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Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan
Vermont Health Connect 2021 Individual and Small Group Rate Filing
SERFF # MVPH-132371260

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2021 Individual and Small Group Filing for MVP Health Plan, Inc. (MVP or Company) and to assist the Green Mountain Care Board (Board) in assessing whether to approve, modify, or disapprove the Company's requested rate increase.

FILING DESCRIPTION

1. MVP provides individual and small group coverage to be sold on Vermont Health Connect (VHC). This filing requests premiums for MVP's Qualified Health Plans (QHPs) that will be offered on VHC, beginning January 1, 2021.

2. This filing addresses MVP's individual members and small groups. As of February 2020, there were 36,980 members enrolled in plans affected by this filing. Enrollment in these plans has increased in recent years, as demonstrated in the following table:

MEMBERSHIP BY COVERAGE YEAR

Coverage Year	Members[1]	Percent Change
2015	6,417	
2016	6,614	3.1%
2017	10,305	55.8%
2018	25,223	144.8%
2019	30,887	22.5%
2020	36,980	19.7%

3. As required by law, insurers selling plans on VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters with certain income levels. These members pay a reduced

[1]L&E uses the term "members" to refer to the number of covered lives. That is, a single policy covering two family members is comprised of two members.

premium that is limited to a specified percentage of their income. These plans include premium funding to offset the loss of federal CSR payments.

In addition to the Silver plans offered on VHC, in 2019 carriers began offering "Silver Reflective" plans outside of VHC. The Silver Reflective plans do not include CSP premium funding since federal CSR payments do not apply.

While the VHC Silver plan premiums are substantially higher than the Silver Reflective premiums, most members in these plans will not pay higher premiums because of the federal premium subsidies.

4. The overall impact of this filing is a proposed average rate increase of 7.3%, which is $41.17 on a per member per month (PMPM) basis. This average increase is broken down by metal level in the first table below. The second table illustrates the proposed and approved premium rate changes for the 2020 QHP filing.

2021 PROPOSED RATE CHANGES[2]

Plan Type	Average 2020 Premium PMPM	Average 2021 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$336.24	$354.84	5.5%	$18.60	0.0%
Bronze	$487.00	$523.83	7.6%	$36.55	23.5%
Silver Loaded	$649.72	$695.06	7.1%	$46.21	16.4%
Silver Reflective	$571.66	$607.84	6.5%	$36.84	15.1%
Gold	$657.84	$711.09	8.1%	$52.88	35.2%
Platinum	$784.52	$835.03	6.4%	$50.51	9.8%
Overall	***$560.36***	***$602.14***	***7.3%***	***$41.17***	***100.0%***

[2] Chiropractic and physical therapy copays for the bronze and silver plans may be out of compliance with state law pending bill approval. If the bill is not approved in the necessary time frame, these copays will need to be changed. This may have an impact on the proposed rates.

2020 PROPOSED AND APPROVED RATE CHANGES

Plan Type	Proposed Percent Change	Approved Percent Change	Approved PMPM Change	Percent of Membership
Catastrophic	11.5%	12.3%	$36.93	0.1%
Bronze	11.2%	12.1%	$52.67	25.4%
Silver Loaded	6.8%	7.5%	$45.44	21.1%
Silver Reflective	9.9%	10.8%	$55.66	12.9%
Gold	10.3%	10.7%	$63.46	32.2%
Platinum	8.5%	9.5%	$67.98	8.3%
Overall	***9.4%***	***10.1%***	***$51.33***	***100.0%***

STANDARD OF REVIEW

Pursuant to *8 V.S.A. §4062, 18 V.S.A. §9375(6)*, and Green Mountain Care Board *Rule 2.000: Health Insurance Rate Review*, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

SUMMARY OF RECEIVED DATA

MVP provided the methodology used to develop the proposed 2021 individual and small group premiums. The Company provided exhibits which provided the quantitative development for each component of the premium request, including the index rate development with adjustments for trend, administrative costs, and taxes and fees.

Exhibit 2a illustrates the assumed annual allowed and paid medical cost trends by benefit category for 2020 and 2021 and the annual pharmacy cost trends by drug category. Exhibit 2b illustrates the application of pharmacy trends by drug category to the experience period paid PMPMs to develop the projected pharmacy paid PMPMs.

Exhibit 3 shows the index rate development, starting from MVP's experience period claims (encompassing about 360,000 total member months) from ACA-compliant individuals and small groups. Adjustments are applied to adjust for incurred but not reported (IBNR) claims, pooling charges, paid medical/Rx trend, etc.

Exhibit 4 shows the development of the single conversion factor of 1.097, using the distribution and the average contract size by tier derived from February 2020 enrollment data.

Exhibit 5 shows the development of the proposed retention loads, taxes, assessments, and paid claim surcharges.

Exhibit 6 shows the calculations for the load on the On-Exchange Silver Plan to account for the defunding of the Cost Sharing Reductions (CSRs).

Exhibit 7 calculates final PMPM premiums based on the assumptions in the prior exhibits.

The "Loss Ratio Information" section of the Actuarial Memorandum demonstrates that the expected claims and premiums produce a projected traditional loss ratio of 90.1%. After adjusting for taxes, fees, and Quality Initiatives, the 2021 federal MLR is projected to be 91.1%, which exceeds the minimum requirement MLR of 80%.

MVP provided additional exhibits and information as requested during the rate review process.

L&E ANALYSIS

The average proposed 2021 rate increase of 7.3% is attributable to several rating components. To create a consistent comparison for both companies filing QHP products, L&E categorized the proposed premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

COMPONENTS OF 2021 PROPOSED RATE INCREASE

Rating Component[3]	Percentage Change[4]	PMPM Change
1. 2019 Actual/Projected Claims Experience	1.4%	$7.94
2. Difference in trend from 2019 to 2020	-0.7%	-$4.03
3. Trend from 2020 to 2021	7.1%	$38.75
4. Changes to Population Morbidity Adjustment	-0.3%	-$1.63
5. Demographic Shift	0.0%	$0.00
6. Plan Design Changes	-4.6%	-$25.02
7. Changes to Other Factors	-1.0%	-$5.42
8. Manual Rate Impact	0.0%	$0.00
9. Changes due to Reinsurance	0.0%	$0.00
10. Changes to Risk Adjustment	1.2%	$6.56
11. Changes in Exchange User Fees	0.0%	$0.00
12. Changes in Actuarial Value	4.7%	$25.85
13. Changes in Administrative Costs	0.2%	$1.15
14. Changes in Taxes & Fees	-1.1%	-$5.98
15. Changes in Contribution to Reserves	0.0%	$0.00
16. Changes in Single Contract Conversion Factor	0.5%	$3.02
Total Proposed Rate Increase	**7.3%**	**$41.17**

1. 2019 ACTUAL/PROJECTED CLAIMS EXPERIENCE: MVP experienced higher than expected claims in 2019. The 2021 URRT shows that the 2019 allowed claim experience was 1.4% higher than what was projected in the 2020 filing. Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate.

2. DIFFERENCE IN TREND FROM 2019 TO 2020: The annual trend from 2019 to 2020 in the 2021 URRT is consistent with the trend assumed in the final 2020 URRT, resulting in a decrease of 0.7%. L&E notes that the facility unit cost trend factors reflect known and assumed price increases from MVP's provider network. L&E's review of these factors confirmed that the factors are consistent with the Vermont hospital budgeting process. This is the primary cause of the factor

[3] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

[4] The percentage changes are multiplicative and may not sum to the requested 7.3% premium increase.

change.

The assumed 2019 to 2020 total allowed trend is seen in the table below:

2019 TO 2020 ALLOWED TREND

Cost Category	Total Allowed Trend
Unit Cost	3.7%
Utilization	1.1%
Total	***4.9%***

3. TREND FROM 2020 TO 2021: The Company requested a total allowed trend of 7.1% for the 2020 to 2021 trend. The breakdown between unit cost and utilization is seen below:

2020 TO 2021 ALLOWED TREND

Cost Category	Total Allowed Trend
Unit Cost	5.8%
Utilization	1.1%
Total	***7.1%***

The allowed trend of 7.1% is broken down between an allowed medical trend of 7.0% and an allowed Rx trend of 7.2%.

ALLOWED AND PAID TRENDS BY COST CATEGORY

Cost Category	Allowed Trend	Paid Trend[5]	Share of Total Cost
Medical	7.0%	6.6%	88%
Pharmacy	7.2%	8.3%	12%
Total	***7.1%***	***6.8%***	***100%***

The effective paid medical trend reflects the actual claim payments made by the carrier and is derived from the proposed allowed cost trend rates, adjusted for the impact of cost sharing leveraging. The resulting annual effective paid trend is 6.8%.

[5] "Allowed trend" reflects the change in the total reimbursement paid to hospitals and other providers. Because copays and deductibles are fixed, the portion paid by the insurer generally increases at a higher rate. This change in the insurer's responsibility, or "Paid Trend", is the trend figure that directly impacts premium rates.

MEDICAL TREND: The allowed trend reflects changes in the both the cost of medical services and changes in utilization of medical services by members. The Company projected an annual allowed medical trend of 7.0%, which is broken down into a unit cost trend of 6.0% and a utilization trend of 1.0%.

MEDICAL UNIT COST TREND

MVP computed its allowed trend as a weighted average of the medical claim unit cost trends in 2020 and 2021 for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network. This approach is consistent with prior rate filings. These increases reflect the changes to the unit cost increases ordered by the Green Mountain Care Board during the Hospital Budget Review.

Since the 2021 Hospital Budget Review is not yet finalized, MVP has assumed that hospital increases will match the 2020 increases with a few exceptions by facility. These expected assumptions for hospital budget increases are based on information from MVP's contracting department. The overall increase for hospital-based costs differs from the Board's Vermont-wide projections for several reasons:

- MVP's costs are distributed differently from the other carriers in the commercial market. This produces a different average cost across all facilities.
- Approximately 40% of medical services are provided by hospitals not subject to the GMCB Hospital Budget Review.
- The hospital budgets are not effective on a calendar year basis, while the proposed rates are for calendar year 2021.
- Additional budget orders were made after the 2020 Hospital Budget Review was finalized.

GMCB HOSPITAL BUDGET REVIEW

The overall unit cost medical trend of 6.0% includes:

1) a trend of 6.2% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and

2) a trend of 5.5% for other medical facilities and providers that are not subject to the Hospital Budget Review.

L&E believes the assumed unit cost trends are reasonable and appropriate.

MEDICAL UTILIZATION TREND AND INTENSITY

In the 2020 QHP filing, L&E recommended an annual utilization trend range of 1.0% to 4.0% based on a market-wide analysis. MVP implemented an annual utilization trend of 1.0%, which was approved by the Board.

Since 2017, MVP has experienced a rapid membership growth of approximately 250%. To account for this, MVP analyzed a closed cohort of members that included only members currently active with MVP. MVP ran 10,000 simulations in which individual trend values were picked based on the closed cohort experience data to produce a distribution of the total expected utilization trend.

This produced a very wide range of forecasted utilization trends with a 10th percentile of -7.6%, a mean trend of 0.0%, and a 90th percentile of 4.9%. Since the simulation produced a volatile and wide range, MVP decided to assume a utilization trend of 1%, which is consistent with the 2020 approved filing.

L&E performed a series of independent trend calculations using MVP's monthly normalized allowed medical claims cost PMPM data from 2016 to 2019. Based on this analysis, L&E observed the following:

- The 3-year average annual utilization trend was approximately 0.0%.
- Annual utilization trend has significantly increased over the last three years, with utilization trend shifting from negative to positive levels.
- MVP's membership growth significantly increased the statistical credibility of the data from 2018 to 2019. The annual utilization trend from 2018 to 2019 was approximately 2.5%.
- A regression analysis using all 4 years of data produced a fitted utilization trend rate of approximately 1.2%.

Based on the above analyses, L&E considers the assumed utilization trend of 1% to be reasonable and appropriate.

TOTAL ALLOWED MEDICAL TREND

Based on the information available, L&E considers the total allowed medical trend of 7.0% to be reasonable and appropriate.

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost assumption underlying the 2021 premium rate calculations. Due to the disruptions from COVID-19, it appears likely that the submitted hospital budget requests will be higher than last year. If this is the case, it may mean that a higher premium increase is necessary.

PHARMACY TREND: The Company projected an annualized allowed Rx trend of 7.2%. This trend forecast was provided by MVP's Pharmacy Benefit Manager (PBM) based on MVP's Vermont experience by drug class. The chart below shows that the specialty trend category is the primary driver of the Rx trend assumption.

ANNUALIZED ALLOWED RX TRENDS

Tier	Unit Cost	Utilization	Total Trend
Generic	-12.8%	2.6%	-10.6%
Brand	8.2%	-2.7%	5.2%
Specialty	6.2%	8.7%	15.5%
Total	***4.8%***	***2.3%***	***7.2%***

After accounting for member cost sharing, the total annualized effective paid Rx trend is 8.3%.

As in prior filings, MVP has not used historical pharmacy trend analysis to form assumptions for future pharmacy trends as they believe their prior experience is not indicative of future trends.

L&E recognizes that historical trends may not be indicative of future trends because historical trends do not account for other factors such as: 1) the slowing growth of the generic dispensing rate, 2) drugs losing their patents in the projection period, 3) the adjustments to the future contract terms with the Company's PBM, and 4) the significant increase in membership. The proposed allowed Rx trend is lower on an annual basis than the 8.2% trend assumed by MVP last year. As this methodology is consistent with MVP's other filings, L&E does not propose any changes.

MVP separately projects pharmacy rebates, which are negotiated with the Company's PBM. The latest contractual terms for brand and specialty rebates for 2020 were provided in Exhibit 2b. The projected Rx paid trend after adjustments for rebates is 8.3%. L&E considered MVP's historic experience as well as the PBM's recommendation and opines that the requested Rx trend appears to be reasonable and appropriate.

4. **CHANGES TO POPULATION MORBIDITY ADJUSTMENT:** The estimated impact from population morbidity changes is a reduction of 0.3%. The prior filing included a morbidity adjustment of 0.9% while this filing a includes a morbidity adjustment of 0.6%. The morbidity adjustment of 0.6% in this filing is due to the projected impacts of high-cost pooling and the COVID-19 pandemic.

   MVP pools claims in excess of $100,000 each year and replaces the actual claims with the amount of expected claims above $100,000, which smooths out the rate increases in a given year. This results in a decrease of 0.7% to the rates and appears to be reasonable and appropriate.

   As a result of the COVID-19 pandemic, elective surgeries and associated services were postponed for two months in 2020 (mid-March through mid-May 2020). Based on a Society of Actuaries research paper, "Potential Impact of Pandemic Influenza on the U.S. Health Insurance Industry"[6], the Company assumed that 20% of these deferred services would not be ultimately fulfilled. Based on information from the Company's medical management team, providers of elective services were already working at near full capacity prior to the pandemic.

   The Company believes that providers will be financially incentivized to make up for financial losses during the pandemic. Therefore, to fulfill the remaining 80% of deferred services, MVP assumed that providers will operate at 110% capacity beginning in August 2020 through April 2021.

[6] https://www.soa.org/globalassets/assets/files/research/projects/research-2010-pandemic-health-report.pdf

In 2019, elective services cost $45.09 PMPM. An increase of 10% would result in $4.51 PMPM of additional costs. This increase produces an annualized 2021 increase of $1.50 PMPM, or 0.3%. This development assumes that there will not be a second wave of stay-at-home orders in 2020 or 2021.

In addition to the scenario described above, the Company also considered the following additional scenarios:

- An additional 1-4 months of COVID-19 stay-at-home orders in 2020 which would cause a larger amount of deferred services which would be fulfilled in 2021. This scenario would increase costs by $4.51 PMPM.

- An additional 1-4 months of COVID-19 stay-at-home orders in 2020 *and* another 3 months of stay-at-home orders in 2021. This scenario would push some of the deferred services to 2022. This scenario would decrease costs by $7.89 PMPM for 2021.

L&E does not believe that the assumption that providers will run at 110% capacity is adequately supported based on the following:

- Providers have had an opportunity to receive financial assistance from the government[7] to alleviate financial hardship, which reduces the financial incentive to run at greater than 100% capacity in the future.

- There is an immense uncertainty regarding how long social distancing, cleaning, and other safety guidelines[8] will continue into 2021, which limits provider capacity.

- Vermont had a quicker than average turnaround from shelter-in-place to reopening, which potentially sets the stage for all deferred care to be recouped in 2020.[9, 10]

L&E recommends that the adjustment for COVID-19 pent-up demand be reduced to 0.0%.

The Company assumed that a vaccine will be available beginning in January 2021, based on the Federal Government announcement of Operation Warp Speed[11] and announced trials that

[7] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html

[8] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html

[9] https://governor.vermont.gov/press-release/governor-phil-scott-issues-"stay-home-stay-safe"-order-directs-additional-closures

[10] https://governor.vermont.gov/press-release/governor-phil-scott-announces-some-elective-health-care-procedures-resume

[11] https://www.hhs.gov/about/news/2020/05/15/trump-administration-announces-framework-and-leadership-foroperation-warp-speed.html. Stated goal is "to have substantial quantities of a safe and effective vaccine available for Americans by January 2021."

are in phases I/II as of late May[12]. The Company assumed that the vaccine cost will be $75, which is based on the cost of Tamiflu.

The Company assumed that 80% of the covered population will receive the vaccination in 2021. This assumption was based on published research by Wakely Consulting Group[13]. While the Company acknowledges that flu vaccination rates are lower, at approximately 55%, the Company believes that the vaccination rate for COVID-19 will be higher than the vaccination rate for the flu. This was assumed because of the unique nature of the removal of social distancing requirements being contingent on individuals receiving the vaccine. These COVID-19 vaccination assumptions produce a projected 2021 PMPM cost of $5.00 ($75 * 80% / 12), or a rate increase of 1.0%.

L&E believes that the assumed vaccination rate of 80% is not adequately supported. L&E considers the 80% vaccination rate used in the Wakely report to be a sample scenario, not the expected scenario. Additionally, the filing does not consider that there could be constraints in supply of a vaccine, once available, which could restrict access to only the most vulnerable population initially[14].

L&E recommends a vaccination rate assumption of 55%[15], consistent with flu vaccination rates. Making this change would decrease the PMPM impact from $5.00 PMPM to $3.44 PMPM, reducing the rate increase from 1.0% to 0.7%.

L&E's recommendation decreases the total COVID-19 adjustment from 1.3% to 0.7%. This will decrease rates by approximately 0.5%.

5. **DEMOGRAPHIC SHIFT:** The Company did not make any adjustments for demographic shifts in 2021. L&E reviewed the average age factors of the population over the last several years. While MVP has experienced significant increases in their enrollment, MVP has maintained a stable aged population.

[12]London School of Hygiene and Tropical Medicine's vaccine pipeline tracker, https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/

[13]"COVID-19 Cost Scenario Modeling"

[14]https://hub.jhu.edu/2020/07/01/covid-vaccine-ethics-faden/

[15]"https://www.cdc.gov/flu/fluvaxview/coverage-1819estimates.htm"

AVERAGE AGE FACTORS

Year	Average Age Factor
2016	1.69
2017	1.66
2018	1.65
2019	1.65
2020	1.66

L&E considers MVP's assumption to be reasonable and appropriate.

6. **PLAN DESIGN CHANGES:** The estimated impact from plan design changes is a reduction of 4.6%. That is, the prior filing included a plan design adjustment of 5.4%, while this filing includes a plan design adjustment of 0.6%.

   The actual paid to allowed ratio during the experience period and the assumed paid to allowed ratio for the projection period are different because: 1) the federal cost sharing reduction (CSR) subsidies are no longer paid to carriers, which increases the claims paid by 3.6%, and 2) MVP updates their internal benefit relativity model each year, which decreased the claims by 3.0% this year.

   L&E considers MVP's assumptions to be reasonable and appropriate.

7. **CHANGES TO OTHER FACTORS:** The estimated impact from other factors is a reduction of 1.0%. The prior filing included an adjustment of 1.3%, while this filing a includes an adjustment of 0.3%. This change is due to the impact of the national high cost reinsurance pool within the U.S. Department of Health and Human Services' (HHS) risk adjustment program.

   In the initial filing, MVP included the estimated 0.28% impact of the nationwide reinsurance program under the Other Factor. Per page 19 of the 2021 Unified Rate Review Instructions, this impact should be included in Changes to Reinsurance section, and therefore, L&E is recommending this be moved. It will also be discussed below.

8. **MANUAL RATE IMPACT:** The Company did not use a manual rate because the 359,516 member months of experience was considered fully statistically credible. L&E considers this to be reasonable and appropriate.

9. **CHANGES DUE TO REINSURANCE:** In the HHS high-cost reinsurance program, carriers with members who have claims exceeding $1,000,000 will be reimbursed 60% of the excess costs. The cost of this program is collected from each carrier such that the program will be budget neutral to the carriers and HHS at the national level.

MVP relied on a confidential nationwide study performed by Wakely Consulting Group to develop their estimate that the reinsurance program will result in a net collection of 0.28% for MVP in 2021. Since MVP has not had any claimants that exceeded $1,000,000 since 2014, the net cost was loaded into the premium development. If a claimant was expected to exceed the $1,000,000 threshold, then L&E would expect MVP to remove the claims that would be reimbursed under the program from the rate development. This would lead to more stable premiums going forward if large claimants did occur.

Additionally, HHS published the final 2018 Risk Adjustment Summary Report on June 28, 2019, which clarified that the actual 2018 high-cost risk pool charge was 0.21% for merged market plans. The final 2019 Risk Adjustment Summary Report is not available at the time of this report.

Based on our analysis, MVP's assumption appears to be reasonable and appropriate.

10. **CHANGES TO RISK ADJUSTMENT:** In the initial filing, MVP projected the expected 2021 risk adjustment transfer payment based on the most recent data available, which was the interim report published by CMS in late March 2020[16].

    L&E requested that both carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports to compile them confidentially and to provide both carriers with an updated risk adjustment estimate. This calculation indicated that MVP's 2019 risk adjustment payment would be $20,258,520 for the merged market and $15,359 for the catastrophic market. In total, the 2019 risk adjustment payment is $20,273,879. This is an approximate $2.2 million decrease versus MVP's initial expectations and corresponds to approximately a decrease of $6 PMPM in premiums. This recommended change results in a 1.2% decrease to the 2021 premium rates.

    L&E recommends revising the risk adjustment calculation such that each carrier begins with the same 2019 value. Therefore, L&E recommends that each company use a 2019 risk adjustment transfer payment estimate of $20,273,879. If CMS releases final 2019 transfer amounts prior to final rate approval and they differ from L&E's calculations, L&E recommends that the CMS numbers be used.

11. **CHANGES IN EXCHANGE USER FEES:** This is not applicable to Vermont in 2021, as Vermont operates its own Exchange and does not charge users a fee.

12. **CHANGES IN ACTUARIAL VALUE:** The Change in Actuarial Value (AV) assumption reflects Pricing AV changes, such as changes in Metal AVs, induced utilization, cost sharing changes, and changes in projected enrollment among plans. This factor also reflects any changes to the Pricing AVs calculated by MVP. The rate impact for the AVs is an increase of 4.7% and is materially offset by the Plan Designs Changes section.

    The actuarial value for each plan was determined using MVP's in-house benefit pricing tools.

[16] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2019.pdf

MVP's pricing tools value the expected net paid claims associated with unique benefit plan designs. The actuarial value is the ratio of the expected paid to allowed amount for each plan design. For Silver plans, the actuarial value is adjusted for CSR funding. The adjustment is based on the experience period federal CSR funding PMPM. This is then adjusted for IBNR and trend, as a percentage of net claim costs. L&E considers this methodology to be reasonable and appropriate.

The induced utilization assumptions are consistent with the induced utilization factors developed by HHS for use with this population.

In MVP's original federal AV calculation for the Bronze 1 plan design, there were cost sharing items entered contrary to the filed Summary of Benefit Coverage (SBC). Once those changes were accounted for in the federal AV calculator, the plan's AV fell outside of the permissible range for a Bronze plan. The change that was made to achieve compliance was to offer the Tier 1 pharmacy at a copay prior to the deductible (as opposed to after the deductible as was originally filed). This allowed the plan design to qualify for the expanded Bronze AV range and allowed it to become AV-compliant. At the time of this report, this change has not been accounted for in the rate filing. This change is expected to increase rates by approximately 0.02%.

13. **CHANGES IN ADMINISTRATIVE COSTS:** MVP is projecting general administrative costs to be $43.75 PMPM, which is an increase relative to the 2020 Exchange filing's assumption of $42.00. The overall rate impact is an increase of 0.2%.

MVP declined to provide a breakdown of the $43.75 PMPM for 2021 since a detailed analysis was not performed prior to filing. However, MVP did provide the expense breakdown for 2020. Utilizing the 2020 breakdown, L&E projected an allocation by expense category for 2021 expenses:

PROJECTED EXPENSES PMPM

Expense Category	2020 PMPM	L&E Projected 2021 PMPM
Personnel Expenses	$24.53	$25.56
Software	$3.33	$3.47
Project Expenses	$2.94	$3.06
Consulting Expenses	$2.53	$2.64
All Other Admin	$8.66	$9.02
Total	***$42.00***	***$43.75***

In response to the COVID-19 pandemic, MVP has begun to allow small groups to pay their premium via credit card. This policy is expected to continue in 2021 and would create an additional expense for the Company. MVP assumes that 10% of small group premiums will be paid via credit card, at a cost of 2.8% of premium. This equates to a $0.49 PMPM cost across

all individual and small group members. This assumption is included in the total administrative costs of $43.75 PMPM.

The administrative costs assumed in the 2021 filing are consistent with MVP's recent individual and small group administrative costs as reported in the last three years of the Company's Supplemental Health Care Exhibits (SHCE). The Company's expenses have decreased since 2013, when they were $46.57 PMPM.

L&E notes that while enrollment in Vermont has been increasing, MVP's overall enrollment (including enrollment in New York) decreased by 4% in 2018, decreased by 4% in 2019, and decreased by another 1% as of March 2020. Many of the administrative functions are shared between Vermont and the much larger New York block of members. Therefore, the increased membership in Vermont does not directly result in a decrease in administrative costs. Considering the reduced administrative costs over the recent years, L&E considers the assumed 2021 administrative costs to be reasonable and appropriate.

14. **CHANGES IN TAXES & FEES:** The expected rate change due to taxes and fees is a decrease of 1.1%. This change is driven primarily by the federal Health Insurer Fee being suspended for 2021. The 2020 assumption was 1.0%, while the 2021 assumption is 0.0%.

    The taxes and fees provision also includes the 18 VSA 9374(h) Billback, whereby the Company will be required to contribute a portion of the GMCB and HCA's operating costs. The taxes and fees assumptions appear to be reasonable and appropriate.

15. **CHANGES IN CONTRIBUTION TO RESERVES:** The proposed contribution to reserves (CTR) of 1.5% is consistent with the CTR that was proposed and approved in the 2020 filing. The projected federal loss ratio using this CTR is 91.1%, which exceeds the statutory minimum MLR of 80% and is reasonably consistent with the overall QHP market.

    As a reasonableness check of the proposed CTR provision, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs). In 2020, there were 783 QHP Filings (individual and small group combined) filed across the country. Across the 783 filings, the average submitted CTR was 3.45% and the median submitted CTR was 3.24%. Based on the 2020 filings, an assumed base CTR of 1.5% would rank 630th out of the 783 filings. That is, over 80% of the filings had assumed CTRs higher than 1.5%. In 2019, over 82% of the filings had assumed CTRs higher than 1.5%. In 2018, over 79% of the filings had assumed CTRs higher than 1.5%.

    MVP provided the bad debt as a percentage of premium over each of the last 3 years which averaged 0.3% per year. MVP's assumption of 0.4% is to account for the non-payment of premium risk in the development of the 2021 rates, which is consistent with the 2020 rate filing.

    L&E believes the CTR and bad debt assumptions are reasonable and appropriate. Additionally, L&E recommends that any solvency analysis performed by the Department of Financial Regulation (DFR) be considered.

16. **CHANGES IN SINGLE CONVERSION FACTOR:** The single conversion factor[17] used in the 2020 rate filing was 1.091. For this year's filing, MVP utilized February 2020 enrollment to calculate the 2020 single conversion factor of 1.097, which is an increase of 0.5%.

    L&E reviewed the calculation of this adjustment, and the calculations appear to be reasonable and appropriate.

RECOMMENDATIONS

After modification, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modifications:

- **CONSIDER UPDATED HOSPITAL BUDGET INFORMATION:** If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends updating the assumed unit cost trends in the 2021 premium rate calculations. The impact of such a change cannot be estimated at this time.

- **REDUCE COVID-19 ADJUSTMENT:** L&E recommends decreasing the total COVID-19 adjustment from 1.3% to 0.7%. This will decrease rates by approximately 0.5%.

- **MOVE REINSURANCE FACTOR:** L&E recommends that the assumption for the federal high-cost member program be moved in the URRT from Risk Adjustment to "Net Reinsurance". This has no impact on the rates.

- **UPDATE RISK ADJUSTMENT:** L&E recommends that the projected risk adjustment receivable be changed to reflect L&E's estimate of the 2019 risk transfers. This will decrease rates by approximately 1.2%. If L&E's estimate does not ultimately agree with CMS' final published transfers, the CMS values should be used in the rate increase calculation instead.

- **UPDATE ACTUARIAL VALUE:** L&E recommends modifying the premiums due to statutorily required benefit changes. This increases the projected premiums by approximately 0.02%.

After the modifications, the anticipated overall rate increase will decrease from 7.3% to approximately 5.5%.

[17] The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average for all adults and children. However, the tiered premiums require the base premium to be for a single adult.

2021 RECOMMENDED RATE CHANGES

Metal Tier	MVP Proposed Rate Change	L&E Recommended Rate Change	Percent of Membership
Catastrophic	5.5%	3.8%	0.0%
Bronze	7.6%	5.8%	23.5%
Silver Loaded	7.1%	5.3%	16.4%
Silver Reflective	6.5%	4.7%	15.1%
Gold	8.1%	6.2%	35.2%
Platinum	6.4%	4.7%	9.8%
Overall	***7.3%***	***5.5%***	***100.0%***

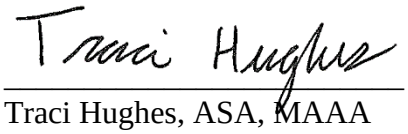
A breakdown of L&E's recommendation by rating component is provided below:

COMPONENTS OF 2021 RECOMMENDED RATE INCREASE

Rating Component	Filed Change	L&E Recommendation
1. 2018 Actual/Projected Claims Experience	1.4%	No change
2. Difference in trend from 2018 to 2019	-0.7%	No change
3. Trend from 2019 to 2020	7.1%	No change
4. Changes to Population Morbidity Adjustment	-0.3%	-0.9%
5. Demographic Shift	0.0%	No change
6. Plan Design Changes	-4.6%	No change
7. Changes to Other Factors	-1.0%	No change
8. Manual Rate Impact	0.0%	No change
9. Changes due to Reinsurance	0.0%	No change
10. Changes to Risk Adjustment	1.2%	0.1%
11. Changes in Exchange User Fees	0.0%	No change
12. Changes in Actuarial Value	4.7%	4.7%[18]
13. Changes in Administrative Costs	0.2%	No change
14. Changes in Taxes & Fees	-1.1%	No change
15. Changes in Contribution to Reserves	0.0%	No change
16. Changes in Single Contract Conversion Factor	0.5%	No change
Total Rate Change	**7.3%**	**5.5%**

[18]The impact of the recommended change to actuarial value for the Bronze 1 AV compliance is +0.02%, which has no impact when rounded to the nearest tenth of a percent.

Sincerely,



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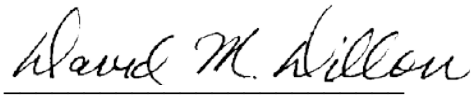

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ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[19], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[20], to observe the ASOPs of the ASB when practicing in the United States. ASOP #41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Traci Hughes, ASA, MAAA, Consulting Actuary.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal.
- David M. Dillon, FSA, MAAA, MS, Senior Vice President & Principal.

These actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 7, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 1,2020.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

- Lewis & Ellis Inc. is financially and organizationally independent from MVP. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.

- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.

- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

- Lewis & Ellis has reviewed the data provided by MVP, but the data has not been audited. L&E, nor the responsible actuaries, assume responsibility for these items that may have a

[19] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[20] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- Notwithstanding the COVID-19 pandemic, L&E is not aware of any subsequent events that may have a material effect on the findings.

- There are no other documents or files that accompany this report.

ACTUARIAL FINDINGS
The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA
The methods, procedures, assumptions, and data used by the actuaries can be found in body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW
This report was prepared as prescribed by applicable law, statues, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS
The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOPs.