



## 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:	Director, Commercial Market & Valuation Actuary
Primary Contact Phone #:	518-991-3417
Primary Contact Address:	625 State Street Schenectady, NY 12305
Primary Contact E-mail:	EBachner@mvphealthcare.com

# **ACTUARIAL MEMORANDUM**

## **2025 Vermont Individual Exchange Filing**

### **Purpose and Scope of Filing**

This memorandum details the methods and assumptions underlying the proposed 2025 premium rates for the State of Vermont's Individual 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 1/1/2025 and 12/31/2025. There is one benefit plan being retired and one new benefit plan being added. MVP modified several of the benefits being offered, and the updated forms have been submitted in a separate SERFF filing as well as forms for the new plan. The proposed average rate increase (MVP's revenue increase) is 11.7%, with increases ranging from 2.7% to 34.3%.

### **Market/Benefits**

All benefit plans included in this rate filing are available to everyone eligible to purchase coverage in the individual market, except for the Catastrophic plan. That plan has specific age and financial hardship requirements to be eligible to purchase.

A description of benefits is included in Exhibit 1 of the rate filing. As in 2024, 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 a plan which has no cost sharing after the deductible.

Exhibit 1A of the filing provides an overview of benefit changes for renewing plans from 2024 to 2025. 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 7,689 policyholders, 7,689 subscribers and 10,616 members based on February 2024 membership.

### **Experience Period Claims**

MVP historical claim data was the basis of the premium rate development. All ACA compliant Individual 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 1/1/23 and 12/31/23, paid through 2/29/24. MVP has restated its incurred medical claim estimates to complete the claims through 3/31/24.

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 2.0% which is our best estimate of ultimate liabilities as of 3/31/24. 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. Our emerging unpaid experience indicates that there are high-cost claims that are only attributable to small group, so we have modified the IBNR factor for the entire VT population to reflect these amounts specifically in the small group filing. Please see the following table comparing incurred and paid claim amounts by month for the experience period.

<b>Incurred Month</b>	<b>Paid Claims</b>	<b>Incurred Claims</b>	<b>IBNR Factor</b>
202312	\$15,290,309	\$17,350,110	1.135
202311	\$16,637,866	\$17,401,828	1.046
202310	\$16,172,146	\$16,762,348	1.036
202309	\$16,238,927	\$16,611,553	1.023
202308	\$15,669,658	\$15,845,804	1.011
202307	\$14,087,163	\$14,181,084	1.007
202306	\$15,263,143	\$15,843,689	1.038
202305	\$15,679,643	\$15,774,380	1.006
202304	\$15,703,226	\$15,737,218	1.002
202303	\$17,603,896	\$17,643,311	1.002
202302	\$12,895,950	\$12,893,145	1.000
202301	\$13,884,444	\$13,901,258	1.001
<b>Total</b>	<b>\$185,126,371</b>	<b>\$189,945,727</b>	<b>1.026</b>

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 claim 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.

Please note the following changes from this table in the 2024 Actuarial Memorandum:

*Well-Being Reimbursement*

MVP offers a program where members can submit for up to \$600 in reimbursement for activities in the following four domains: Social, Surroundings, Physical, and Mind and Spirit. This iteration of MVP’s wellness benefit began in 2023. In the 2024 rate filing, MVP included the claims incurred in 2022 under the old program in its fee for service paid medical claims and did not include any trend for the program. MVP saw a large increase in utilization under the new program as compared to the old one, and so we are reflecting the rewards in this table in the 2025 filing in order to account for them outside of our normal trend.

*Claim Settlements to Providers*

MVP paid \$1.3 million to providers in 2023 for claim settlements outside of our fee for service claim system. Because of the nature of these settlements, they should be considered claim expense and accounted for in our base period experience (and trended appropriately into the rating period).

<b>Summary of Experience Period Non-FFS and Capitation Amounts</b>	
Other Medical Expenses not in claim warehouse	\$2.13
Net Reinsurance Expense	\$0.38
Medical Home and PCP Incentive	\$3.57
Well-Being Reimbursement	\$1.47
Claim Settlements to Providers	\$3.81
<b>Total Non-FFS and Capitation Amounts</b>	<b>\$11.37</b>

\*Note: VT Paid Claim Surcharge (0.999% of paid claims) and NY HCRA Surcharge (0.17% of paid claims) are not reflected in figures above. Line 9 of Exhibit 3 = (line 5 of Exhibit 3 + line 8 of Exhibit 3) \* 1.169% + 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 \$0.25 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 for these services began to be the member’s responsibility in 2024 with the unwinding of the Public Health Emergency.

*Line 12- Adjustment for COVID Vaccines*

During the experience period, MVP was responsible for the administration cost of COVID-19 vaccines for all 12 months but began to be responsible for the full ingredient cost of those vaccines starting in September 2023. MVP is projecting the cost for 2025 to be: the 2023 utilization of COVID-19 vaccines for all 12 months multiplied by \$140, which represents

the full amount for ingredient and administration costs. Therefore, the \$0.43 PMPM value found in line 12 represents the difference between the projected cost and the experience cost.

*Line 13- Adjustment for Hearing Aids as EHB*

Hearing aids were 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 \$0.33 PMPM.

*Line 14- 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 15- Adjustment for High Cost Claimant in 2023 Above National Threshold*

MVP is expecting a recovery for a member with incurred claims in the experience period above the national threshold of \$1 million. This recovery is worth \$0.79 PMPM.

*Not Included- Adjustment for H.766*

Vermont House Bill H.766 is “an act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts,” and it has the potential to significantly raise the cost of medical claims in the Vermont commercial health insurance market. MVP is still analyzing the contents of the bill (and subsequent amendments that have been filed and approved), but our preliminary analysis suggests this would increase premium rates by 8-10%.

At the time of this filing (last action being taken on 5/3/24), the bill has been approved by both chambers of the Vermont Legislature and is awaiting signature or veto by the Governor.

Given the timing of this decision, the likelihood of a signature or override of the Governor’s veto, and the magnitude of the bill in question, MVP is preparing to file an amendment to our rate filing shortly after submission to include the final impact of the bill in our premium rates.

**Medical Trend Factors**

The development of annual medical paid claim trend factors for 2024 and 2025 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 2024. We are using approved 2024 increases as the best estimate of future budgeted changes for 2025. 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 4.6% for 2024 and 4.5% for 2025.

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 5.6%. The annual paid leveraging factor is 0.5% which results in an average annual paid FFS medical trend of 6.1%. This can be found on line 17 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 2024 and 2025. 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 2024 and 2025 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 (33.8%) 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 7.4%, and the average annual paid Rx trend net of Rx rebates is 8.1% which can be found in line 18 of Exhibit 3.

The Annual FFS Claim Trend Projection factor shown in line 19 of Exhibit 3 represents the blended FFS annual trend projection. To arrive at the blended trend projection shown in line 19, the following calculation is performed:  $[\text{line 5} * \text{line 17} + \text{line 8} * \text{line 18}] / [\text{line 5} + \text{line 8}]$ . 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 21 of Exhibit 3.

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

The paid claim surcharges, capitation, and non-FFS expenses shown in lines 22 and 23 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 23 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	\$2.13
Net Reinsurance Expense	\$1.52
Medical Home and PCP Incentive	\$3.57
Well-Being Reimbursement	\$2.06
Claim Settlements to Providers	\$4.08
<b>Total Non-FFS and Capitation Amounts</b>	<b>\$13.37</b>

*Net Reinsurance Expense*

MVP has experienced recoveries across all of its lines of business that have outpaced reinsurance premiums paid for the past couple of years. Because of this, MVP is anticipating that reinsurance premiums will be significantly increasing in 2025. The net reinsurance expense reflected here is the projected reinsurance premium paid for VT commercial members in 2025 less 2023 actual recoveries for VT commercial members.

*Well-Being Reimbursement*

As stated above, MVP instituted a new version of its wellness reward program starting in 2023. From 2022 to 2023, the expense related to this program has increased over 600% (from \$0.23 PMPM to \$1.47 PMPM). MVP's expectation is that the utilization of this program will continue to grow, given its initial popularity, the broad range of categories from which members can submit for reimbursement, and the method which MVP has chosen to allow members to submit for reimbursement. Therefore, MVP has assumed a 20% annual trend from 2023 to 2025 in this rate filing to account for increased utilization of the program.

*Claim Settlements to Providers*

As stated above, MVP has made settlements to providers outside of its claim system for 2023, settlements which should be considered medical claims (as they were for services which will flow through MVP's claim system in future time periods). MVP has trended the experience period PMPM using the unit cost trends for the providers to which the payments were made.

MVP is assuming that the VT paid claim surcharge will remain unchanged in 2025 and equal 0.999%. The NYS HCRA surcharge was updated to 0.17% based on historical data.

**Silver Load Membership Movement Claim Adjustment**

In response to the prescribed silver loading guidance described below, MVP assumed a membership movement of individual members who currently have purchased a base Silver, 73% CSR, or 77% CSR plan to a corresponding Gold plan.

This has been reflected in MVP's projected "Benefit Relativity \* Induced Demand Reflected In Index Rate" on Exhibit 6 but it also warrants an adjustment to experience period incurred claim cost to reflect the discrepancy between net claim expense and projected actuarial value for these members. The impact was determined by calculating the book of business experience period benefit actuarial value (including induced demand) including these members in their current plan and then comparing to the book of business actuarial value after assuming the membership movement has occurred. This was calculated as a 4% load which is shown on line 25 and incorporated into line 26 of Exhibit 3.

**Federal Risk Adjustment Program**

MVP contracted with an external actuarial consultant to project expected transfer for 2023. MVP is expected to pay \$7,810,438 into the individual market transfer pool for 2023. This is \$60.07 on a PMPM basis or 8.4% 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 is the best estimate of the rating period claim expense. This results in an estimated payment of \$70.70 PMPM or \$9,192,346 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 2025. This is the starting net claim cost that will be used to set 2025 premium rates. Gross Index rates and contract tier rates are calculated in Exhibit 6. The plan specific net claim cost for each plan is computed as follows on Exhibit 6:

$$\text{Adjusted Claim Cost For Pricing (see Exhibit 6)} = \frac{\text{Projected Paid Index Rate After Adjustments PMPM (line 28 of Exhibit 3)}}{[\text{Avg Inforce Actuarial Value} * \text{Induced Utilization Factor}]}$$

$$\text{Plan Specific Net Claim Cost PMPM (see Exhibit 6)} = \text{Adjusted Claim Cost for Pricing} * \text{Benefit Actuarial Value} * \text{Plan Induced Utilization Factor}$$

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 (with adjustments for membership movement and Silver loading) actuarial value times induced demand factor (0.8313) can be found in Exhibit 6.

### **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 \$0.45 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis. This is comprised of \$0.18 PMPM for the risk adjustment user fee levied by the Department of Health and Human Services and \$0.27 PMPM for the Patient Centered Outcome Research Fee.

#### *State Taxes PMPM Based*

\$2.58 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 market share from 2022 to 2025. We have not received updated expense information from the Green Mountain Care Board and we will



seek to amend our filing once we receive this for FY 2024, should the expense be materially different from what is currently assumed.

*State Taxes Premium based – VT Vaccine Assessment*

Based on information provided by the Vermont Vaccine Purchasing Program (VVPP) in 2023, MVP’s rates are estimated to be \$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, resulting in \$3.64 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 0.36%. These rates are subject to change at the VVPP annual assessment meeting on May 30, 2024, and we will seek to amend our filing if we receive updated data from the VVPP that is materially different from the current assumptions.

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

In the 2025 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 an external actuarial consulting group, the estimate of the load charged to individual market issuers in 2025 will be 0.41%.

*General Administrative Expense Load (Including QI component)*

The total administrative expense load included as a plan level adjustment equals \$59.13 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 6% of MVP’s total administrative expense was spent on QI. Therefore, \$3.55 PMPM of the \$59.13 PMPM administrative expense is attributable to QI.

MVP’s projected administrative expense reflects the 2023 SHCE administrative expense on a PMPM basis trended at 3% per year annually for 2 years.

The following table summarizes the administrative expenses for small group and individual lines of business from the 2021, 2022, and 2023 SHCEs compared to the available admin expense built into the rates for the same period.

<b>Combined VT AR42 and AR44</b>	<b>Year</b>	<b>Exchange Available Admin PMPM</b>	<b>SHCE Admin PMPM*</b>
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
Individual	2023	\$51.46	\$55.73
Small Group	2023	\$43.56	\$48.49
Combined	2023	\$46.74	\$51.41

*\*Reflects lines 1.7, 6.6, 8.3, 10.1, and 10.4 of SHCE, Part 1*

### *Risk Margin*

MVP is building a 1.5% risk margin into the VT Exchange premium rates for 2025. 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 0.34% 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 6.

### **Acupuncture Allowance (Benefit in Addition to EHBs)**

MVP is including a \$500 acupuncture allowance in its benefits in 2025. 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 6.

### **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 0.575 and is reflected in the “Induced Utilization Factor” adjustment of Exhibit 6 for this plan.

<b>Catastrophic Plan Level Adjustment</b>	
	<b>HHS Age Factor</b>
Ages 0-29, Meeting Subscriber Qualifications	1.055
Single Risk Pool Total	1.836
Catastrophic Adjustment	0.575

### **Per Contract Premium Rates**

The Plan Specific Gross Claim Cost PMPMs computed in Exhibit 6 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 2024. 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 Green Mountain Care Board’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 low-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.

New guidance on silver loading was implemented by the Green Mountain Care Board in 2025. Based on this, MVP has calculated base pricing actuarial values for on-exchange Silver plans and applied the CSR load factor supplied by the Board (1.4187). The initial actuarial values and the calculated load applied to the net claim cost can be found on Exhibit 6 of the rate filing. The CSR load significantly increased the cost of Silver plans, and we compared the premium relativities (net of APTC payments) of other metal levels to Silver as proposed. Our current proposed relativities indicate that there is incentive for base Silver, 73% CSR and 77% CSR variant members to move to a different metal level. We assumed that 100% of members in these plans would shift to a corresponding Gold plan.

**Loss Ratio Information**

The traditional target loss ratio (claims cost / premium) for the rates proposed in this rate filing is 91.2%. After adjusting for taxes/assessments and expenses associated with quality improvements, the Federal target loss ratio for the rates proposed in this filing is 92.5%. Please see the following table for a calculation of these loss ratios based on MVP’s projected starting claim cost in 2025:

Target Loss Ratio for 2025 VT Individual	
A) Claims Expense	\$914.66
B) Taxes/Assessments	\$10.75
C) Quality Improvement	\$3.55
D) Premium	\$1,003.00
E) Traditional Loss Ratio = A) / D)	91.2%
F) Federal Loss Ratio = [A) + C)] / [D) - B)]	92.5%

MVP does not anticipate having to rebate members for 2023 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 2024, the Federal URRT, and the Federal Actuarial Memorandum.

*Projection Period Enrollment*

MVP’s projection period membership equals the February 2024 enrollment of the population eligible to purchase these products, or 10,616 members. On Worksheet 2 of the URRT, members are mapped based on their February 2024 benefit to the same benefits for 2025. There are two exceptions: retired Gold 2 members who are mapped to the Gold 1 plan and Silver members in response to the CSR load as described above. Silver members have been mapped to the corresponding Gold plan that it resembles in benefit structure.

**New Products**

MVP is offering one new base product to this market effective 1/1/25: Non-Standard Gold 4 (77566VT0040032). MVP utilized its proprietary benefit relativity model to value the benefits associated with the new plan and this is reflected in the premium rate.

### **Retired Products**

MVP is retiring the following base product in Vermont in 2025: Non-Standard Gold 2 (77566VT0040004).

### **Actuarial Certification**

I, Kathleen Fish, 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 2025 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 2025 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.



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Kathleen Fish, FSA, MAAA  
Senior Director, Actuarial Services / Chief Actuary  
MVP Health Care, Inc.

05/13/2024

Date