member Wellness Incentive (Form: FRVT366). This benefit provides subscribers with up to $600 in wellness rewards per year, subject to certain guidelines. MVP projects the net cost of this benefit to equal $0.88 PMPM, which is converted to a percentage of the net claim cost and applied to the non-Standard plans only.

Catastrophic Plan Adjustment (Worksheet 2, Section 3)
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.

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

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:

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:

Combined VT AR42 and AR44	Year	SHCE Admin PMPM*
Individual	2017	$38.54
Small Group	2017	$40.72
Combined	2017	$39.59
Individual	2018	$42.78
Small Group	2018	$39.29
Combined	2018	$40.72
Individual	2019	$41.04
Small Group	2019	$38.84
Combined	2019	$39.86

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

Profit/Risk Load

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. A plan level adjustment equal to 0.40% of premium was added to account for non-payment of premium risk.

Age/Geographic/Tobacco Calibration (Worksheet 2, Section 3)

Per Vermont stating rating rules, variation in rates due to tobacco and age are not allowed. Therefore, all calibration factors are 1. Additionally, there is only 1 rating region in Vermont, so the geography calibration is also 1.

Consumer Adjusted Premium Rates

The Calibrated Plan Adjusted Index Rate PMPMs are converted to per contract premium rates using the computed single conversion factor and the prescribed standard load ratios. Please note that due to the rounding present in the URRT template, actual Plan Adjusted Index Rate PMPMs may vary from the URRT to the actual rates as filed.

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.

Projection Period Membership

MVP's projection period membership equals the February 2019 enrollment of the population eligible to purchase these products, or 30,887 members. On Worksheet 2 of the URRT, members are mapped based on their February 2019 benefit to the same benefits for 2019.

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%

Actuarial Certification

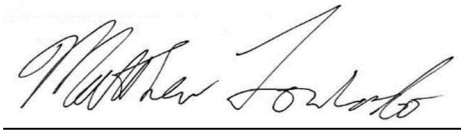
I, Matthew Lombardo, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. The projected Index Rate and Adjusted Paid Amount used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 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. The EHB portion of premium reflected in Worksheet 2, Sections 3 and 4 was calculated in accordance with actuarial standards of practice.

The URRT does not demonstrate the process that was used to develop premium rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases and for certification that the Index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

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 Actuarial Standards of Practice; ASOP #5, ASOP#8, ASOP #12, ASOP #23, ASOP #25, ASOP#41, ASOP#42, ASOP#45, and ASOP#50.



5/7/2020
Date

Matthew Lombardo, FSA, MAAA
Senior Leader, Actuarial Services
MVP Health Care, Inc.

Consumer Disclosure about Proposed Health Insurance Rate Increase
VT 2021 ACA Exchange Rate Filing

About Us

MVP Health Plan, Inc. is a non-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.

Why We Are Changing Our Premiums

MVP must obtain approval from the Green Mountain Care Board for the health insurance premium rates charged. MVP files annual premium rates for the Exchange which are guaranteed for 12 months. This rate filing seeks approval of MVP's 2021 Exchange rates for effective dates of coverage between January 1, 2021 and December 31, 2021. The premium rates filed 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. Changes in the filed premium rates (relative to previously approved rates) are driven by many factors, including:

-Increases in base period experience. Premium rates are increasing by **0.3%** because claims are higher than expected compared to the previous year.

-Increases in cost and utilization of services. The cost and utilization of medical and pharmacy services generally increase over time. Premium rates are increasing by **5.2%** because of this estimated trend in 2021.

-Impact of the COVID-19 pandemic. MVP is assuming that a vaccine to prevent the virus will be available in 2021. Additionally, MVP is assuming that services postponed as a result of the outbreak in 2020 will be made up in 2021. These two items combine to increase the premium rate by **1.6%**.

-Impact of the Federal Risk Adjustment Program. The federal risk adjustment program seeks to "level the playing field" among insurers. MVP has enrolled a population of lower-risk members, so it is required to pay into the program. MVP's payment has decreased slightly from last year, decreasing premium rates by approximately **-0.1%**.

-Fees and assessments charged by the government to insurers. The repeal of the Federal Insurer Tax for 2021 is decreasing premium rates by -**1.0%.**

-Increases in the cost of doing business. As the cost of doing business rises over time, MVP must increase the amount of administrative expenses built into premium rates. Additionally, MVP must collect a portion of the premium revenue to protect consumers by ensuring its solvency. These increases are worth approximately **0.6%** of the premium increase.

-Impact of Changes in Product Mix. MVP has changed plan benefits on most plans from 2020 to 2021. Additionally, members have purchased different products in 2020 than 2019. The two are combining to drive up the rate increase by approximately **0.5%.**

Conclusion

The proposed rates reflect an average rate adjustment to prior rates of 7.3%, ranging from 0.5% to 9.5%. Increases for subscribers receiving Advanced Premium Tax Credits will vary based on income. There are 14,848 policyholders, 23,872 subscribers and 36,980 members impacted by this rate filing.

Vermonters can provide public comment on the proposed rate increases during the public comment period from May 11 to July 22. For information about providing public comment, please visit
https://ratereview.vermont.gov/public_comment

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: Karla Austen	Title: Chief Financial Officer & Executive Vice President
Signature:	Date: 05/08/2020

Unified Rate Review v5.1

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.

Company Legal Name:	MVP Health Plan, Inc.	State:	VT
HIOS Issuer ID:	77566	Market:	Combined
Effective Date of Rate Change(s):	1/1/2021		

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Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 1/1/2019 to 12/31/2019

	Total	PMPM
Allowed Claims	$182,476,995.91	$507.56
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$149,698,913.25	$416.39
Risk Adjustment	-$22,492,428.13	-$62.56
Experience Period Premium	$182,486,583.88	$507.59
Experience Period Member Months	359,516	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$82.09	1.051	1.010	1.070	1.010	$94.17
Outpatient Hospital	$215.27	1.044	1.010	1.065	1.010	$244.16
Professional	$129.11	1.013	1.010	1.046	1.010	$139.55
Other Medical	$9.06	1.020	1.010	1.050	1.010	$9.90
Capitation	$10.25	1.052	1.000	1.052	1.000	$11.34
Prescription Drug	$61.78	1.048	1.023	1.048	1.023	$71.01
Total	$507.56					**$570.14**

Morbidity Adjustment		1.006
Demographic Shift		1.000
Plan Design Changes		1.006
Other		1.003
Adjusted Trended EHB Allowed Claims PMPM for	**1/1/2021**	**$578.73**

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

			Projected Period Totals
Projected Index Rate for	**1/1/2021**	**$578.73**	$256,817,224.80
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		-$91.34	-$40,533,038.40
Exchange User Fees		0.00%	$0.00
Market Adjusted Index Rate		**$670.07**	**$297,350,263.20**

Projected Member Months	**443,760**

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.**
HIOS Issuer ID: **77566**
Effective Date of Rate Change(s): **1/1/2021**

State: **VT**
Market: **Combined**

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.
To validate, select the Validate button or Ctrl + Shift + I.
To finalize, select the Finalize button or Ctrl + Shift + F.
To remove a product, navigate to the corresponding Product Name/Product ID field and select the Remove Product button or Ctrl + Shift + R.
To remove a plan, navigate to the corresponding Plan Name/Plan ID field and select the Remove Plan button or Ctrl + Shift + A.

Product/Plan Level Calculations

Field #	Section I: General Product and Plan Information																					
1.1	Product Name		Individual																			
1.2	Product ID		77566VT004																			
1.3	Plan Name		FRVT-HMO-P-001-	FRVT-HMO-G-001-	FRVT-HMO-G-002-	FRVT-HMOH-G-	FRVT-HMO-S-003-	FRVT-HMOH-S-	FRVT-HMOH-S-	FRVT-HMO-S-001-	VT-HMO-S-003-S ii	VT-HMOH-S-004-S	VT-HMOH-S-002-N	VT-HMO-S-001-N	FRVT-HMO-B-002-	FRVT-HMOH-B-	FRVT-HMO-B-004-	FRVT-HMO-B-005-	FRVT-HMO-B-001-	FRVT-HMO-C-001-
1.4	Plan ID (Standard Component ID)		77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040023	77566VT0040005	77566VT0040006	77566VT0040024	77566VT0040007	77566VT0040030	77566VT0040031	77566VT0040029	77566VT0040028	77566VT0040009	77566VT0040010	77566VT0040025	77566VT0040026	77566VT0040011	77566VT0040013
1.5	Metal		Platinum	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Catastrophic
1.6	AV Metal Value		0.897	0.819	0.819	0.794	0.718	0.712	0.720	0.718	0.718	0.712	0.720	0.718	0.641	0.638	0.648	0.648	0.626	0.617
1.7	Plan Category		Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing
1.8	Plan Type		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
1.9	Exchange Plan?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
1.10	Effective Date of Proposed Rates		1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021
1.11	Cumulative Rate Change % (over 12 mos prior)		6.44%	6.21%	5.09%	9.55%	5.11%	5.35%	5.19%	7.49%	5.54%	5.82%	5.64%	8.33%	9.24%	7.36%	0.54%	6.20%	7.21%	5.53%
1.12	Product Rate Increase %		7.17%																	
1.13	Submission Level Rate Increase %																			7.34%

Worksheet 1 Totals	Section II: Experience Period and Current Plan Level Information																				
	2.1 Plan ID (Standard Component ID)	Total	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040023	77566VT0040005	77566VT0040006	77566VT0040024	77566VT0040007	77566VT0040030	77566VT0040031	77566VT0040029	77566VT0040028	77566VT0040009	77566VT0040010	77566VT0040025	77566VT0040026	77566VT0040011	77566VT0040013
$182,476,996	2.2 Allowed Claims	$182,476,996	$6,216,044	$11,830,089	$2,145,114	$10,612,560	$4,320,197	$3,908,097	$1,557,440	$32,279,483	$223,331	$546,474	$647,435	$1,482,173	$5,454,069	$2,993,518	$821,271	$2,321,363	$2,265,258	$20,288
$0	2.3 Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	2.4 Member Cost Sharing	$32,778,083	$529,918	$1,997,598	$313,251	$1,702,747	$594,356	$459,539	$142,712	$2,870,384	$89,802	$152,886	$162,770	$321,792	$1,867,267	$995,602	$291,561	$606,891	$772,030	$12,688
	2.5 Cost Sharing Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$149,698,913	2.6 Incurred Claims	$149,698,913	$5,686,126	$9,832,492	$1,831,863	$8,909,812	$3,725,841	$3,448,558	$1,414,729	$29,409,099	$133,530	$393,588	$484,666	$1,160,380	$3,586,801	$1,997,916	$529,710	$1,714,472	$1,493,228	$7,600
-$22,492,428	2.7 Risk Adjustment Transfer Amount	-$22,492,428	$1,958,467	-$1,599,527	$328,227	$743,808	$1,132,977	$978,790	$633,147	-$878,671	-$144,259	-$212,035	-$257,657	-$964,332	-$4,482,597	-$2,349,477	-$303,690	-$1,263,753	-$1,214,476	-$14,392
$182,486,584	2.8 Premium	$182,486,584	$3,647,682	$11,497,002	$1,473,570	$6,820,212	$3,532,446	$2,520,493	$695,299	$33,727,963	$457,593	$580,453	$602,298	$1,744,721	$8,824,882	$4,955,820	$1,272,020	$3,067,005	$3,183,528	$45,495
359,516	2.9 Experience Period Member Months	359,516	5,556	19,944	2,534	12,609	5,652	4,160	1,160	57,375	969	1,336	1,378	4,098	21,783	12,258	2,781	7,256	7,860	152
	2.10 Current Enrollment	36,980	656	2,011	268	1,327	490	306	136	5,122	103	135	125	441	1,852	1,234	352	726	844	9
	2.11 Current Premium PMPM	$560.97	$733.00	$629.06	$662.62	$591.15	$659.30	$651.43	$640.81	$633.66	$507.05	$479.97	$490.73	$481.91	$453.62	$454.03	$521.52	$475.31	$452.79	$336.24
	2.12 Loss Ratio	93.57%	101.43%	99.34%	101.67%	117.79%	79.86%	98.55%	106.49%	89.53%	42.62%	106.83%	140.63%	148.69%	82.60%	76.66%	54.70%	95.08%	75.83%	24.44%
	Per Member Per Month																			
	2.13 Allowed Claims	$507.56	$1,118.80	$593.17	$846.53	$841.67	$764.37	$939.45	$1,342.62	$562.61	$230.48	$409.04	$469.84	$361.68	$250.38	$244.21	$295.31	$319.92	$288.20	$133.47
	2.14 Reinsurance	$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
	2.15 Member Cost Sharing	$91.17	$95.38	$100.16	$123.62	$135.04	$105.16	$110.47	$123.03	$50.03	$92.67	$114.44	$118.12	$78.52	$85.72	$81.22	$104.84	$83.64	$98.22	$83.47
	2.16 Cost Sharing Reduction	$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
	2.17 Incurred Claims	$416.39	$1,023.42	$493.00	$722.91	$706.62	$659.21	$828.98	$1,219.59	$512.58	$137.80	$294.60	$351.72	$283.16	$164.66	$162.99	$190.47	$236.28	$189.98	$50.00
	2.18 Risk Adjustment Transfer Amount	-$62.56	$352.50	-$80.20	$129.53	$58.99	$200.46	$235.29	$545.82	-$15.31	-$148.87	-$158.71	-$186.98	-$235.32	-$205.78	-$191.67	-$109.20	-$174.17	-$154.51	-$94.69
	2.19 Premium	$507.59	$656.53	$576.46	$581.52	$540.90	$624.99	$605.89	$599.40	$587.85	$472.23	$434.47	$437.08	$425.75	$405.13	$404.29	$457.40	$422.69	$405.03	$299.31

	Section III: Plan Adjustment Factors																			
	3.1 Plan ID (Standard Component ID)		77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040023	77566VT0040005	77566VT0040006	77566VT0040024	77566VT0040007	77566VT0040030	77566VT0040031	77566VT0040029	77566VT0040028	77566VT0040009	77566VT0040010	77566VT0040025	77566VT0040026	77566VT0040011	77566VT0040013
	3.2 Market Adjusted Index Rate																			$670.07
	3.3 AV and Cost Sharing Design of Plan		1.0431	0.8698	0.9037	0.8807	0.8763	0.8594	0.8711	0.8530	0.7530	0.7362	0.7449	0.7297	0.6240	0.6319	0.6580	0.6386	0.6095	0.6340
	3.4 Provider Network Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
	3.5 Benefits in Addition to EHB		1.0000	1.0000	1.0015	1.0015	1.0000	1.0000	1.0015	1.0015	1.0000	1.0000	1.0018	1.0018	1.0000	1.0000	1.0000	1.0021	1.0022	1.0000
	Administrative Costs																			
	3.6 Administrative Expense		5.75%	6.81%	6.56%	6.72%	6.76%	6.89%	6.79%	6.92%	7.78%	7.94%	7.84%	7.99%	9.23%	9.12%	8.80%	9.02%	9.41%	13.53%
	3.7 Taxes and Fees		0.61%	0.65%	0.64%	0.65%	0.65%	0.66%	0.65%	0.66%	0.70%	0.71%	0.70%	0.71%	0.77%	0.76%	0.75%	0.76%	0.77%	0.98%
	3.8 Profit & Risk Load		1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%
	3.9 Catastrophic Adjustment		1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.6371
	3.10 **Plan Adjusted Index Rate**		$761.88	$643.01	$667.16	$651.40	$647.46	$635.96	$644.80	$632.38	$563.00	$551.49	$558.32	$547.91	$474.60	$479.96	$497.92	$485.51	$465.54	$323.71
	3.11 Age Calibration Factor	1.0000																		1.0000
	3.12 Geographic Calibration Factor	1.0000																		1.0000
	3.13 Tobacco Calibration Factor	1.0000																		1.0000
	3.14 **Calibrated Plan Adjusted Index Rate**		$761.88	$643.01	$667.16	$651.40	$647.46	$635.96	$644.80	$632.38	$563.00	$551.49	$558.32	$547.91	$474.60	$479.96	$497.92	$485.51	$465.54	$323.71

	Section IV: Projected Plan Level Information																			
	4.1 Plan ID (Standard Component ID)	Total	77566VT0040001	77566VT0040002	77566VT0040004	77566VT0040023	77566VT0040005	77566VT0040006	77566VT0040024	77566VT0040007	77566VT0040030	77566VT0040031	77566VT0040029	77566VT0040028	77566VT0040009	77566VT0040010	77566VT0040025	77566VT0040026	77566VT0040011	77566VT0040013
	4.2 Allowed Claims	$279,870,634	$5,234,304	$15,116,429	$2,041,253	$10,029,179	$4,218,605	$2,620,163	$1,169,103	$43,869,321	$745,443	$968,342	$899,789	$3,159,099	$12,916,948	$8,619,477	$2,474,951	$5,076,896	$5,862,683	$39,784
	4.3 Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	4.4 Member Cost Sharing	$71,048,068	$486,730	$2,980,284	$360,815	$1,920,114	$1,173,318	$754,099	$328,755	$12,863,570	$207,330	$278,792	$253,743	$926,326	$4,898,073	$3,209,486	$867,981	$1,860,182	$2,293,444	$14,561
	4.5 Cost Sharing Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	4.6 Incurred Claims	$208,822,566	$4,747,574	$12,136,145	$1,680,438	$8,109,065	$3,045,286	$1,866,065	$840,348	$31,005,752	$538,113	$689,550	$646,046	$2,232,773	$8,018,875	$5,409,990	$1,606,970	$3,216,714	$3,569,239	$25,223
	4.7 Risk Adjustment Transfer Amount	-$32,039,126	-$749,980	-$1,917,160	-$265,461	-$1,280,998	-$404,399	-$246,906	-$111,471	-$4,096,597	$85,006	-$108,929	-$102,057	-$352,714	-$1,266,751	-$854,622	-$253,855	-$508,148	-$563,837	-$3,984
	4.8 Premium	$267,343,890	$5,992,088	$15,505,293	$2,143,946	$10,365,091	$3,804,066	$2,333,299	$1,051,514	$38,839,716	$695,275	$892,620	$836,820	$2,897,264	$10,538,843	$7,101,473	$2,101,229	$4,225,930	$4,711,140	$34,934
	4.9 Projected Member Months	443,760	7,872	24,132	3,216	15,924	5,880	3,672	1,632	61,464	1,236	1,620	1,500	5,292	22,224	14,808	4,224	8,712	10,128	108
	4.10 Loss Ratio	88.75%	90.57%	89.31%	89.46%	89.27%	89.58%	89.44%	89.39%	89.24%	88.18%	87.99%	87.93%	87.75%	86.48%	86.60%	86.99%	86.52%	86.06%	81.50%
	Per Member Per Month																			
	4.11 Allowed Claims	$630.68	$664.93	$626.41	$634.72	$629.82	$717.45	$713.55	$716.36	$713.74	$603.11	$597.74	$599.86	$596.96	$581.22	$582.08	$585.93	$582.75	$578.86	$368.37
	4.12 Reinsurance	$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
	4.13 Member Cost Sharing	$160.10	$61.83	$123.50	$112.19	$120.58	$199.54	$205.36	$201.44	$209.29	$167.74	$172.09	$169.16	$175.04	$220.40	$216.74	$205.49	$213.52	$226.45	$134.82
	4.14 Cost Sharing Reduction	$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
	4.15 Incurred Claims	$470.58	$603.10	$502.91	$522.52	$509.24	$517.91	$508.19	$514.92	$504.45	$435.37	$425.65	$430.70	$421.91	$360.82	$365.34	$380.44	$369.23	$352.41	$233.54
	4.16 Risk Adjustment Transfer Amount	-$72.20	-$95.27	-$79.44	-$82.54	-$80.44	-$68.78	-$67.24	-$68.30	-$66.65	-$68.78	-$67.24	-$68.04	-$66.65	-$57.00	-$57.71	-$60.10	-$58.33	-$55.67	-$36.89
	4.17 Premium	$602.45	$761.19	$642.52	$666.65	$650.91	$646.95	$635.43	$644.31	$631.91	$562.52	$551.00	$557.88	$547.48	$474.21	$479.57	$497.45	$485.07	$465.16	$323.46

Small																
77566VT005																
FRVT-HMO-P-001-	FRVT-HMO-G-001-	FRVT-HMO-G-002-	FRVT-HMOH-G-	FRVT-HMO-S-003-	FRVT-HMOH-S-	FRVT-HMOH-S-	FRVT-HMO-S-001-	VT-HMO-S-003-S11	VT-HMOH-S-004-S	VT-HMOH-S-002-N	VT-HMO-S-001-N	FRVT-HMO-B-002-	FRVT-HMOH-B-	FRVT-HMO-B-004-	FRVT-HMO-B-005-	FRVT-HMO-B-001-
77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050023	77566VT0050005	77566VT0050006	77566VT0050024	77566VT0050007	77566VT0050030	77566VT0050031	77566VT0050029	77566VT0050028	77566VT0050009	77566VT0050010	77566VT0050025	77566VT0050026	77566VT0050011
Platinum	Gold	Gold	Gold	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze
0.897	0.819	0.819	0.794	0.718	0.712	0.720	0.718	0.718	0.712	0.720	0.718	0.641	0.638	0.648	0.648	0.626
Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing
HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes	Yes
1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021	1/1/2021
6.44%	6.21%	5.09%	9.55%	5.11%	5.35%	5.19%	7.49%	5.54%	5.82%	5.64%	8.33%	9.24%	7.36%	0.54%	6.20%	7.21%
7.47%																

77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050023	77566VT0050005	77566VT0050006	77566VT0050024	77566VT0050007	77566VT0050030	77566VT0050031	77566VT0050029	77566VT0050028	77566VT0050009	77566VT0050010	77566VT0050025	77566VT0050026	77566VT0050011
$19,870,277	$12,215,586	$1,254,966	$30,084,495	$341,846	$900,963	$170,421	$233,028	$4,399,151	$5,370,332	$1,513,375	$3,152,725	$3,327,565	$7,878,137	$160,824	$1,522,423	$436,675
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$1,643,681	$2,152,901	$185,336	$6,003,144	$125,018	$227,038	$13,821	$74,948	$1,143,704	$1,350,142	$413,498	$770,415	$1,335,098	$2,900,732	$68,150	$390,673	$95,989
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$18,226,596	$10,062,685	$1,069,631	$24,081,351	$216,828	$673,925	$156,600	$158,080	$3,255,447	$4,020,190	$1,099,877	$2,382,310	$1,992,467	$4,977,405	$92,674	$1,131,750	$340,686
$941,177	-$1,984,180	$137,563	-$1,108,226	-$196,529	-$231,638	-$17,893	-$254,157	-$2,160,360	-$1,449,471	-$792,023	-$1,835,733	-$1,630,597	-$3,712,898	-$174,805	-$45,245	-$67,963
$15,929,534	$13,192,080	$1,039,066	$27,240,879	$639,075	$936,596	$63,357	$616,531	$6,299,927	$5,642,274	$1,890,498	$4,299,056	$4,517,210	$9,683,911	$374,016	$1,130,940	$343,153
25,250	24,617	1,853	54,255	1,238	1,904	108	1,197	12,986	12,386	4,432	9,397	11,322	25,163	829	2,771	947
2,965	3,128	242	6,034	0	5	5	0	1,537	1,493	499	1,245	1,151	2,246	64	111	118
$697.16	$582.12	$614.62	$562.46	$0.00	$661.70	$512.02	$0.00	$530.28	$496.58	$509.46	$501.43	$439.95	$429.08	$500.60	$460.49	$438.93
108.04%	89.78%	90.91%	92.15%	49.00%	95.60%	344.44%	43.62%	78.64%	95.88%	100.13%	96.71%	69.02%	83.38%	46.52%	104.24%	123.80%
$786.94	$496.23	$677.26	$554.50	$276.13	$473.20	$1,577.98	$194.68	$338.76	$433.58	$341.47	$335.50	$293.90	$313.08	$194.00	$549.41	$461.11
$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
$65.10	$87.46	$100.02	$110.65	$100.98	$119.24	$127.98	$62.61	$88.07	$109.01	$93.30	$81.99	$117.92	$115.28	$82.21	$140.99	$101.36
$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
$721.85	$408.77	$577.24	$443.85	$175.14	$353.95	$1,450.00	$132.06	$250.69	$324.58	$248.17	$253.52	$175.98	$197.81	$111.79	$408.43	$359.75
$37.27	-$80.60	$74.24	-$20.43	-$158.75	-$121.66	-$165.68	-$212.33	-$166.36	-$117.02	-$178.71	-$195.35	-$144.02	-$147.55	-$210.86	-$16.33	-$71.77
$630.87	$535.89	$560.75	$502.09	$516.22	$491.91	$586.64	$515.06	$485.13	$455.54	$426.56	$457.49	$398.98	$384.85	$451.17	$408.13	$362.36

77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050023	77566VT0050005	77566VT0050006	77566VT0050024	77566VT0050007	77566VT0050030	77566VT0050031	77566VT0050029	77566VT0050028	77566VT0050009	77566VT0050010	77566VT0050025	77566VT0050026	77566VT0050011
1.0431	0.8698	0.9037	0.8807	0.8763	0.8594	0.8711	0.8530	0.7530	0.7362	0.7449	0.7297	0.6240	0.6319	0.6580	0.6386	0.6095
1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
1.0000	1.0000	1.0015	1.0015	1.0000	1.0000	1.0015	1.0015	1.0000	1.0000	1.0018	1.0018	1.0000	1.0000	1.0000	1.0021	1.0022
5.75%	6.81%	6.56%	6.72%	6.76%	6.89%	6.79%	6.92%	7.78%	7.94%	7.84%	7.99%	9.23%	9.12%	8.80%	9.02%	9.41%
0.61%	0.65%	0.64%	0.65%	0.65%	0.66%	0.65%	0.66%	0.70%	0.71%	0.70%	0.71%	0.77%	0.76%	0.75%	0.76%	0.77%
1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%
1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
$761.88	$643.01	$667.16	$651.40	$647.46	$635.96	$644.80	$632.38	$563.00	$551.49	$558.32	$547.91	$474.60	$479.96	$497.92	$485.51	$465.54
$761.88	$643.01	$667.16	$651.40	$647.46	$635.96	$644.80	$632.38	$563.00	$551.49	$558.32	$547.91	$474.60	$479.96	$497.92	$485.51	$465.54

77566VT0050001	77566VT0050002	77566VT0050004	77566VT0050023	77566VT0050005	77566VT0050006	77566VT0050024	77566VT0050007	77566VT0050030	77566VT0050031	77566VT0050029	77566VT0050028	77566VT0050009	77566VT0050010	77566VT0050025	77566VT0050026	77566VT0050011
$23,658,096	$23,512,774	$1,843,221	$45,603,665	$0	$42,813	$42,982	$0	$11,123,746	$10,709,146	$3,591,958	$8,918,545	$8,027,758	$15,688,286	$449,991	$776,220	$819,664
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$2,199,928	$4,635,667	$325,811	$8,730,947	$0	$12,322	$12,087	$0	$3,093,842	$3,083,229	$1,012,942	$2,615,138	$3,044,105	$5,841,577	$157,815	$284,408	$320,647
$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$21,458,168	$18,877,107	$1,517,410	$36,872,718	$0	$30,491	$30,895	$0	$8,029,904	$7,625,917	$2,579,016	$6,303,407	$4,983,653	$9,846,708	$292,176	$491,812	$499,017
-$3,389,771	-$2,982,038	-$239,707	-$5,824,824	$0	-$4,034	-$4,098	$0	-$1,268,493	-$1,204,675	-$407,410	-$995,756	-$787,273	-$1,555,495	-$46,155	-$77,692	$78,830
$27,083,140	$24,117,631	$1,935,952	$47,131,091	$0	$38,126	$38,659	$0	$10,375,119	$9,871,716	$3,340,585	$8,179,351	$6,549,789	$12,925,371	$382,042	$646,113	$658,667
35,580	37,536	2,904	72,408	0	60	60	0	18,444	17,916	5,988	14,940	13,812	26,952	768	1,332	1,416
90.57%	89.31%	89.46%	89.27%	#DIV/0!	89.44%	89.39%	#DIV/0!	88.18%	87.99%	87.93%	87.75%	86.48%	86.60%	86.99%	86.52%	86.06%
$664.93	$626.41	$634.72	$629.82	#DIV/0!	$713.55	$716.36	#DIV/0!	$603.11	$597.74	$599.86	$596.96	$581.22	$582.08	$585.93	$582.75	$578.86
$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$61.83	$123.50	$112.19	$120.58	#DIV/0!	$205.36	$201.44	#DIV/0!	$167.74	$172.09	$169.16	$175.04	$220.40	$216.74	$205.49	$213.52	$226.45
$0.00	$0.00	$0.00	$0.00	#DIV/0!	$0.00	$0.00	#DIV/0!	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$603.10	$502.91	$522.52	$509.24	#DIV/0!	$508.19	$514.92	#DIV/0!	$435.37	$425.65	$430.70	$421.91	$360.82	$365.34	$380.44	$369.23	$352.41
-$95.27	-$79.44	-$82.54	-$80.44	#DIV/0!	-$67.24	-$68.30	#DIV/0!	-$68.78	-$67.24	-$68.04	-$66.65	-$57.00	-$57.71	-$60.10	-$58.33	-$55.67
$761.19	$642.52	$666.65	$650.91	#DIV/0!	$635.43	$644.31	#DIV/0!	$562.52	$551.00	$557.88	$547.48	$474.21	$479.57	$497.45	$485.07	$465.16

Rating Area Data Collection

Specify the total number of Rating
Select only the Rating Areas you ar
To validate, select the Validate but
To finalize, select the Finalize butto

Rating Area	Rating Factor
Rating Area 1	1.0000

Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.
re offering plans within and add a factor for each area.
:ton or Ctrl + Shift + I.
on or Ctrl + Shift + F.

PRIMMER PIPER EGGLESTON & CRAMER PC
ATTORNEYS AT LAW
30 Main Street, Suite 500| P.O. Box 1489 |Burlington, VT 05402-1489

EXHIBIT
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RYAN M. LONG
ADMITTED IN VT AND NY
rlong@primmer.com
TEL: 802-864-0880
FAX: 802-864-0328

June 19, 2020

VIA E-MAIL ONLY – Michael.Barber@vermont.gov

Michael Barber, Esq.
General Counsel
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan, Inc. 2021 Vermont Health Connect
Rate Filing – Docket No. GMCB-006-20rr

Dear Hearing Officer Barber:

On behalf of MVP Health Plan, Inc., enclosed please find *MVP's Responses to The Green Mountain Care Board's First Set of Non-Actuarial Interrogatories* and *Certificate of Service.*

Respectfully submitted,

/s/ Ryan M. Long

Ryan M. Long

Cc: ***(VIA E-MAIL ONLY)***
Kaili Kuiper, Esq., kkuiper@vtlegalaid.org
Eric Schultheis, Esq., ESchultheis@vtlegalaid.org
Christina McLaughlin, Christina.McLaughlin@vermont.gov
Amerin Aborjaily, Esq., Amerin.Aborjaily@vermont.gov
Thomas Crompton, Thomas.Crompton@vermont.gov

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2021	)	
Vermont Health Connect Rate Filing	)	DOCKET NO. GMCB-006-20rr
	)	
SERFF No. MVPH-132371260	)	
	)	

MVP'S RESPONSES TO THE GREEN MOUNTAIN CARE BOARD'S FIRST SET OF NON-ACTUARIAL INTERROGATORIES

MVP Health Plan, Inc., ("MVP") by and through Primmer Piper Eggleston & Cramer PC hereby objects to the Green Mountain Care Board's ("GMCB" or "Board") June 12, 2020 First Set of Non-Actuarial Interrogatories pursuant to 8 V.S.A. § 4062 and 18 V.S.A. § 9375(b)(6) as follows:

NON-ACTUARIAL INTERROGATORIES

1. Last year, MVPHP provided information regarding its pending action against the federal government, *Common Ground Healthcare Cooperative v. United States*, in its June 21, 2019 response to question #2 of HCA non-actuarial questions in GMCB-05-19rr. Please provide an update including any changes in the nature and amount of damages you are seeking in the case; the status of the proceedings; and the timeframe within which you expect the claim to be resolved.

Response to Non-Actuarial Interrogatory No. 1: MVP Health Plan, Inc. (HIOS 56184 and HIOS 77566) is an opt-in class member of the cost-sharing reduction class action captioned *Common Ground Healthcare Coop. v. United States, 142 Fed. Cl. 38 (2019)*. Since MVP's response to this inquiry last year, the Government appealed the decision on December 16, 2019 to the United States Court of Appeals for the Federal Circuit, where the appeal remains pending. The nature and amount of damages sought for 2017 and 2018 CSR payments remain unchanged. In addition, the Government and MVP have begun the CSR reconciliation process for 2019 CSR payments and have not yet come to an agreement on the

amount of 2019 reconciliation payments. Generally, because of COVID-19, courts have been delayed in deciding cases. At this time, it is unknown when we will receive a decision.

2. Please specify whether MVPHP has a pending case against the federal government to recoup unpaid risk corridor payments and the amount, if any, MVPHP is seeking to recover.

Response to Non-Actuarial Interrogatory No. 2: The risk corridor program was designed to mitigate unexpected gains and losses when the ACA was rolled out in 2014 – 2016. The *Maine Cmty. Health Options* decision was rendered on April 27, 2020. *Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1331 (2020). In complex litigations such as this, it typically takes a great deal of time to work through a number of procedural and process issues and it is likely that there will be no resolution of the risk corridor litigation in the foreseeable future, much less when or if payments will be made to health insurers. The outstanding receipts below are due to MVP because claim experience was unfavorable relative to expectations, and the receipts mitigate a portion of the losses experienced in these blocks of business.

Program	Outstanding Balance
RC VT Individual 77566	$1,121,741
RC VT Small Group 77566	$663,839
Total	$1,785,580

However, whether any health insurers will receive risk corridor payments for the years 2014-2016 and any amounts they might receive is entirely speculative at this time.

3. Please provide more detail on the extent to which MVPHP expects to participate in OneCare Vermont 2021. Please describe the following:

a. which populations you expect to include in an agreement with OneCare, if any;

Response to Non-Actuarial Interrogatory No. 3(a): [redacted]

b. whether you expect to include upside risk, downside risk, or both;

Response to Non-Actuarial Interrogatory No. 3(b): [redacted]

c. whether you plan to implement your fixed prospective payments; and

Response to Non-Actuarial Interrogatory No. 3(c): [redacted]

d. any impact you expect your OneCare participation to have on rates.

Response to Non-Actuarial Interrogatory No. 3(c): [redacted]

Whatever impact the program has on 2020 claims expense would factor into our 2022 rates however, COVID-19 will make understanding true impact challenging.

Dated: June 19, 2020.

PRIMMER PIPER EGGLESTON & CRAMER PC

By: /s/ *Gary F. Karnedy*

Gary F. Karnedy, Esq.
Ryan M. Long, Esq.
Primmer Piper Eggleston & Cramer PC
30 Main Street, Suite 500
P.O. Box 1489
Burlington, VT 05402-1489
(802) 864-0880
gkarnedy@primmer.com
rlong@primmer.com

Attorneys for MVP Health Plan, Inc.

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2021	)	
Vermont Health Connect Rate Filing	)	DOCKET NO. GMCB-006-20rr
	)	
SERFF No. MVPH-132371260	)	
	)	

CERTIFICATE OF SERVICE

I, Ryan M. Long, Esq., hereby certify that I have served a copy of ***MVP Health Plan, Inc.'s Responses to The Green Mountain Care Board's First Set of Non-Actuarial Interrogatories*** via e-mail upon the following:

Michael Barber, Esq.
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
Michael.Barber@vermont.gov

Amerin Aborjaily, Esq.
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
Amerin.Aborjaily@vermont.gov

Kaili Kuiper, Esq.
Office of the Health Care Advocate
Vermont Legal Aid
56 College Street
Montpelier, VT 05602
kkuiper@vtlegalaid.org

Eric Schultheis, Esq.
Office of the Health Care Advocate
Vermont Legal Aid
56 College Street
Montpelier, VT 05602
ESchultheis@vtlegalaid.org

Dated at Burlington, Vermont, this 19th day of June, 2020.

PRIMMER PIPER EGGLESTON & CRAMER PC

By: */s/ Ryan M. Long*
Ryan M. Long, Esq.
Gary F. Karnedy, Esq.
Michelle T. Bennett, Esq.
30 Main Street, Suite 500
P.O. Box 1489
Burlington, VT 05402-1489
(802) 864-0880
gkarnedy@primmer.com
rlong@primmer.com
mbennett@primmer.com

Attorneys for MVP Health Plan, Inc.

EXHIBIT
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MATTHEW R. LOMBARDO

mlombardo@mvphealthcare.com

Education and Qualifications

Fellow, Society of Actuaries	*2012*
Member, American Academy of Actuaries	*2010*
B.S. in Actuarial Science, State University of New York at Albany, Albany, NY	*2005*

Experience

MVP Health Care Jan 2008 – Present
Senior Leader, Actuarial Services *Schenectady, NY*

- Oversee premium rate setting for commercial lines of business
- Develop corporate budget for Commercial and Medicaid lines of business
- Oversee loss ratio analysis
- Manage company's monthly IBNR calculations
- Lead new product pricing and assist in new product development
- Lead analysis of ACA risk adjustment models and results
- Assist in development of corporate strategic initiatives
- Manage competitive intelligence and assist in competitor financial statement review
- Oversee provider risk share arrangements

Capital District Physicians' Health Plan Oct 2005 – Jan 2008
Actuarial Analyst *Albany, NY*

- Developed Medicare Part D bids
- Analyzed trends for Commercial and Medicare lines of business
- Computed monthly reserves
- Assisted in development of commercial benefit pricing tool

Skills

Excel, Access, Word, Power Point, SQL

EXHIBIT

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ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 26

Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans

Developed by the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
October 1996
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November 1996

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice No. 26

This booklet contains the final version of Actuarial Standard of Practice (ASOP) No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*.

Background

Recently, statutes and regulations have been enacted by a majority of states that have imposed various constraints on carriers for small employer health benefit plans. These statutes and regulations often require an actuarial certification that a small employer carrier is in compliance with the statutory or regulatory constraints. This is a new area of practice for actuaries; therefore, this actuarial standard of practice has been developed to provide guidance for actuaries preparing such certifications.

The first draft of this standard was exposed for review in October 1995, with a comment deadline of March 29, 1996. Thirty-five letters of comment were received. Additionally, the Health Committee of the ASB, as the drafting committee of this standard, presented a workshop on the proposed standard at a Society of Actuaries meeting in June 1996. The committee took very seriously its responsibility to review all of the comments it received regarding the exposure draft. Most of the comments exhibited a great deal of thought, and many of the suggestions made were incorporated into the final standard. However, no substantive positions taken in the exposure draft were changed. The committee believes that the final standard—like that of the exposure draft—correctly reflects the ASB's mission to provide guidance relating to the actuarial certifications of compliance required by state laws and regulations. (For a detailed discussion of the issues raised in the comment letters, and the committee's responses to such, please see appendix 2. Note in particular the discussion on p. 11 regarding the fact that this standard imposes a higher documentation requirement than those required by some states.)

Format Changes

A number of format changes have also been made since publication of the exposure draft. The ASB voted in May 1996 to change the format of all future actuarial standards of practice. Thus, sections 3 and 4 now form an appendix titled, Background and Current Practices. (Appendix 1 of this standard contains sections 3 and 4 of the exposure draft.) Further, sections 5 and 6 of the exposure draft have now been renumbered as sections 3 and 4. The "new" sections 3 and 4, along with sections 1 and 2, now form the actual standard of practice. The heading *Preamble*, which used to apply to the first four sections of the standard, has been deleted. The board made these format changes to help the reader distinguish between a standard's substantive requirements and language intended for general information.

The Health Committee thanks everyone who provided input during the exposure process. The comments were helpful in making revisions. The ASB voted in October 1996 to adopt the final standard.

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ACTUARIAL STANDARD OF PRACTICE NO. 26

COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS FOR THE ACTUARIAL CERTIFICATION OF SMALL EMPLOYER HEALTH BENEFIT PLANS

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—Many states require the filing of an actuarial certification of compliance stating that the rating methods and other actuarial practices applicable to carriers for small employer health benefit plans comply with relevant statutes, regulations, or other mandatory requirements set forth in any applicable, generally distributed interpretative materials. (Hereafter, the phrase *regulatory requirements* will refer to such statutes, regulations, and/or applicable, generally distributed interpretative materials.) The purpose of this actuarial standard of practice is to guide the preparer of a certification of compliance by identifying the issues to be addressed and the required documentation regarding relevant regulatory requirements.

1.2 Scope—This standard applies to actuarial certifications of compliance prescribed by regulatory requirements that a carrier's rating methods and other actuarial practices applicable to small employer health benefit plans comply with statutory and regulatory rating constraints. Since specific regulatory requirements for such certifications vary between jurisdictions, the actuary must satisfy the specific regulatory requirements of a jurisdiction in preparing the certification.

This standard applies to rating methods and other actuarial practices only and does not apply to other market conduct activities (e.g., marketing, enrollment and billing procedures, and renewal notices) that may be covered under regulatory requirements.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard will be effective for all certifications rendered on or after January 1, 1997, regardless of the time period covered.

Section 2. Definitions

The definitions below are defined for use in this actuarial standard of practice.

2.1 Actuarial Soundness—Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

For either a retrospective or a prospective certification, the determination of actuarial soundness is based on information available at the time the premium rates were established.

2.2 Carrier—Any entity subject to state regulation that offers health benefit plan coverage for sale. *Carrier* includes an insurance company, a prepaid hospital or medical service plan, a fraternal benefit society, a health maintenance organization, and any other entity offering for sale a plan of health insurance or health benefits.

2.3 Cost of Capital—The rate of return that capital could earn in an alternative investment of equivalent risk. The source of the capital may be internal or external.

2.4 Health Benefit Plan—Any hospital or medical policy or certificate; medical expense insurance; or subscriber contract or contract of insurance provided by a prepaid hospital, medical service plan, or health maintenance organization.

2.5 Small Employer—Any person, firm, corporation, partnership, or organization that employs a number of eligible employees within a statutorily specified range that has an upper bound and that satisfies any other statutorily defined criteria.

2.6 Subsequent Events—Subsequent events are events (1) that have occurred since the end of the certification period and before the date of the certification, (2) that could materially affect current or future certifications rendered, and (3) about which the actuary has knowledge.

Section 3. Analysis of Issues and Recommended Compliance

3.1 Introduction—The purpose of the actuarial certification of compliance is to satisfy applicable regulatory requirements. This certification should be appropriate to the circumstances. The actuary should review the applicable regulatory requirements, which generally contain a statement of purpose that the actuary should keep in mind when preparing the certification of compliance. The actuary should also consider any other mandatory requirements set forth in any applicable, generally distributed interpretive materials issued by regulators in support of the applicable regulatory requirements, and should satisfy those requirements when preparing the certification.

3.2 Testing of Rates for Compliance with Rating Constraints—The actuary should ensure that sufficient testing has been done so that he or she is reasonably satisfied that there are no material violations of the rating constraints. Such testing should be detailed enough to assure that an appropriate range of health benefit plan designs and demographic characteristics has been tested.

3.3 Analysis of Rates for Actuarial Soundness—If required, the actuary should perform sufficient analysis so that he or she is reasonably satisfied the rates are actuarially sound. For a *retrospective* certification of actuarial soundness, the certification relates to the premium rates in effect during the time period to which the certification applies, and the determination of actuarial soundness should be based on information that was reasonably available at the point in time when the premium rates were established. For a *prospective* certification of actuarial soundness, the certification relates to the premium rates developed for the time period to which the certification applies.

3.4 Documentation of Compliance—Documentation should be available to support the actuarial certification, and should include the items listed in sections 3.4.1–3.4.3 below, if applicable. The state will define what documentation should be submitted, if any.

3.4.1 Rating Methods and Underwriting Practices—Materials that have been reviewed in order to certify compliance with requirements for rating methods and new business and renewal underwriting practices, such as the following:

a. a description of the carrier's rating methods and new business and renewal underwriting practices; this should include any exceptions or variations that may be used for the business or any subset of the business for which rates are determined;

b. when actuarial soundness is being certified, experience, reinsurance, pooling considerations, and other relevant data used in the analysis of the business for which rating practices are being certified;

c. the health benefit plan contracts and certificates;

d. the sales brochures and other materials for each health benefit plan;

e. the rating manual;

f. formulas for calculating any group's rate from the rating manual, including both new business rates and renewal rates;

g. a sufficient sample of test calculations of the rating formulas to verify that the rates actually being charged are in accordance with the rating manuals;

h. a description of any material changes to previously reviewed health benefit plan contracts and certificates that were not mandated by regulatory requirements;

i. information concerning any policy fees, administrative charges, or application charges that may apply to any group in any class of business, regardless of whether such fees or charges are remitted to the carrier; and

j. any other information prescribed by the regulatory requirements.

3.4.2 Demonstration of Compliance with Rating Constraints—A written demonstration supporting the actuarial certification that the rates are in compliance with applicable regulatory requirements. The demonstration should include an explanation as to how items such as classes of business, average rates, rating bands, and rate increases comply with statutory and regulatory rating constraints.

3.4.3 Demonstration of Compliance with Actuarial Soundness—If a certification of actuarial soundness is required, a written demonstration supporting the determination, including documentation of underlying assumptions.

3.5 Time Period Covered by Certification—The actuary's certification that the rates are in compliance should apply to the time period specified by applicable regulatory requirements. In the absence of any specification in such regulatory requirements, the actuary should generally certify to the prior calendar year. In any event, the actuary should explicitly state the time period to which the certification applies.

3.6 Qualified or Limited Opinions—If the actuary is aware that any rating methods or other practices are not in compliance with applicable regulatory requirements, such noncompliance should be reported in a qualified opinion. If the regulatory requirement requires a certification of actuarial soundness and the actuary does not believe the rates are actuarially sound, even though they are in compliance with the regulatory requirements, this should be noted in a qualified opinion. If the actuary is not able to certify some of the items required in the regulatory requirement, this should be noted in a limited opinion.

Section 4. Communications and Disclosures

4.1 Content of Certification—The content of the certification should include, as a minimum, the following:

a. certification whether all practices, as required by regulatory requirement to be included in the certification, are in compliance;

b. a listing of practices that are covered in the certification;

c. identification of the time period covered by the certification;

d. changes in rating methods and other practices that have occurred during the time period covered by the certification and that affect compliance;

e. a description of any subsequent events;

f. where a qualified certification is given, any actions that are being taken to bring the carrier into compliance; and

g. where a limited certification is given, any sections of the regulatory requirements regarding certification that are not addressed.

4.2 Additional Required Disclosure—If the actuary is unable to certify actuarial soundness based on sections 2.1 and 3.3 of this standard, but certifies actuarial soundness based on regulatory requirements at variance with those sections, the actuary should so state in the certification. The actuary should also include the following, as applicable, in an actuarial communication:

a. the disclosure in ASOP No. 41, *Actuarial Communications*, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);

b. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

c. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes, but is not part of the standard of practice.

Background

In 1990, the National Association of Insurance Commissioners (NAIC) adopted a model act relating to small employer health insurance availability titled, *Premium Rates and Renewability Coverage for Health Insurance Sold to Small Employer Groups*. Since that time, two additional model acts have been adopted: *Small Employer Health Insurance Availability (Allocation with or without an Opt-out)*, and *Small Employer Health Insurance Availability (Prospective Reinsurance with or without an Opt-out)*; as well as a model regulation, *Model Regulation to Implement the Small Employer Health Insurance Model Act (Prospective Reinsurance with or without an Opt-out)*.

Recently, statutes and regulations enacted by a majority of states, often adopting some sections of the NAIC model regulations, have imposed statutory and regulatory constraints on carriers for small employer health benefit plans. These constraints may vary substantially from the NAIC model regulations, but generally have a similar intent. In particular, many of these statutes and regulations focus on narrowing the differences between premium rates charged to individual small employers with similar plan designs and case characteristics. The stated goals of these regulations often include the broad pooling of risks, the avoidance of extreme rate differences (which have occurred under certain tier and durational rating methods), and the expansion of access to health insurance coverage.

Current Practices

As noted above, applicable regulatory requirements vary considerably as to the extent of rating constraints imposed, as well as the specific language describing such constraints. In most situations, few, if any, restrictions exist as to the number and design of health benefit plans that can be offered in the marketplace. The current variety of state statutes and regulations renders it extremely difficult to provide precise rules for determining compliance. These conditions necessitate that the actuary apply a great deal of judgment in completing the certification of compliance.

Appendix 2

Comments on the Exposure Draft and Committee Responses

The first draft of this standard was exposed for review in October 1995, with a comment deadline of March 29, 1996. Thirty-five letters of comment were received. Additionally, the Health Committee of the ASB presented a workshop on the proposed standard at a Society of Actuaries meeting in June 1996 at Colorado Springs, which was attended by thirty-seven individuals (most responded positively to the proposed standard's text). Summarized below are the significant issues raised and questions contained in the comment letters, printed in lightface. The committee's responses to those issues appear in **boldface**.

Note also that, as mentioned in the transmittal memorandum to this standard of practice, the ASB adopted on May 1, 1996, a new format for all actuarial standards of practice. (See p. v for a detailed explanation of such changes.) Thus, the section numbers below refer to section numbers in the exposure draft, unless otherwise noted (some section numbers have remained the same).

General Observations

The nature of the comment letters reflected the divergence of opinion on the subject of the standard. Many respondents commented that they thought the standard represented a reasonable effort to assist the actuary in preparing the certification of compliance. Others thought that, given the "actuarially unsound" nature of the rating constraints prescribed by state law, it is impossible to produce a reasonable standard. Some respondents requested that the standard make clearer that it is simply a *guide* to compliance and does not represent a validation of the rating constraints. A few respondents suggested that the standard be expanded to go beyond certifications and include other aspects of rating and financial solvency. Others requested that the standard address issues unique to individual states. It was also suggested that the title be changed to more accurately reflect the nature of the standard.

Promulgation of this standard does not imply either approval or disapproval of the nature of prescribed laws in various states. The purpose of the standard is to provide the actuary with guidance regarding certifications of compliance with prescribed laws. In the event the actuary believes the rating constraints prescribed by law are "actuarially unsound," the standard allows the actuary to issue a qualified opinion regarding actuarial soundness (if necessary), while certifying compliance with other aspects of the law as necessary (see section 3.6). The scope of the standard has not been expanded to go beyond actuarial rating practices or other aspects of rating and financial solvency. Further, due to the variance in state laws, as well as the dynamic nature of these laws, it would not be appropriate nor realistic to address within the standard the compliance requirements for each state. The title of the standard was not changed. The ASB felt that the nature of the standard is adequately detailed in the purpose and scope sections (see sections 1.1 and 1.2).

Transmittal Memorandum Questions

In the transmittal memorandum to the exposure draft of this standard, the committee posed four questions to practitioners to keep in mind while reading the text. The questions are reprinted in full below:

1. Some regulations require an actuary to certify that market conduct activities, which are often non-actuarial in nature, are in compliance with the regulations. The proposed standard does not address these non-actuarial activities. Is this an appropriate approach?

2. Many regulations do not make specific provision for limited or qualified opinions. This standard provides that the actuary may issue such limited or qualified opinions. Is this approach satisfactory?

3. Sections 5.4 and 6.1 define minimum requirements for the documentation and content of certifications, respectively. Given the varying nature of statutes and regulations in effect, are the requirements in this proposed standard either too restrictive or not comprehensive enough?

4. Section 2.1 provides a definition of *actuarial soundness* for purposes of this standard. Is this definition satisfactory for the purposes of preparing a certification in those states requiring a certification of actuarial soundness?

Comments on the four issues listed above, and the committee responses to such, follow.

Transmittal Memorandum Issue #1: Non-Actuarial Matters—Several respondents commented on whether the standard should be expanded to address non-actuarial items. The responses ranged across the full spectrum of options. Some respondents thought it would be inappropriate for non-actuarial issues to be addressed in an actuarial standard of practice. Others thought it was a weakness for the standard not to give detailed guidance regarding all matters relative to which the actuary is certifying. One respondent pointed out that there is not necessarily a clear distinction between actuarial and non-actuarial topics, and he suggested that the standard should address all issues that could be interpreted to be actuarial in nature. Some respondents suggested that some general guidance would be helpful relative to non-actuarial matters, such as enlisting an officer of the company to certify those items that are beyond the scope of the actuary's expertise. **The committee continues to believe that it is not appropriate for this actuarial standard of practice to set standards for any non-actuarial activities related to actuarial certification of compliance with statutes or regulations (hereafter referred to as *regulatory requirements*) for small employer health benefit plans. Thus, the standard does not address any such non-actuarial activities.**

Transmittal Memorandum Issue #2: Limited or Qualified Opinion—With one exception, the respondents agreed that it *is* appropriate for the standard to authorize the issuance of a limited or qualified opinion. The contrary respondent stated that "the regulation need not mention a partial or qualified opinion for one to be given by an actuary with integrity." Several of the respondents noted that the qualified or limited opinion should include clear statements as to the nature of the

qualification or limitation. One respondent asked for more details in the standard regarding the circumstances that would necessitate such an opinion and its contents. Another respondent noted that it would be the regulators' decision as to whether to accept that such an opinion satisfied a state's regulatory requirements. **The committee was pleased with the overwhelming support for the option of using a limited or qualified opinion, which is contained in section 3.6 of the standard. However, individual states will still need to determine—on an individual basis—how to respond to any qualified opinions that may be submitted.**

Transmittal Memorandum Issue #3: Minimum Requirements for Documentation and the Content of the Certification—For this issue, responses varied between those that thought the standard's requirements are reasonable and those that believed the requirements are excessive. The most common criticism was that the documentation and certification requirements should not extend beyond those explicitly mandated by law. One respondent was particularly concerned that the inclusion of "subsequent events" in the certification went beyond any regulatory requirement. Another thought that some guidance ought to be given where state law mandated different requirements than the standard. **It was the intention of the committee to set high standards for required documentation, as evidenced in the exposure draft. Given the nature of the certification of compliance required and the potential reliance placed upon such certification, the required documentation was established at a level the committee felt represented good actuarial practice. The committee felt that supporting documentation at this level would be to the actuary's advantage if the actuary were ever required to support the relevant certification. However, note that only documentation specifically required by a state need actually be submitted. The "subsequent events" test was another area where, because the committee believes it to be good actuarial practice, the committee deliberately set a standard that was higher than that specifically required by several states.**

Transmittal Memorandum Issue #4: Definition of *Actuarial Soundness*—Many respondents voiced the opinion that state laws pertaining to small employer health benefit plan ratemaking are inherently actuarially unsound. In light of this perception, many argued that not only should no definition of *actuarial soundness* be attempted, but that the existence of any standard of practice at all is, at best, giving undue credibility to unsound laws. Other respondents went even further and suggested that it is professionally unconscionable to promulgate any standard on this particular subject. Some felt that a standard could be produced without including a definition of *actuarial soundness*, but they argued that the standard should make clear that it was merely a tool for implementing statutorily mandated certifications. Others argued for producing a standard without a definition of *actuarial soundness* because states interpret this phrase in different ways, thereby making any single definition impossible. One respondent argued that no definition is needed because the drafters of the model legislation probably did not have a precise concept in mind when they inserted this phrase.

Many of the respondents suggested changing the definition. Some wanted to include a clearer statement that this definition only applies to the small group certification, and that other situations would call for differing definitions. Several respondents asked for clarification as to whether the definition is prospective or retrospective in nature. Many questioned limiting the time period to that "covered by the certification," arguing that actuarial soundness is more long-term in nature. Several respondents questioned the aggregate nature of the definition, and

suggested that *actuarial soundness* necessitates that each rate is determined using appropriate methods. Some respondents asked that the definition allow for expenses to be determined on a marginal basis and that subsidies be permitted between the small group and other lines of business. One commentator suggested that the definition be made more general so as to allow the carrier to better respond to competitive forces.

Another respondent suggested that the restriction to a single state is too narrow, and also requested some recognition of initial losses incurred by start-up companies. One writer suggested that the phrase "based on information that was reasonably available at the point in time when the premium rates were established" be added. Another asked for clarification as to how this definition relates to the standards on risk classification and rate filings [see Actuarial Standard of Practice (ASOP) Nos. 8 and 12]. Some respondents asked that *investment income* be added to the definition, and one asked that the phrase *cost of capital* be clarified.

The committee carefully considered all of the responses received regarding the definition of *actuarial soundness*, but basically reaffirmed the scope of the definition used in the exposure draft. In developing the definition, the committee grappled with two main issues: (1) the definition needed to work within the context of the certification of compliance being prepared, and (2) the definition had to be one such that an actuary addressing a small group line of business could reasonably certify to. The committee feels the definition in this standard meets these two defining characteristics.

With regard to the comment that no definition of *actuarial soundness* should be attempted, the committee believes that, since the standard relates to actuarial issues, and since many of the applicable laws, including the NAIC model laws, require the actuary to address *actuarial soundness*, it *is* appropriate to address the issue within this standard. Further, the committee believes it has created a better standard of practice by doing so.

Although the committee did not alter its position on the scope of the definition or the necessity of including such a definition within the standard, the committee did make the following changes to the definition of *actuarial soundness*, based on the comments received: (1) combined the original retrospective and prospective definitions into a single definition; (2) inserted the phrase "including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, . . ."; (3) inserted the word *expected* before *costs*; (4) changed *health benefit expenses* to *health benefits*; (5) changed *operational* to *marketing*; and (6) inserted a second paragraph, as follows: "For either a retrospective or a prospective certification, the determination of actuarial soundness is based on information available at the time the premium rates were developed."

The committee notes that the definition of *actuarial soundness* used is an aggregate definition. It is based on the premise that actuarial soundness is an aggregate rate adequacy test. Some commentators suggested a more specific definition be used, based on the rates having appropriate actuarial balance or equivalence between benefit plans or demographic risk characteristics. This approach was considered by the committee, but ultimately rejected.

Issues relating to how to address expense allocations were viewed as too narrow to be considered here. These are valid issues for the pricing actuary to consider in practice.

As noted in section 2, the definitions included in the standard are defined for use *in this standard of practice*. Although it might be helpful to develop definitions that would have more widespread acceptance, the nature of the certification seems to preclude the development of such definitions. However, the committee did add one definition, that of *cost of capital*.

With regard to the request for clarification as to how this definition relates to the standards of practice on risk classification and rate filings, the committee believes that this standard does not conflict with these other ASOPs.

Section 1. Purpose, Scope, and Effective Date

Section 1.1, Purpose—Two comments were received on this section. One suggested that the purpose of the standard be broadened to address more elements of small group reform that may impact the certification. The other suggested that the phrase "actuarial practices applicable to carriers for small employer health benefit plans" was too broad, in that there are actuarial practices, such as setting reserves, that are beyond the scope of the standard. **The committee believes that the language in the Purpose section is appropriate. It is the purpose of this standard of practice to address actuarial items relative to which the states require a certification of compliance. It is not appropriate for the standard to go beyond that.**

Section 1.2, Scope—One respondent proposed that the standard be expanded to include issues pertaining to financial solvency. (Comments regarding certification of market conduct compliance are discussed above under Transmittal Memorandum Issue #1.) **As stated in the committee response to section 1.1 (see above), the committee believes it is not appropriate to extend the scope beyond the required *actuarial* aspects of the certification.**

Section 1.3, Effective Date—Comments were received asking for clarification as to the meaning of the January 1, 1997 date. **The committee changed the wording in an effort to clarify its intent.**

Section 2. Definitions

Section 2.1, Actuarial Soundness—See the comments above (again, the committee's response is in **bold**) under Transmittal Memorandum Issue #4.

Section 2.2, Carrier—One respondent suggested changing "*Carrier* includes an insurance company, . . ." to "*Carrier* includes, but is not limited to, an insurance company . . .". It was also suggested that the standard clarify that it is the definition of *carrier* in the state regulation that is the controlling factor. **The committee believes the existing language is suitable and is sufficiently broad to include any entity regulated by the states.**

Section 2.3, Health Benefit Plan—Comments included substituting *medical* for *health* and changing the words to read "provided by a small employer carrier." **The committee believes that the existing language is consistent with common usage in regulatory requirements.**

Section 2.4, Small Employer—One respondent suggested that the actuary certify that the small employers that are insured meet the statutory definition. Others suggested that the definition be modified to clarify that statutory constraints may exist as to who is considered an eligible employee, over what time period the number of eligible employees is determined, and the handling of small employers whose employees are in more than one state. Another suggested that an example of a specific upper bound be provided, such as 50, in order to list specifically what size group would typically be subject to this standard. Another respondent suggested that the phrase *For purposes of this standard* be added at the beginning of the definition, and another suggested that the definition be changed to eliminate the reference to *association*. **Based on the comments received, the committee made the following changes: (1) the word *association* was changed to *organization*; (2) the word *eligible* was inserted before *employees*; and (3) the phrase *and that satisfies any other statutorily defined criteria* was added. In addition, all standards of practice now contain the following introductory sentence, which applies to all definitions listed in section 2: "The definitions below are defined for use in this actuarial standard of practice."**

Section 2.5, Subsequent Events—One commentator suggested dropping the phrase *or future*. **The committee considered this suggestion, but decided not to make this change.**

Section 3. Background and Historical Issues (now in Appendix 1 under Background)

Suggestions included removing the last sentence, adding the phrase *and case characteristics* in the next to last sentence of the second paragraph, and removing the first paragraph entirely on the grounds that these points are more appropriately included in the Scope and Purpose sections. **The committee added the phrase *and case characteristics* to more accurately reflect the intent of the regulatory requirements. The committee also decided to leave the first paragraph in this section, because it believes that this material *does* address the historical background pertaining to the subject of the standard.**

Section 4. Current Practices and Alternatives (now in Appendix 1 under Current Practices)

The only comment on this section was a suggestion to revise the last paragraph to read, "While the current variety of state statutes and regulations and the variety of reasonable interpretations of these statutes and regulations render it extremely difficult to provide precise rules for determining compliance, . . .". **The committee revised the wording in the paragraph to improve readability.**

Section 5. Analysis of Issues and Recommended Compliance (Now Section 3)

Section 5.1, Introduction (now section 3.1)—One respondent suggested adding as a separate item the interpretive material distributed by the state insurance department to the list of items for review. Another suggested deleting the last clause of the last sentence. **The committee added the following sentence:**

> **The actuary should also consider any other mandatory requirements set forth in any applicable, generally distributed interpretive materials issued by regulators in support of the applicable regulatory requirements, and should satisfy those requirements when preparing the certification.**

Section 5.2, Testing of Rates for Compliance with Rating Constraints (now section 3.2)—One respondent suggested adding the following text: "Testing of rates in a community rating system may consist of an examination of the methods and factors used, and audits of their implementation." Another suggested adding the sentence, "All known violations of the rating constraints that result in a rate materially higher than permitted by the statute or regulation must be addressed in a qualified opinion." This respondent suggested that *material* be defined as no greater than 5%. Another thought the words *reasonably*, *materially*, and *appropriate* were too general to be consistently interpreted. **As for the first comment, the committee believes that the suggested language represents a specific example, whereas the standard (appropriately) addresses only the general case. It would be very difficult indeed to create a standard that could address all specific concerns, and, thus, the change was not made. As for the second comment, the committee did not provide definitions for the words *material, reasonable,* or *appropriate,* since these words are used frequently in actuarial literature. The definitions of such words are dependent on the context of their use.**

Section 5.3, Testing of Rates for Actuarial Soundness (now section 3.3 and titled Analysis of Rates for Actuarial Soundness)—A couple of respondents suggested substituting *testing* for *analysis* in the first sentence. Several respondents also questioned whether the description of the *retrospective* certification makes sufficiently clear that it is not a test of actual results. One respondent suggested that adding the word *expected* before the word *costs* in the definition of *actuarial soundness* might make this point clearer. Two of the respondents suggested that a retrospective certification is theoretically inappropriate, in that such a certification ignores the most relevant information available. One respondent suggested that only the first sentence be retained, or that the remaining sentences be modified to be more general in nature. Another asked for clarification as to how a certification that is both retrospective and prospective should be handled, and another suggested that the language more specifically point out that "each rate certified is clearly subject to certification only once." Another questioned the value of prospective certifications, given that rate schedules change so frequently. **In response to the first comment listed above, the committee did change the word *testing* to *analysis* (the title to the section was also changed accordingly). The definition of *actuarial soundness* was also revised so that the description of a retrospective certification is more clear. As for the remainder of the comments regarding this section, they apply to the appropriateness of state legislation, and, as such, the topic of these comments is outside the scope of the ASOP.**

Section 5.4, Documentation of Compliance (now section 3.4)—One respondent pointed out that there was no mention of a requirement within the standard relating to the documentation of the data used and commentary on the quality of the data. Another wanted the phrase *if applicable* added to the end of the first sentence. Another suggested that if the actuary receives information from a source outside the actuary's firm, the actuary should obtain signed correspondence from the source verifying the accuracy and completeness of the information. **As for the first comment, a standard already exists on data quality (see ASOP No. 23), so the committee did not believe that any additional language on this subject was necessary within this standard. As for the second comment, the phrase *if applicable* was added at the end of the first sentence. The suggestion regarding obtaining signed correspondence may be a good idea in practice, and the committee notes that such a practice can be used. However, this practice is not *required* by the standard.**

Section 5.4.1, Rating Methods and Renewal Underwriting Practices (now section 3.4.1 and titled Rating Methods and Underwriting Practices)—One respondent suggested changing the title to Rating Methods and New Business and Renewal Underwriting Practices. Others suggested deleting sections (b), (c), and (g) on the grounds of being overly burdensome on small companies. Another thought that all of the sections should be eliminated. If the sections were not eliminated, this respondent suggested combining sections (a), (d), and (e); combining sections (b) and (g); and eliminating section (c). Another suggested that the list of items should be expanded to include the basis of the data on which claims were estimated, corporate practices regarding expense and investment income allocation, pooling/reinsurance mechanisms, and any subsidizing of the small group line by other lines. A couple of respondents also suggested removing the parentheses from the parenthetical phrase in section (a). **In response to the above comments, the committee changed the title of this section by removing the word *renewal*. The committee also added a new section (b) in response to comments received on investment income, pooling/reinsurance, and other items. Further, the committee removed the parentheses in section (a), as was suggested.**

Section 5.4.2, Fees and Charges (now section 3.4.1(i))—One respondent welcomed the reference to fees or charges that may or may not be remitted to the carrier. Another respondent asked for clarification relative to the treatment of association dues. **This section was moved to section 3.4.1, Rating Methods and Underwriting Practices, as being one of several items that are usually reviewed in order to certify compliance with requirements for rating methods and new business and renewal underwriting practices. As for the latter comment, the answer is dependent on regulatory interpretation, and, thus, the material is too specific for this ASOP.**

Section 5.4.3, Demonstration of Compliance with Rating Constraints (now section 3.4.2)—One respondent asked for clarification as to whether the standard requires that the documentation supporting the certification be submitted to regulators. **The committee believes that *regulators* define what documentation they should receive, not the ASOP. Thus, no change was made to the text.**

Section 5.4.4, Demonstration of Compliance with Actuarial Soundness (now section 3.4.3)—One respondent asked for clarification as to whether the required documentation was similar to

the actuarial memorandum regulation required for the statutory annual statement. This respondent also asked for clarification regarding the extent to which this information would be considered confidential. One respondent suggested that methods be included as well as assumptions. Another respondent commented that while this section reflected "common sense," it was good to explicitly include it. Two others suggested that this section be eliminated. **All of the items described within this section of the standard (i.e., everything in sections 3.4.1–3.4.3) are to be available in the file, but not submitted to the regulator unless requested, as noted in the introductory paragraph of section 3.4.**

Section 5.5, Time Period Covered by Certification (now section 3.5)—One respondent suggested deleting the second sentence. Another suggested that compliance should only be certified prospectively. **The committee did not make any changes to the second sentence, since it believes that this text provides some flexibility and room for actuarial judgment. The other comment reflects upon the appropriateness of the *regulation*, which, again, is outside the scope of the ASOP.**

Section 5.6, Qualified or Limited Opinions (now section 3.6)—One respondent suggested deleting the second sentence. Another asked for more explanation regarding what circumstances would warrant a qualified or limited opinion. **The committee believes that the section contains sufficient information regarding the circumstances that necessitate a qualified or limited opinion.**

Section 6. Communications and Disclosures (Now Section 4)

Section 6.1, Content of Certification (now section 4.1)—One respondent stated that the certification should explicitly include the statement that the plan is actuarially sound for the period involved, and that the certification should explicitly include the definition of *actuarial soundness* that is being utilized. Another asked for clarification of section 6.1(d), and pointed out that many of the other sections within section 6.1 seem overlapping and redundant. Another asked that information regarding the name of the actuary and corporate affiliation be required, and that a description of the data used should be included.

Regarding the first point raised, the committee reaffirmed its decision that a certification need only address *actuarial soundness* if required by regulatory requirement. To do otherwise would significantly expand the scope of such a required certification in states where such a certification is not required. In practice, the actuary can always include a certification of actuarial soundness even when not required. If the actuary is using a definition of *actuarial soundness* that differs from that contained in the standard of practice, it must be so noted, either as indicated in the new section 4.2 or in a qualified opinion, as appropriate. (If the actuary is using the standard's definition of *actuarial soundness*, it is not necessary to include such in the certification.) As for the comment that the sections listed in section 6.1 seem overlapping and redundant, the committee believes that section 6.1 (now section 4.1) does not contain overlapping material. The committee decided to leave the items listed in this section unchanged.

The committee thanks everyone who took the time and made the effort to write comment letters. The input was helpful in developing the final standard.