LEWIS & ELLIS
Actuaries and Consultants

6600 Chase Oaks Blvd, Suite 150
Plano, TX 75023-2383

972-850-0850
lewisellis.com

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Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan
Vermont Health Connect 2024 Individual Rate Filing
SERFF # MVPH-133660955 (Individual)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2024 Individual 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 changes.

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 Individual Qualified Health Plans (QHPs) that will be offered on VHC, beginning January 1, 2024.

2. As of February 2023, there were 11,602 members enrolled in individual plans. Enrollment in these plans in recent years is shown in the following table:

INDIVIDUAL MEMBERSHIP BY COVERAGE YEAR

Coverage Year	Members	Percent Change
2019	14,491	
2020	16,137	11.4%
2021	15,371	-4.7%
2022	15,026	-2.2%
2023	11,602	-22.8%

3. For the 2022 rating year, the Small Group and Individual markets were separated for rating purposes. In accordance with Act 7, Section 9, the markets will continue be to separate for rating year 2024. This report will focus on the proposed unmerged premium rates for the Individual market.

4. As required by the Affordable Care Act, insurers selling plans on VHC must offer silver plans with cost-sharing reductions (CSRs) to Vermonters below certain income levels, known as "Silver Loaded." These members pay a reduced 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, beginning in 2019, carriers began offering "Silver Reflective" plans outside of VHC. The Silver Reflective plans do not include CSR premium funding since federal CSR payments do not apply. While the VHC Silver Loaded 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.

5. The proposed rate impact of this filing is an average rate increase of 12.8%. The tables below illustrate the approved premium rate changes for last year's 2023 QHP filing and the proposed premium rate increase for the 2024 QHP filing.

2023 APPROVED INDIVIDUAL RATE CHANGES

Plan Type	Percent Change	Percent of Membership
Catastrophic	+15.2%	0.0%
Bronze	+17.4%	30.8%
Silver Loaded	+15.3%	35.6%
Silver Reflective	+19.5%	3.4%
Gold	+25.3%	24.5%
Platinum	+24.5%	5.6%
Overall	**+19.3%**	**100.0%**

2024 PROPOSED INDIVIDUAL RATE CHANGES

Plan Type	Average 2023 Premium PMPM	Average 2024 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$415.71	$450.17	+8.3%	$34.46	0.1%
Bronze	$648.02	$711.74	+9.8%	$63.72	31.6%
Silver Loaded	$834.65	$953.94	+14.3%	$119.29	39.0%
Silver Reflective	$691.78	$750.33	+8.5%	$58.55	3.6%
Gold	$898.25	$1,022.42	+13.8%	$124.17	20.9%
Platinum	$1,059.08	$1,197.13	+13.0%	$138.04	4.8%
Overall	**$794.27**	**$895.66**	**+12.8%**	**$101.39**	**100.0%**

STANDARD OF REVIEW

Pursuant to *8 V.S.A. §4062, 18 V.S.A. §9375(6)*, and Green Mountain Care Board (Board) *Rule 2.000: Health Insurance Rate Review*, this letter is to assist the Board in determining whether the proposed rate increase 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 2024 individual premiums. The Company provided exhibits which demonstrated 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.

Exhibits 1 and 1a outline a summary of benefits by plan and a comparison of benefits offered in 2023 versus 2024.

Exhibit 2a illustrates the assumed annual allowed and paid medical cost trends by benefit category for 2023 and 2024 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 165,000 individual member months) from ACA-compliant individuals. Adjustments were applied to adjust for incurred but not reported (IBNR) claims, paid medical/Rx trend, and other factors.

Exhibit 4 shows the development of the individual market single conversion factor of 1.045 using the distribution and the average contract size by tier derived from February 2023 enrollment data.

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

Exhibit 6 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 91.2% for the individual market. After adjusting for taxes, fees, and quality initiatives, the 2024 federal MLR is projected to be 92.7% for the individual market, which exceeds the 80% minimum requirement.

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

L&E ANALYSIS

The average proposed 2024 individual market rate increase of 12.8% is attributable to several rating components. To create a consistent comparison for both companies filing QHP products, L&E categorized the proposed premium changes reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

COMPONENTS OF 2024 PROPOSED RATE CHANGE

Rating Component[1]	Percentage Change[2]
1. 2022 Actual/Projected Claims Experience	-0.5%
2. Difference in Trend from 2022 to 2023	+0.5%
3. Trend from 2023 to 2024	+6.1%
4. Changes to Population Morbidity Adjustment	+0.9%
5. Demographic Shift	+0.0%
6. Plan Design Changes	+0.0%
7. Changes to Other Factors	+1.3%
8. Changes to Risk Adjustment	-0.0%
9. Changes in Actuarial Value	+1.9%
10. Changes in Administrative Costs	-0.6%
11. Changes in Taxes & Fees	+0.8%
12. Changes in Contribution to Reserves	+1.8%
13. Changes in Single Contract Conversion Factor	+0.1%
Total Proposed Individual Rate Change	**+12.8%**

1. **2022 ACTUAL/PROJECTED CLAIMS EXPERIENCE:** Actual 2022 claims experience for the individual market was approximately 0.5% lower than the one-year-trended 2021 costs, projected in the rating year 2023 filing.

2021 Experience Allowed PMPM	$670.57
Prior Year's Assumed 2022 Trend	7.0%
Prior Year's Projected 2022 Allowed PMPM	$717.49
Actual 2022 Allowed PMPM	$713.96
Impact of Actual-to-Projected Experience	-0.5%

   Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate.

2. **DIFFERENCE IN TREND FROM 2022 TO 2023:** In the 2023 filed rates, the assumed 2022 to 2023 trend was approximately 10.8%. MVP now projects a 2022 to 2023 allowed trend rate of

[1] 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.

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

approximately 11.3%. The primary driver of this increase is an increase in the assumed medical unit cost trends, which were updated to reflect final approved GMCB hospital budget increases.

The trend development is discussed further in the next section.

3. **TREND FROM 2023 TO 2024:** The Company requested a total allowed trend for 2023 to 2024 of approximately 6.1%.

2023 TO 2024 ALLOWED TRENDS

Cost Category	Total Allowed Trend
Medical	5.7%
Pharmacy	8.7%
Total	***6.1%***

MEDICAL TREND: The allowed trend reflects changes in both the cost of medical services and utilization of medical services by members. The Company projected an annual allowed medical trend of 5.7%, which is comprised 4.6% for unit cost changes and 1.0% for utilization changes.

MEDICAL UNIT COST TREND

MVP computed its allowed trend as a weighted average of 2023 medical claim unit cost trends for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network. The trend also includes cost trend for capitation payments. This approach is consistent with prior rate filings. These increases reflect the changes to the unit cost increases allowed by the Green Mountain Care Board during the Hospital Budget Review.

GMCB HOSPITAL BUDGET REVIEW

The overall unit cost medical trend of 4.6% includes:

1) a trend of 5.1% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and

2) a trend of 3.8% for other medical facilities and providers that are not subject to the Hospital Budget Review.

Since the fiscal year 2024 Hospital Budget Review is not yet finalized, MVP has assumed that hospital increases will match the fiscal year 2022 approved increases. MVP has historically assumed that hospital increases would match the prior year's approved increases. However, the 2023 approved increases were unusually large outliers. Therefore, MVP assumed 2024 increases would be more comparable to 2022 approved increases. The overall unit cost increase 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 37% of medical services utilized are administered by providers 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 2024.

L&E believes utilizing the 2022 hospital budget figures for the assumed unit cost trends is reasonable and appropriate. Once 2024 hospital budget requests are submitted, L&E recommends that this new information be considered.

MEDICAL UTILIZATION TREND

For the 2024 filing, MVP analyzed historical utilization patterns and ran simulations of forecasted utilization trends at the service category level and in total. This approach produced a wide range of forecasted total utilization trends with a 10th percentile of -1.2%, a mean trend of 1.2%, and a 90th percentile of 3.5%. Since the simulation produced a wide range, MVP decided to assume a utilization trend of 1.0%, which is consistent with the last several approved rate filings. L&E notes the following:

- MVP has historically performed this analysis producing a much wider range between the 10th and 90th percentiles exceeding 10 percentage points, where the range for the 2024 filing analysis is only about 5 percentage points.
- While MVP explained why recent historical data may not be ideal (COVID-19, membership growth and decline, etc.) and that the results of the forecast are not very succinct, the mean trend of 1.2% does appear to support the chosen 1.0% utilization trend.

L&E also reviewed MVP's monthly normalized allowed medical claims cost PMPM data. Due to the COVID-19 pandemic, 2020 and 2021 data were excluded from the analysis. Other recent historical annual medical utilization trends for MVP ranged from 1% to 3%. L&E finds this to be a reasonable range for forecasted utilization trend. L&E concludes that an annual utilization trend of 1.0% appears reasonable.

TOTAL ALLOWED MEDICAL TREND

Based on the information available, L&E considers the 5.7% total allowed medical trend to be reasonable and appropriate.

If updated information regarding unit cost trends is 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 2024 premium rate calculations.

PHARMACY TREND: The Company projected an 8.7% annualized allowed Rx trend. 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	-4.4%	2.6%	-2.0%
Brand	3.2%	4.4%	7.8%
Specialty	3.3%	8.4%	12.0%
Total[3]			***8.7%***

MVP was provided pharmacy trend estimates by their PBM. As a basis for trend estimates, trends are analyzed for all of MVP's Vermont fully insured membership (ACA and Large Group) by using historical utilization and unit cost data for these populations. This historical data is then combined with the PBM estimates for changes in utilization, unit cost, and generic dispensing rates. This combined information is used to calculate their best estimate of Gross PMPM claim cost trends. MVP also applies its best estimate of contract changes between the experience period and the rating period to the unit cost information using a trend model provided by the PBM.

MVP separately projects pharmacy rebates, which are negotiated with the Company's Pharmacy Benefit Manager (PBM). The projected rebate percentage is equal to the rebate percentage observed in the experience period.

This methodology is consistent with historical filings. The past five years of projected and observed pharmacy trends, for MVP's VT Exchange business only, are shown in the table below:

HISTORICAL ALLOWED RX TRENDS

Year	Projected Trend	Actual Trend	(Under)/Over Projection
2018/2017	12.4%	5.1%	+6.5%
2019/2018	7.4%	2.5%	+4.6%
2020/2019	5.8%	21.7%	-15.0%
2021/2020	5.3%	13.7%	-8.0%
2022/2021	11.4%	20.7%	-8.3%
4-year Average	7.5%	14.7%	
3-year Average	7.5%	18.7%	

L&E notes the unusually large 2020 and 2022 pharmacy trends, for which the largest driver was large spikes in specialty tier utilization and unit cost. L&E believes 2020 and 2022 were outlier years that should be mitigated and accounted for when considering future trends.

[3] Due to mix shifts and the order in which the two components can be applied, a weighted average of the trend components would not be accurate.

Excluding 2020 and 2022, the 4-year and 5-year average of the actual trends are 8.1% and 7.1%, respectively. Given that there were two outlier trend years within the last 3 years, a slightly higher trend than what is calculated by completely excluding the outliers is considered reasonable.

Based on recent historical trends and striking an appropriate balance for smoothing outlier years, L&E concludes that MVP's assumed Rx trend of 8.7% is reasonable.

4. **CHANGES TO POPULATION MORBIDITY ADJUSTMENT:** The estimated impact from population morbidity changes is an increase of 0.9%. This filing includes a 0.3% morbidity adjustment, which is due to the projected impacts of COVID-19 testing and vaccinations. The morbidity adjustment and its components for the 2023 and 2024 QHP filings are shown in the next table:

BREAKDOWN OF POPULATION MORBIDITY ADJUSTMENT

	2023 QHP Filing (As Ordered)	2024 QHP Filing
COVID-19 Services	-0.6%	--
COVID-19 Testing	--	-0.04%
COVID-19 Vaccinations	--	+0.3%
Total Morbidity Adjustment	**-0.6%**	**+0.3%**

COVID-19 TESTING: -0.04%

With the ending of the Public Health Emergency (PHE), COVID-19 services will no longer be required to be covered without cost-sharing[4]. MVP assumed a 10% reduction in COVID-19 testing utilization in the projection period compared to the experience period, due to cost sharing no longer being waived. The decrease in cost to the plan due to the reinstitution of cost sharing is reflected in section 9 of this report. The projected utilization decrease removes $0.31 PMPM. This results in a 0.04% decrease to the total 2024 projected rate. Testing is more elective than treatments and visits, and changes in cost sharing for testing could have a greater effect on member behavior than treatments and visits. Therefore, MVP did not assume a similar decrease in utilization for COVID-19 treatments and visits. This is considered reasonable and appropriate.

COVID-19 VACCINATIONS: +0.3%

In addition to the ending of the PHE, the Biden Administration announced that it no longer had funding[5], absent further Congressional action, to make additional vaccine purchases and it began preparing for the full transition of COVID-19 vaccine costs to the commercial market[6]. Therefore, MVP assumed that commercial payers will be responsible for paying the full

[4] https://www.healthaffairs.org/content/forefront/why-end-public-health-emergency-really-matters

[5] https://www.whitehouse.gov/omb/briefing-room/2022/09/02/meeting-critical-needs-for-the-american-people-in-the-new-fiscal-year/

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

ingredient cost of COVID-19 vaccines by 2024. MVP currently pays $40 per vaccine for the administration of the vaccine only. MVP expects to pay $130 per vaccine in 2024 for both the ingredient cost and administration of the vaccine, based information gathered and published by KFF[6]. The total claims expenses PMPM for COVID-19 vaccines in 2022 was $1.02. The increase to $130 results in a $3.31[7] PMPM for COVID-19 vaccines in 2024 and a 0.3% increase to the total 2024 projected rate. This is considered reasonable and appropriate.

5. **DEMOGRAPHIC SHIFT:** The Company did not make any adjustments for demographic shifts in 2024. L&E reviewed the average age factor of the population over the last several years, which has not seen significant changes.

AVERAGE AGE FACTORS

Year	Average Age Factor
2020	1.75
2021	1.78
2022	1.81
2023	1.83

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

6. **PLAN DESIGN CHANGES:** The plan design changes factor addresses any impact to allowed costs resulting from plan benefit design changes. This filing includes a 0.05% plan design adjustment for the addition of hearing aids as an essential health benefit (EHB) in 2024. MVP reviewed its New York population experience to determine the 0.05% impact, a state where hearing aids have been covered as an EHB since the beginning of the ACA. This adjustment rounds to 0.0% in the URRT. Therefore, the estimated impact from plan design changes is 0.0%.

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

7. **CHANGES TO OTHER FACTORS:** Last year's 'Other Factor' was -1.0% in total. L&E outlines the prior year ordered 'Other Factor' breakdown and this year's filed 'Other Factor' breakdown in the following table.

[7] $1.02 * $130 / $40

BREAKDOWN OF OTHER FACTOR

	2023 QHP Filing (Ordered)	2024 QHP Filing
HCRP Fee	+0.4%	--
HCRP Recovery	-0.8%	--
Large Claims Adjustment	-0.6%	--
Leap Year	--	+0.3%
Total Other Factor	**-1.0%**	**+0.3%**

This year, the High-Cost Risk Pool (HCRP) Fee was moved to the load for Taxes and Fees, discussed in section 11 of this report. Last year, there was a high-cost claimant recovery in the base period data that was removed. This year, there is no such claimant in the base period data. Lastly, for the 2023 QHP Filing, calendar year 2021 data served as the base period data for which there was concern about the impact of 2020 COVID-19 "lockdown" deferred care and also deferred care from the University of Vermont Health Network (UVMHN) cyberattack in October 2020. Therefore, L&E recommended a "smoothing" large claims adjustment. For the 2024 QHP Filing, calendar year 2022 data serves as the base period data, for which there are no such concerns. Therefore, a similar adjustment is not recommended.

LEAP YEAR ADJUSTMENT: +0.3%

The 2024 rate development includes an adjustment to account for the extra day because 2024 is a Leap year. This factor increases the rates by 0.3%[8]. This is considered reasonable and appropriate.

8. **CHANGES TO RISK ADJUSTMENT:** Under the Affordable Care Act, premiums are transferred between carriers in this market based on the age, sex, and health status of the enrolled members. MVP consistently pays funds through this system, known as "Risk Adjustment," in this market. This payout requires additional premium be collected from MVP members. MVP projected the expected 2022 risk adjustment transfer payment based on the most recent data available, which was CMS's interim risk adjustment report published in March 2023[9].

   Actual risk adjustment transfers were published[10] by CMS on June 30, 2023. Based on the report, MVP owes $11,867,950 in risk adjustment payments for the 2023 individual market benefit year.

[8] This adjustment is equal to 366 divided by 365, minus one.

[9] https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/interim-ra-report-by2022.pdf

[10] https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs

2022 RISK ADJUSTMENT TRANSFERS (PAYMENTS)

Market	MVP Estimate	CMS Report
Individual (Incl. Cat.)	($13,309,301)	($11,867,950)

We recommend that the Board require that MVP use this updated transfer information in calculating the final premiums. The recommended risk adjustment amounts result in an approximate 1.3% decrease to the 2024 premium rates.

9. **CHANGES IN ACTUARIAL VALUE:** The Change in Actuarial Value (AV) assumption reflects Pricing AV changes, including changes in paid-to-allowed ratios, induced utilization, CSR load, and changes in projected enrollment distribution among plans. The changes in actuarial value result in a 1.9% rate increase.

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

   PAID-TO-ALLOWED RATIOS

   During the course of the review, a couple of errors were found: the trend in MVP's pricing model was not input correctly, and once the trend was corrected, and the paid-to-allowed ratios were affected and needed to be updated accordingly in the URRT. MVP has proposed the following corrections in conjunction with the Board Order: (1) correction to the MVP pricing model trend (Exhibit 2a and following affected Exhibits 3 & 6) and (2) a corresponding correction to the paid-to-allowed ratios on Worksheet 2 of the URRT. These proposed corrections result in a 0.2% decrease to the 2024 premium rates.

   After the filing was submitted, the Internal Revenue Service (IRS) released final guidance regarding high-deductible health plans and the plan designs for HDHP plans were modified accordingly. This change is expected to decrease rates for the various HDHP plans by 0.03% to 0.54% depending on the specific plan. These changes result in an overall 0.02% decrease to rates, which L&E considers to be reasonable and appropriate. L&E recommends that these modified HDHP plan designs, due to the IRS guidance, be reflected.

   NEW CSR GUIDANCE ENROLLMENT SHIFT

   On March 15, 2023, the Board issued guidance for Silver Loading. For On-Exchange Silver Plans, the pricing actuarial value is prescribed to be the membership weighted average benefit richness of silver members, inclusive of the CSR adjusted benefits. This is a change from the CSR load methodology that MVP has used in the past.

   The new CSR load methodology results in the silver metal level plans getting a higher rate increase on average in 2024 than other metal level plans, as shown in the table on Page 2 of this report. MVP did not assume any membership distribution shifts out of silver plans, particularly non-CSR silver plans, into other metal levels, citing the following reasons:

[redacted]

- The additional member premium required to "buy up" in metal level will increase in 2024. Therefore, MVP does not expect members to see value in moving from silver to gold or platinum. MVP acknowledges that some members may move from silver to gold, but some may also move from gold to silver, where in aggregate the membership shift is expected to be immaterial.
- MVP does not feel there is any data to support a membership shift from silver to bronze, and that the difference between the cheaper silver plans and bronze plans is not proposed to change in a significant enough manner relative to current premium differentials to induce any membership changes.

L&E disagrees with MVPs assumption that there will be no material membership shift as a result of the new CSR load methodology for the following reasons:

- The savings from "buying down" to the cheapest bronze plan from the cheapest silver plan is increasing in 2024. Additionally, while the premium required to "buy up" from a silver to a gold plan may be increasing in 2024 on average, the "buy up" from the most expensive silver plan to the cheapest gold plan is decreasing in 2024 on a revenue PMPM basis.
- When membership movement out of non-CSR silver plans is assumed, it increases the silver premiums, which decreases the amount to "buy up" and increases the amount of savings from "buying down".

[redacted]

	[redacted]		[redacted]		[redacted]		[redacted]	
	[redacted]		[redacted]		[redacted]		[redacted]	
	[redacted]		[redacted]		[redacted]		[redacted]	
	[redacted]		[redacted]		[redacted]			

- Texas and New Mexico introduced CSR guidance in 2022 and 2023, respectively. In year one of implementing the new CSR guidance, these states saw decreases of 11% and 22% in the portion of members enrolled in silver plans, respectively[11]. While both states'

[11] https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-metal-level-2/

guidance mandated methodologies that generated higher CSR loads than Vermont's CSR guidance, this suggests that such changes do impact enrollment decisions.

L&E estimates an assumed net enrollment shift of 30% of non-CSR silver members (approximately 250 members) into other metal levels, where the distribution of migration to non-silver metal levels would mirror the current distribution amongst non-silver metal levels. This would result in an approximate 5% decrease in the portion of members enrolled in silver plans. This estimate accounts for the fact that Vermont's CSR guidance has a smaller impact compared to that of TX and NM, observed MVP APTC member migration patterns from 2021 to 2023, and the total enrollment decrease of approximately 23% observed by MVP in 2023.

MEDICAID REDETERMINATION ENROLLMENT SHIFT

Separately from the effect of the new VT CSR guidance, the pandemic public health emergency ended in May 2023, effectively ending the Medicaid continuous enrollment provision that has been in effect since February 2020. The ending of the Medicaid continuous enrollment provision is also referred to as Medicaid Redetermination.

MVP did not assume any membership shifts into CSR silver plans due to Medicaid Redetermination, citing the following reasons:

- MVP has no data to support that most enrollees moving from Medicaid to ACA would be eligible for CSR.
- In the event that most enrollees moving from Medicaid to ACA would be eligible for CSR, MVP still does not believe that is sufficient information to determine an impact on rates. MVP does not have any data to suggest which CSR levels member would enter into and, for example, if there was an influx of members at the 73 CSR level, it would reduce silver premium, while an influx of 94 CSR members would increase the silver premiums.

L&E disagrees with MVP's assumption that there will be no material membership shift as a result of Medicaid redetermination for the following reasons:

- A recent study by NORC at the University of Chicago[12] estimated that approximately 2,700 Vermonters would enter the Marketplace as a result of Medicaid redetermination. Of those 2,700 Vermonters, approximately 1,400 (or about 52%) are estimated to enter as subsidized members.
- Medicaid members moving to the ACA market would have had to qualify for Medicaid based on being below a certain income level within the last few years. Some of those households will continue to have Medicaid-eligible incomes but have lost eligibility for other reasons. Even among those who lose eligibility due to income changes, it does not seem reasonable to assume that their income is now independent of their prior income and distributed just like the rest of the individual market, as MVP's method implicitly assumes. Disproportionately allocating these members to CSR variants would reasonably reflect that they will continue to have lower incomes.

[12] https://www.ahip.org/resources/medicaid-redetermination-coverage-transitions

- Medicaid members moving to the ACA market have been paying no premium while enrolled in Medicaid. It thus appears reasonable to expect that they would preferentially choose the least expensive plans in the marketplace. Members who are eligible for CSRs also see relatively little variation in benefits between plans, making the plan premium the main determinant in their plan selection.

L&E also disagrees with MVP's assertion that additional CSR members would or should have no impact on non-silver premiums. In general, CSR members exhibit low allowed costs (and therefore paid costs) relative to other members at similar benefit levels. This pattern persists even when risk adjustment is applied. An influx of CSR members would increase the average benefit richness of silver plans, thus increasing the CSR load for Silver plans only. This migration would also decrease the index rate, impacting non-silver plans.

L&E estimated an assumed 700 subsidized members selecting MVP plans, disproportionately distributed into the 87 and 94 CSR levels and into MVP's lowest-premium silver plan, the HDHP Non-Standard plan. L&E selected these assumptions based on the information cited above.

L&E acknowledges that assumed enrollment shifts can impact other aspects of the rate development. Ideally, a party with all of the detailed information would be making these assumptions and have the ability to evaluate any impact on those other aspects. Given that L&E had limited information, L&E has evaluated the effect of such assumptions as best as possible. During the course of this review, L&E asked MVP six questions about the CSR enrollment shifting and Medicaid Redetermination. MVP did not propose any modification or resolutions in their responses.

After accounting for L&E's estimated enrollments shifts due to both the new VT CSR guidance as well as Medicaid Redetermination, the resulting recommended silver plan CSR loads are shown in the table below alongside the silver plan CSR loads that were filed. L&E defines the silver plan CSR load as the On-Exchange silver plan premium rate divided by the Off-Exchange silver plan premium rate.

On-Exchange Silver Plan	Filed On-Exchange Silver Load	Recommended On-Exchange Silver Load
Standard	12.8%	14.3%
HDHP Standard	11.3%	13.6%
HDHP Non-Standard	8.4%	11.0%
Non-Standard	16.0%	17.7%

After these modifications, L&E considers the AV methodology to be reasonable and appropriate.

10. **CHANGES IN ADMINISTRATIVE COSTS:** MVP is projecting 2024 general administrative costs to be 5.9% of premium ($52.74 PMPM), which is a decrease relative to the 2023 assumption of 6.4% of premium ($51.46 PMPM). The overall rate impact is a decrease of 0.6%.

MVP provided the actual 2022 administrative expenses, projected (approved) 2023 administrative expenses, proposed 2024 administrative expenses, per member per month, by expense category. This information is shown in the table below.

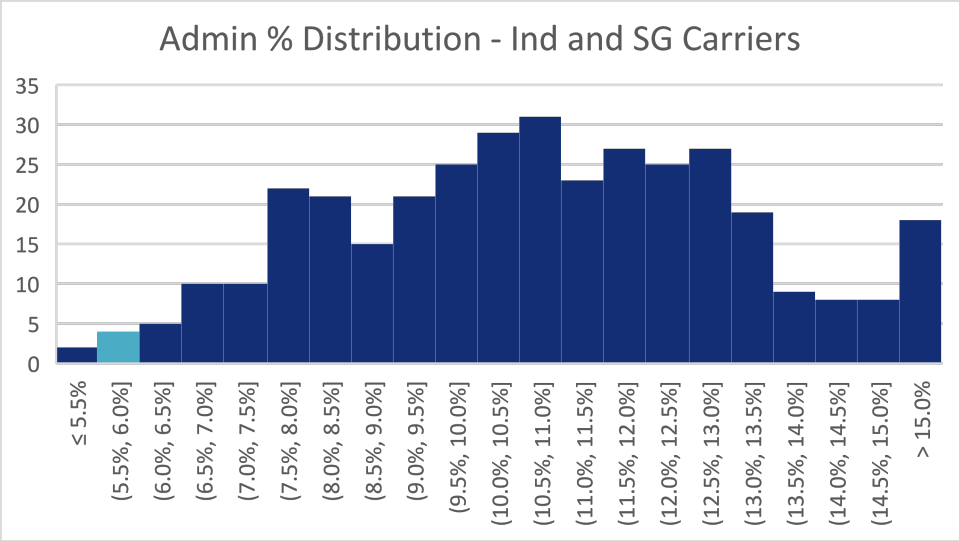
EXPENSES PMPM

Expense Category	2022 Actual Admin PMPM	2023 Projected Admin PMPM	2024 Proposed Admin PMPM
Personnel Expenses	$29.26	$29.01	$31.76
Software	$4.31	$4.39	$3.47
Consulting/Project Expenses	$3.55	$5.15	$3.26
All Other Admin	$11.14	$12.91	$14.26
Total	***$48.26***	***$51.46***	***$52.74***

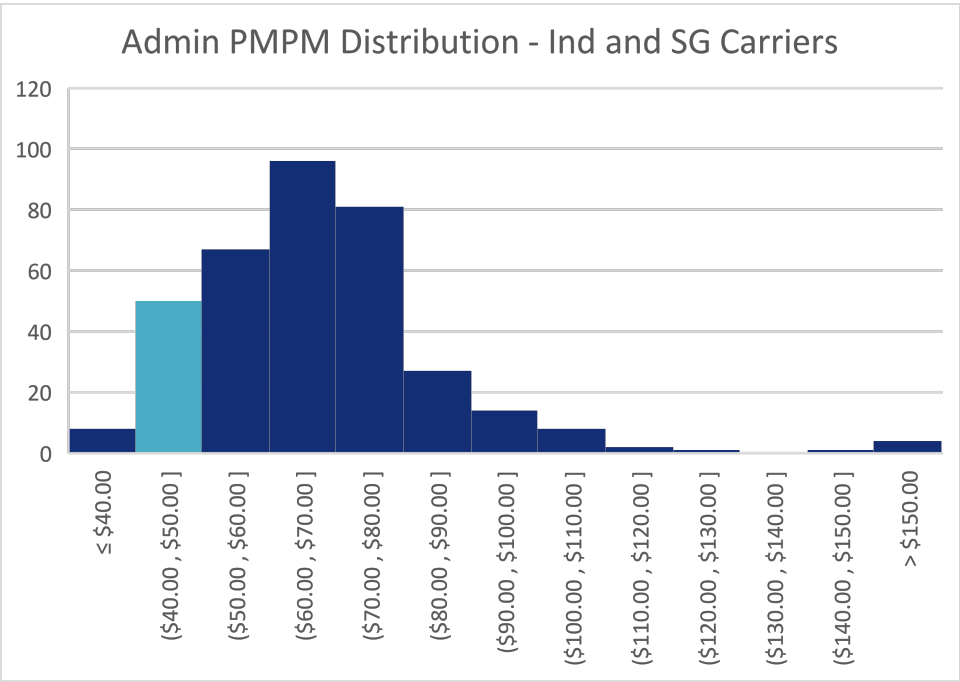
The assumed 2024 administrative costs are $7.62 PMPM higher than MVP's average individual administrative costs as reported in the Company's 2020 to 2022 Supplemental Health Care Exhibits (SHCE) of $45.12. However, in 2022, MVP began managing the billing and payment processing functions, which may make 2020 and 2021 less comparable to 2023 to 2024 administrative costs. Compared to 2022 actual administrative costs, the assumed 2024 administrative costs are $4.48 PMM higher than in 2022. This increase is equivalent to a 4.5% average annual increase from 2022 to 2024.

An increase of $3.12 PMPM, or about 70%, is within the "All Other Admin" category. MVP stated that the following are included in that category: bank fees, printing, postage, facility expense, telephones, insurance, etc. MVP stated that within this category, the largest driver of the increase is bank fees which, while lagging behind the initial year of MVP managing billing and payment processing, have increase due to MVP assuming responsibility for these functions previously performed by the State of Vermont.

The corresponding percent of premium allocated to non-benefit expenses for other carriers nationwide in 2023 is shown below. The range containing MVP's administrative cost level is highlighted in light blue.



The following shows the distribution of administrative costs PMPM for carriers nationwide in 2023:



Among individual and small group carriers nationwide, these figures are in the 10th percentile on a PMPM basis, and the 2nd percentile as a percentage of premium. That is, MVP has atypically low administrative costs, despite not being a very large health plan. It therefore appears that MVP manages and limits administrative costs better than the typical health plan nationally.

L&E considers the assumed 2024 administrative costs to be reasonable and appropriate.

11. **CHANGES IN TAXES & FEES:** The expected rate change due to taxes and fees is a 0.8% increase. The taxes and fees include state taxes, federal taxes (including the HHS risk adjustment user fee and PCORI fee), the VT vaccine assessment, and 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 primary driver of the increase to the taxes and fees, 0.6% of the 0.8%, is due to MVP moving the HCRP fee from the development of the index rate to the load for taxes and fees. The HCRP fee filed is 0.6% of premium, which is a slight increase from 0.4% filed last year, both fee amounts based on national studies performed by Wakely Consulting Group. The taxes and fees assumptions appear to be reasonable and appropriate.

12. **CHANGES IN CONTRIBUTION TO RESERVES:** The contribution to reserves (CTR) is composed of a provision for bad debt of 0.3% and a risk margin of 1.5%.

BREAKDOWN OF CONTRIBUTION TO RESERVES

	2023 QHP Filing (As Ordered)	2024 QHP Filing
Bad Debt	0.3%	0.3%
Risk Margin	-0.1%[13]	1.5%
Total CTR	**0.2%**	**1.8%**

MVP provided the bad debt as a percentage of premium for each of the last four years which averaged 0.3% per year. MVP's assumption of 0.3% accounts for the non-payment of premium risk in the development of the 2024 rates, which is consistent with the 2023 rate filing.

The proposed risk margin of 1.5% is consistent with the risk margin that was proposed in the 2023 filing. However, there was an ordered affordability cut to 2023 rates, which MVP reflected in the CTR within the filing. Therefore, the final approved CTR was -0.1%.

MVP provided that actual to expected risk margin for the most recent four years, as follows.

HISTORICAL RISK MARGIN

Year	Actual	Expected
2019	-1.0%	1.5%
2020	4.4%	1.0%
2021	-10.6%	0.5%
2022	-9.4%	1.0%
Total	-16.6%	4.0%

[13] Includes the ordered rate reduction for affordability.

As a reasonableness check of the proposed CTR provision, L&E again reviewed the 2023 nationwide data. In 2023, there were 359 carriers who submitted On-Exchange individual or small group ACA filings nationally. The filed CTR varied from -24% to +9%, but most often fell between 0% and 5%. The mode is between 2% and 3%, and the premium-weighted average CTR for all carriers was filed as 2.8%. MVP's filed base CTR of 1.5% would place it at around the 23rd percentile for all QHP carriers, and the 0.3% margin for bad debt in the individual market increases this to the 26th percentile.

MVP also provided the Company's historical risk-based capital (RBC) ratio for the last three years, outlined in the table below.

HISTORICAL RBC RATIO

Year	RBC Ratio
2020	429.4%
2021	354.0%
2022	369.3%

It is slightly concerning that MVP has experienced an overall negative profit in the last few years, and there was a significant decrease in the RBC in 2021. Vermont business accounts for approximately 9% of MVP's overall business[14]. Therefore, L&E believes it is not a significant factor in determining the Company's RBC Ratio. L&E notes that it is not sustainable to have long-term negative profits, and therefore, a higher CTR could be justified. Given this information, L&E believes that a CTR between 0.5% to 3.0% would be considered reasonable.

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

13. **CHANGES IN SINGLE CONVERSION FACTOR:** A conversion factor[15] adjustment is used to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single conversion factor used in the 2023 rate filing was 1.044. For this year's filing, MVP utilized February 2023 enrollment to calculate the 2024 single conversion factor of 1.045.

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

[14] Based on direct written premium amounts as reported in the 2022 SHCE.

[15] 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 over all adults and children. However, Vermont's tiered premiums require the base premium to be for a single adult.

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:** With the current information available, L&E believes utilizing recent hospital budget figures for the assumed unit cost trends is reasonable and appropriate. Once 2024 hospital budget requests are submitted, L&E recommends that this new information be considered in the unit cost assumption.

- **REFLECT UPDATED RISK ADJUSTMENT TRANSFERS:** L&E recommends that the projected risk adjustment receivable be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. This will decrease rates by approximately 1.3%.

- **REFLECT RECOMMENDED CSR LOADS:** L&E recommends that enrollment shifts be assumed as a result of Vermont's new CSR guidance as well as Medicaid Redetermination, as discussed in Section 9 of this report. After accounting for L&E's estimated enrollments shifts, the resulting recommended silver plan CSR loads are shown in the table in Section 9 of this report.

- **REFLECT CORRECTED AND/OR UPDATED PAID-TO-ALLOWED RATIOS:** L&E recommends that the paid-to-allowed ratios on Worksheet 2 of the URRT be updated in conjunction with the correction to trend inputs in MVP's pricing model. Additionally, L&E recommends that the modified HDHP plan designs, due to final IRS guidance, be reflected. This will decrease rates by approximately 0.2%.

After the modifications, the anticipated rate change for the individual market is roughly +11.2%,[16] plus any impact from updated hospital budget information.

[16] Due to the complexity of the premium rate development and the possible interdependency of the assumptions modified, the actual implemented rate change may vary from the estimate.

2024 RECOMMENDED RATE CHANGES

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

Rating Component[17]	Percentage Change[18]
1. 2022 Actual/Projected Claims Experience	-0.5%
2. Difference in Trend from 2022 to 2023	+0.5%
3. Trend from 2023 to 2024	+6.1%
4. Changes to Population Morbidity Adjustment	+0.9%
5. Demographic Shift	+0.0%
6. Plan Design Changes	+0.0%
7. Changes to Other Factors	+1.3%
8. Changes to Risk Adjustment	-1.2%
9. Changes in Actuarial Value	+1.7%
10. Changes in Administrative Costs	-0.6%
11. Changes in Taxes & Fees	+0.8%
12. Changes in Contribution to Reserves	+1.8%
13. Changes in Single Contract Conversion Factor	+0.1%
Total Proposed Individual Rate Change	**+11.2%**

[17] 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.

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

Sincerely,

Traci Hughes, FSA, MAAA
Vice President & Senior Consulting Actuary
Lewis & Ellis, Inc.

Jacqueline B. Lee, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

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, FSA, MAAA, Vice President & Senior Consulting Actuary.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal.

These actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 5, 2023. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is June 29, 2023.

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.

- L&E 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 material impact on the analysis. To the extent that there are material inaccuracies in,

[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.

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 the body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW
This report was prepared as prescribed by applicable law, statutes, 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 applicable ASOPs.