Contact Information

Company Information

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

Primary Contact Information

Contact Name: Christopher Pontiff, FSA, MAAA
Contact Title: Senior Director, Commercial Pricing, Network & Trend Actuary
Primary Contact Phone #: 1-800-777-4793, ext. 17696
Primary Contact Address: 625 State Street
Schenectady, NY 12301-2207
Primary Contact E-mail: Cpontiff@mvphealthcare.com

ACTUARIAL MEMORANDUM
2024 Vermont Small Group Exchange Filing

Purpose and Scope of Filing

This memorandum details the methods and assumptions underlying the proposed 2024 premium rates for the State of Vermont's 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 1/1/2024 and 12/31/2024. There are no benefit plans being retired, nor are there any new benefit plans being added. MVP modified several of the benefits being offered, and the updated forms have been submitted in a separate SERFF filing. The proposed average rate increase (MVP's revenue increase) is 12.5%, with increases ranging from 8.4% to 15.2%.

Market/Benefits

All benefit plans included in this rate filing are available to small employer groups.

A description of benefits is included in Exhibit 1 of the rate filing. As in 2023, 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 2023 to 2024. 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 contain two benefits in excess of the EHBs: a wellness benefit and an acupuncture allowance of $500. The wellness benefit and acupuncture allowance are included in all non-standard products and the wellness benefit 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 1,273 policyholders, 10,032 subscribers and 16,262 members based on February 2023 membership.

Experience Period Claims

MVP historical claim data was the basis of the premium rate development. All ACA compliant small group data is included in the experience period data set. The claim data is assumed to be fully credible.

The experience period for the historical claims is incurred dates of service between 1/1/22 and 12/31/22, paid through 2/28/23. MVP has restated its incurred medical claim estimates to complete the claims through 3/31/23.

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. 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 for 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.

Line 4 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 1.8% which is our best estimate of ultimate liabilities as of 3/31/23. 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
202212	$18,211,516	$19,193,037	1.054
202211	$16,714,473	$17,322,906	1.036
202210	$18,629,912	$19,962,840	1.072
202209	$15,745,369	$15,922,114	1.011
202208	$17,689,240	$17,868,631	1.010
202207	$17,196,684	$17,476,872	1.016
202206	$17,427,673	$17,467,389	1.002
202205	$17,299,783	$17,342,327	1.002
202204	$17,055,835	$17,078,435	1.001
202203	$17,459,308	$17,462,993	1.000
202202	$14,493,506	$14,482,313	0.999
202201	$15,014,176	$15,010,911	1.000
Total	$202,937,477	$206,590,768	1.018

Line 5 reflects medical plus dental fee-for-service (FFS) claims, completed with IBNR. The formula is line 2 multiplied by line 4, 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 6 provides the experience period incurred pharmacy claims for the rating pool. Pharmacy claims include any claims which are paid through the pharmacy portion of the member's benefits.

Experience period Rx rebates are reflected in line 7 of Exhibit 3.

Line 8 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.

Line 9 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	$3.66
Net Reinsurance Expense	$1.09
Medical Home and PCP Incentive	$3.76
Total Non-FFS and Capitation Amounts	$8.51

*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 9 of Exhibit 3 = (line 5 of Exhibit 3 + line 8 of Exhibit 3) * 1.149% + the applicable value shown above.

Line 10 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. It is calculated by summing the medical and dental FFS incurred claims completed with IBNR (line 5 of Exhibit 3), the pharmacy incurred claims net of rebates (line 8 of Exhibit 3), and the capitation and non-FFS medical expenses (line 9 of Exhibit 3).

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 11- Adjustment for Waived Cost Share Due to COVID-19

MVP is removing $2.02 PMPM to account for cost sharing related to the COVID-19 pandemic including treatment, visits, and testing that was waived during the experience period. Cost sharing will shift back to the members in 2024 with the unwinding of the public health emergency.

Line 12- Adjustment for COVID Testing

MVP is assuming a 10% reduction in Covid testing costs in the projection period due to a utilization decrease, resulting in the removal of $0.41 PMPM. We expect demand for testing to decrease once cost sharing is reinstituted.

Line 13- Adjustment for COVID Vaccines

It is expected commercial payers will have to pay the full ingredient cost of Covid vaccines by 2024. MVP is taking 2022 experience and increasing it by $130/$40, the expected ingredient cost in 2024 over what we pay currently[1]. This results in an additional $2.32 PMPM.

Line 14- Adjustment for Hearing Aids as EHB

Hearing aids have been added as an essential health benefit in 2024. MVP analyzed historical experience in its New York population and determined this mandate would result in an additional $0.34 PMPM.

Line 15- Adjustment for Abortions Covered in Full

Vermont has mandated coverage of abortions without cost sharing except before the deductible on HDHPs. MVP analyzed its historical VT experience and determined this is worth $0.03 PMPM.

Line 16- Adjustment for Telemedicine Benefit Expansion

Telemedicine is now covered in full on all plans. The Consolidation Appropriations Act of 2023 allowed the extension of safe harbor before the deductible for all telehealth, even for HDHPs. Our benefit relativity model accounts for this so the expansion of telemedicine for all HDHPs is reflected in the AV of the plan. Based on the cost share MVP took in 2022, this benefit is an additional $0.04 PMPM on the rate.

[1] https://www.kff.org/coronavirus-covid-19/issue-brief/how-much-could-covid-19-vaccines-cost-the-u-s-after-commercialization/

Line 17- Adjustment for Leap Year
Because the rating period is a leap year and the experience period is not a leap year, the rating period will have one more day than the experience period. Assuming claims are uniformly distributed among all days in the year, MVP is adjusting the experience period claim expense upward by 0.27% (366 days / 365 days), or $1.52 PMPM.

<u>Medical Trend Factors</u>
The development of annual medical paid claim trend factors for 2023 and 2024 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 2023. Due to the unusually large increases in hospital budgets last year, we are using approved 2022 increases as the best estimate of future budgeted changes for 2024. 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 10.4% for 2023 and 4.9% for 2024.

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 and COVID-19. During the 2020 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). MVP has maintained this same trend in the filing each year. 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 8.7%. The annual paid leveraging factor is 0.9% which results in an average annual paid FFS medical trend of 9.7%. This can be found on line 19 of Exhibit 3.

<u>Rx Trend Factors</u>
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 2023 and 2024. 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 2023 and 2024 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 (30.8%) 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 8.6%, and the average annual paid Rx trend net of Rx rebates is 9.2% which can be found in line 20 of Exhibit 3.

The Annual FFS Claim Trend Projection factor shown in line 21 of Exhibit 3 represents the blended FFS annual trend projection. To arrive at the blended trend projection shown in line 21, the following calculation is performed: [line 5 * line 19 + line 8 * line 20] / [line 5 + line 8]. The annual trend is then applied for 24 months to move the experience period data from the experience period to the rating period, and the rating period FFS claim expense on a PMPM basis is reflected in line 23 of Exhibit 3.

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

The paid claim surcharges, capitation, and non-FFS expenses shown in lines 24 and 25 of Exhibit 3 represent MVP's best estimate of these costs in the projection period. A summary of the expenses driving the capitation and non-FFS expenses in line 25 can be found below. Expenses captured in the "Other Medical Expense not in warehouse" line include student out of area charges, a surcharge levied by the state of Massachusetts, and manual checks.

Summary of Rating Period Non-FFS and Capitation Amounts	
Other Medical Expenses not in claim warehouse	$3.66
Net Reinsurance Expense	$0.75
Medical Home and PCP Incentive	$3.76
Total Non-FFS and Capitation Amounts	$8.17

MVP is assuming that the VT paid claim surcharge will remain unchanged in 2024 and equal 0.999%. The NYS HCRA surcharge of 0.15% is also unchanged.

Federal Risk Adjustment Program

Based on the Interim Risk Transfer results for 2022 provided by CMS, MVP is expected to pay $9,579,344 into the small group market transfer pool for 2022. This is $38.42 on a PMPM basis or 6.9% of experience period claims prior to market-wide adjustments. To calculate line 27 of Exhibit 3, MVP applied this risk adjustment payment as a percentage of claim expense to line 26 of Exhibit 3, which the best estimate of the rating period claim expense. This results in an estimated payment of $46.17 PMPM or $11,510,596 using experience period membership.

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

Line 28 of Exhibit 3 represents MVP's projected paid index rate after adjustments for 2024. This is the starting net claim cost that will be used to set 2024 premium rates. Gross Index rates and contract tier rates are calculated in Exhibit 7. The plan specific net claim cost for each plan is computed as follows on Exhibit 7:

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

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

The Plan Specific Gross Claim Cost PMPM for each plan is derived by 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 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 (0.8350) 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 $0.44 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis. This is comprised of $0.19 PMPM for the risk adjustment user fee levied by the Department of Health and Human Services and $0.25 PMPM for the Patient Centered Outcome Research Fee.

State Taxes PMPM Based

$2.37 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 2022 to 2024.

State Taxes Premium based – VT Vaccine Assessment

Based on information provided by the Vermont Vaccine Purchasing Program (VVPP), MVP's rates are $13.54 per covered child and $2.74 per covered adult for 2024, followed by an estimate of $15.05 per covered child and $3.00 per covered adult for 2025. Based on a blend of MVP's child and adult membership in the projection period, the total PMPM costs were determined for each year and given an equal weight, resulting in $4.42 PMPM. This blended PMPM was then compared to the projection period premium PMPM before the assessment load to convert the assessment to a percent of premium load of 0.58%.

Federal Fees Premium based – National High Cost Reinsurance Pool (HCRP) Charge

In the 2024 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 a national study performed by Wakely Consulting Group, the estimate of the load charged to small group market issuers in 2024 will be 0.69%.

General Administrative Expense Load (Including QI component)
The total administrative expense load included as a plan level adjustment equals $44.62 PMPM and is used to cover SG&A expenses as well as Quality Improvement/Cost Containment Programs (QI). Based on an analysis of MVP's historical Supplemental Health Care Exhibit (SHCE) expenses, approximately 7% of MVP's total administrative expense was spent on QI. Therefore, $3.12 PMPM of the $44.62 PMPM administrative expense is attributable to QI.

The following table summarizes the administrative expenses for small group and individual lines of business from the 2019, 2020, and 2021 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	2020	N/A	$35.40
Small Group	2020	N/A	$33.65
Combined	2020	$42.00	$34.40
Individual	2021	N/A	$51.71
Small Group	2021	N/A	$44.49
Combined	2021	$43.75	$47.44
Individual	2022	$47.10	$48.26
Small Group	2022	$38.75	$39.63
Combined	2022	$42.20	$43.07

**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 2024. 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 0.10% 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 reimbursements for wellness-related activities. The cost of this benefit is included in the experience period claims as well as the plan AVs so an adjustment is not required on Exhibit 7.

Acupuncture Allowance (Benefit in Addition to EHBs)
MVP is including a $500 acupuncture allowance in its benefits in 2024. The cost of this benefit is included in the experience period claims as well as the plan AVs so an adjustment is not required on Exhibit 7.

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 2023. The SCF = weighted average contract size / weighted average load ratio. Please see Exhibit 4 for the derivation of the SCF.

Loss Ratio Information

The traditional target loss ratio (claims cost / premium) for the rates proposed in this rate filing is 91.1%. After adjusting for taxes/assessments and expenses associated with quality improvements, the Federal target loss ratio for the rates proposed in this filing is 93.0%. Please see the following table for a calculation of these loss ratios based on MVP's projected starting claim cost in 2024:

Target Loss Ratio for 2024 VT Exchange	
A) Claims Expense	$711.56
B) Taxes/Assessments	$12.74
C) Quality Improvement	$3.12
D) Premium	$781.42
E) Traditional Loss Ratio *= A) / D)*	91.1%
F) Federal Loss Ratio *= [A) + C)] / [D) - B)]*	93.0%

MVP does not anticipate having to rebate members for 2022 per the ACA minimum MLR requirements.

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 2023, the Federal URRT, and the Federal Actuarial Memorandum.

Projection Period Enrollment

MVP's projection period membership equals the February 2023 enrollment of the population eligible to purchase these products, or 16,262 members. On Worksheet 2 of the URRT, members are mapped based on their February 2023 benefit to the same benefits for 2024.

MVP is aware that the Medicaid continuous enrollment provision will not continue in 2024. We have decided not to assume a membership or morbidity change for this. We expect the impact to be the same as the overall market wide morbidity impact which we do not have data to project or support.

Actuarial Certification

I, Christopher Pontiff, 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 shown 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 2024 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, 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 2024 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 #26, ASOP#41, ASOP#42, ASOP#45, and ASOP#50.

_______________________________ 05/09/2023
Christopher Pontiff, FSA, MAAA Date
Senior Director, Commercial Pricing, Network & Trend Actuary
MVP Health Care, Inc.