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October 14, 2024

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan, Inc.
2025 Large Group HMO Rate Filing
SERFF #: MVPH-134197798

The purpose of this letter is to provide a summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP) for its existing HMO products for coverage year 2025 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP is a non-profit health benefit plan provider. MVP provides large group coverage to employers in Vermont as well as individual and small group coverage sold on Vermont Health Connect (VHC).

2. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio and includes proposed rates for all four quarters of 2025. This product portfolio is comprised of base major medical high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. The example below demonstrates a 1st quarter 2025 manual rate calculation for a group with a base major medical health plan, a medical benefit rider, a pharmacy benefit rider, and a point-of-service (POS) rider (i.e., adds out-of-network coverage):

a) Base Major Medical Health Plan VT4HMO087ZLAN	$729.10	
b) Medical Rider MV3HMB305L	$8.73	
c) Rx Rider RXVT3HMB500ZL	$117.04	
d) Combined In-Network Manual Base Rate[1]	$854.87	= a) + b) + c)
e) POS Rider SV3HMB101L	3.57%	
f) Combined Manual Base Rate w/ POS Rider	$885.39	= d) * [1 + e)]

3. As of April 2024, there were approximately 1,589 members enrolled with 9 policyholders in MVP large group plans in Vermont. Approximately 90% of members have renewal dates during 1st quarter.

[1] Base Rate refers to the premium rate prior to the application of rating factors (ex. age/gender) and retention.

Below is the rate change for the first quarter 2025 as initially filed:

Reason for Change	1Q '25 Manual Rate Change
Base Rate Change	6.0%
Change in Retention	0.1%
Total Manual Rate Change	***6.1%***

For accounts that renew in the first quarter of 2025, the requested annual average rate increase is 11.1%. This is comprised of the previously approved quarterly rate changes for 2Q24 through 4Q24 combined with the proposed 1Q25 manual rate change and membership distribution shift. These quarterly rate changes are outlined as follows:

Quarter	1Q '25 Annual Total Rate Change
2Q '24 / 1Q '24	1.5%
3Q '24 / 2Q '24	1.5%
4Q '24 / 3Q '24	1.5%
1Q '25 / 4Q '24	6.1%
Membership Distribution Shift[2]	0.2%
Total Annual Rate Change	***11.1%***

The quarterly manual rate changes through the remainder of calendar year 2025 are all equal to 1.6%, representing the assumed quarterly trend.

Quarter	Quarterly Rate Change
2Q '25 / 1Q '25	1.6%
3Q '25/ 2Q '25	1.6%
4Q '25 / 3Q '25	1.6%

The following table outlines the proposed total manual rate changes for each quarter in 2025.

Quarter	Membership as of Apr '24	Filed Annual Total Rate Change
1Q24	1,445	11.1%
2Q24	0	11.2%
3Q24	0	11.4%
4Q24	144	11.5%

The proposed rate changes discussed above reflect the revenue increase for a manually rated group. This is used for groups without any past coverage experience or for groups that are too small for the experience to be used entirely. In practice, the large groups represented in this filing have an average credibility of 25%, and thus premiums are a blend of the experience and manual rates. Therefore, some groups will experience higher increases, and some will experience lower increases. If a group experiences a higher rate increase, it is because their claims experience deteriorated relative to the other large groups in this block. All groups will experience the effect of changes in retention, as these

[2] The difference in the membership between the average during the experience period and month-end April 2024, which was the current membership at the time of rate development.

components of the rate are added to the projected claims, whether those claims came from the manual rate or the group's experience.

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory. In this report, L&E refers to assumptions and resulting rates that fit these criteria as 'reasonable and appropriate'.

Summary of the Data Received

MVP provided the methodology used in premium rate development (Exhibit 2a-2b and Exhibit 3a-3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim data and membership, pricing trend assumptions, experience rating formula (Appendices A-C), and additional supporting exhibits, as requested during review of the filing.

L&E Analysis

1. *Rate Development:* MVP utilized large group claim data (constituting HDHP and non-HDHP products) for the period from May 2023 through April 2024 and paid through April 2024 as the base period experience. Incurred but not reported (IBNR) estimates were confirmed using claims paid through June 2024. In prior years, the base period experience was considered fully credible by MVP. However, the base period data in this filing is considered 75% credible. To enhance credibility, MVP utilizes the prior year's manual rate claim costs at 25% (adjusted for trend and Acts 111/185). Using this data source as opposed to other Vermont, nationwide, or MVP New York data helps MVP balance administrative costs and pricing accuracy. L&E considers this approach to be reasonable and appropriate.

   Exhibit 3a illustrates both the claim projection from the experience period to the rating period and the accompanying adjustments applied in deriving the rates for 1Q25.

   MVP uses a pooling charge to mitigate the impact of catastrophic claims (i.e., those exceeding $250,000 per member per year). The purpose of this adjustment is to prevent major swings in premium resulting from a small number of cases. Regardless of the actual value of catastrophic claims, claims in excess of $250,000 are removed and replaced by a flat percentage. Pooling claims is a typical industry practice.

   The pooling charge of 3.0% is equal to the average percentage of claims over $250,000 in Vermont from May 2021 to April 2024. In previous filings, the pooling charge was based on MVP's New York large group experience, which was considered much larger and more stable than Vermont's population. However, MVP observed that over the past five years, the pooling charge that has been added to manual rates is generally higher than what has been experienced, which resulted in MVP utilizing Vermont-specific data for the 2025 pooling charge adjustment. This is considered reasonable and appropriate.

   The adjusted claims were projected forward to the midpoint of the 1Q24 rating period using an annual paid medical trend assumption of 6.0% (elaborated further in item 3 below). MVP's paid medical trend is derived

from its proposed allowed cost trend and the impact of cost share leveraging[3]. The prescription (Rx) claims were projected forward to the midpoint of the 1Q24 rating period using an annual paid Rx trend of 8.2% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q25. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, newly added benefits, adjustments for COVID-19, a leap year adjustment, and the impact of new legislation.

Using the rate development methodology described above, the resulting quarterly base rate change was 6.0% for 1Q25 compared to 4Q24.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in quarterly manual rate increases of 1.6% in each quarter of 2025. The 1.6% quarterly rate increases are based on a 2026 trend assumption that is consistent with the 2025 trend assumption. That is, groups renewing in April will be charged premiums based on manual rates 1.6% higher than groups renewing in January. As noted above, approximately 90% of members have 1st quarter renewal dates.

2. *Age/Gender and Industry Factor Changes:* There were no changes to the age/gender and industry factors proposed in this filing. The experience period claims are normalized for the average age/gender factor (1.067) and average industry factor (1.030) observed in the experience period.

3. *Medical Trend:* MVP is requesting a utilization trend of 0.5% and a unit cost trend of 4.8%. This represents a total average annual allowed trend of 5.3%[4]. Below are the allowed and paid medical trends:

Medical Trend	Unit Cost	Utilization	Total Allowed Trend	Paid Trend
2024/2023	4.0%	0.5%	4.5%	5.2%
2025/2024	5.3%	0.5%	5.8%	6.5%
Total[5]	4.8%	0.5%	5.3%	6.0%

The allowed cost trends are based on the allowed charges (reflecting total amount of claims cost paid by the carrier and the policyholder) while paid trends reflect the actual claim payments made by the carrier. Using the paid trends for each year as shown in the table above, MVP derived a total average annual paid medical trend factor of 6.0%, which was applied for 20 months to trend the experience forward to 1Q25.

Utilization Trend

MVP analyzed historical medical utilization trends for its total Vermont block of business and chose a 0.5% annual utilization trend. MVP used an exponential smoothing forecasting method for analyzing historical

[3] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation.

[4] [(1.048)*(1.005)]-1=5.3%

[5] A weighted average is calculated by applying 8 months of 2024 trend and 12 months of 2025 trend based on the experience period end date of April 30, 2024.

utilization patterns and projecting them to the rating period. MVP notes that it has experienced low membership in the past, which may lead to volatility and influence the results of historical trend methodologies. This approach produces a range of forecasted average annual utilization trends with a 10th percentile of –1.3%, a mean trend of 0.1%, and a 90th percentile of 1.4%. MVP chose a utilization trend of 0.5%, which is between the 60th and 70th percentile results. This is lower than the 1.0% utilization trend that MVP has assumed in the past recent filings.

L&E reviewed MVP's normalized medical PMPM data from 2019 through 2023 and observed a historical utilization trend, averaged across multiple years, ranging from approximately 1.5% to 4.5%. Therefore, L&E does not recommend reducing the trend assumption as filed. The utilization trend of 0.5% is considered reasonable and appropriate.

Unit Cost Trend

The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2025 hospital budgets. The budgeted unit cost increases are lower than anticipated at the time of the filing. Therefore, we recommend that MVP modify the filing to reflect the ordered hospital budget amounts[6]. This reduces the average annual allowed unit cost trend from 4.8% to 2.8%, which reduces the total average annual paid medical trend from 6.0% to 3.8%. The impact of this change to the rate increases in each quarter is as follows:

Manual Rate Change	1Q '25 / 4Q '24	2Q '25 / 1Q '24	3Q '25 / 2Q '24	4Q '25 / 3Q '24
Initially Requested Rate Increases	6.0%	1.6%	1.6%	1.6%
Rate Increases Reflecting Hospital Budget Orders	3.5%	0.9%	0.9%	0.9%

4. *Rx Trend:* MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2024 Trend			2025 Trend		
Tier	**Unit Cost**	**Utilization**	**Total**	**Unit Cost**	**Utilization**	**Total**
Generic	-7.6%	3.9%	-4.0%	1.3%	2.6%	4.0%
Brand	10.8%	-6.7%	3.3%	4.5%	3.7%	8.3%
Specialty	-0.8%	9.8%	8.8%	3.8%	7.1%	11.3%
Total			**5.9%**			**9.7%**

The total average annual allowed trend is 8.2%, composed of a utilization trend of 3.1% and a unit cost trend of 5.0%.

The annualized effective paid trend is 8.6%, which is shown in Exhibit 2b of the filing. The Rx paid trend, which adjusts the allowed trends to account for cost sharing by the insured (by modeling deductible, copay and coinsurance), is used to trend the experience period claim costs to the projection period.

[6] https://gmcboard.vermont.gov/FY2024hospitalbudgets

Annual allowed trend factors by drug category were supplied by MVP's pharmacy benefit manager (PBM), reflecting MVP's large group business in the state of Vermont. The table below shows the comparison of the historical PBM expected trends to the actual allowed trends.

Year	Actual Trend	Expected Trend	Actual-to-Expected Ratio
2019/2018	7.1%	8.2%	0.87
2020/2019	53.9%	5.6%	9.63
2021/2020	3.4%	11.9%	0.29
2022/2021	7.0%	5.9%	1.19
2023/2022	9.4%	8.3%	1.13
5-year Average	16.2%	8.0%	2.03
5-year Average Excluding Outliers	7.8%	7.5%	1.05

L&E notes that outlier trends were observed in 2020 and 2021. L&E does not believe it would be reasonable to include these when analyzing historical trends for the purpose of informing future trend assumptions. L&E recognizes that historical trends do not necessarily represent prospective trends; however, it is important to consider retrospective results when setting trend assumptions. The actual-to-expected analysis shows that, outside of the two outlier years during the peak of COVID-19, MVP has projected pharmacy trend close to what was actually observed for the large group market. Additionally, the analysis shows that overall, excluding the two outlier years, MVP and their PBM have slightly under-projected pharmacy trend. The proposed average annualized allowed trend in this filing of 8.2% is slightly higher than the average historical trend, excluding outliers, of 7.8%. However, this appears reasonable given the overall historical under-projection of pharmacy trend.

Based on these observations, in conjunction with the actual-to-expected gain/(loss) analysis discussed later in this report, L&E considers the proposed Rx trend to be reasonable and appropriate.

5. *Other Rate Adjustments:*

The manual rates are adjusted for the following items for the 2025 rating period:

Acts 111 and 185

On May 28, 2024, a law affecting prior authorization requirements, health care claims edits and prescription drug step therapy protocols was passed to go into effect on January 1, 2025. However, the following month, Act 185 signed into law to delay implementation of some Act 111 provisions related to claims edits. MVP analyzed the legislation and calculated the expected loss of savings. This adjustment results in an increase to the 2025 premium rates of 0.9%. L&E considers the adjustment to be reasonable and appropriate.

COVID-19 Vaccinations

Beginning in September 2023, MVP was charged the full ingredient cost of COVID-19 vaccines. To reflect this additional cost in the projected rates, MVP calculated this adjustment as the difference between

the actual 2023 vaccine cost PMPM and the vaccine cost PMPM that would have been charged if each administered vaccine cost was $140, which is the full amount for ingredient and administrative costs. MVP initially used an adjustment of $0.27 PMPM, which they explained was an error. The actual 2023 vaccine cost PMPM was $0.86 and the vaccine cost PMPM assuming full vaccine cost for the entire year is $0.96. Therefore, the adjustment should be $0.10 PMPM. L&E recommends the adjustment be updated to reflect the difference in actual 2023 and 2025 projected vaccine costs PMPM, as intended. The revised adjustment is considered reasonable and appropriate. The adjustment revision has no material impact on the requested rates.

Additional Benefits

Hearing aid coverage was added as an Essential Health Benefit (EHB) in 2024. MVP estimates the impact of hearing aids as an EHB to be $0.33 PMPM based on review of its New York experience. MVP acknowledged that the mandated EHB was in effect for four months of the experience period data. MVP believes the benefit was under-utilized in the experience period because it was new to members and does not reflect the ultimate claim cost; therefore, MVP did not make an adjustment to remove the data from the experience period prior to adding in the $0.33 PMPM estimate.

Vermont has mandated coverage of abortions without cost sharing before the deductible on HDHPs. MVP estimates the impact of this coverage to be $0.03 PMPM based on review of historical Vermont experience. Similar to hearing aids, mandated coverage of abortion was in effect for four months of the experience period data. MVP did not make an adjustment for this as the total dollar amount was negligible.

Leap Year

MVP adjusts the experience period claims downward by $1.91 PMPM[7] to remove the additional day represented in the experience period since 2024 is a leap year.

6. *Retention:* As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The 13.0% total retention load is composed of the following:

Retention Item	Approved 2024 Retention	Proposed 2025 Retention
Administrative Expenses	7.8%	7.8%
Other Expenses	3.7%	3.2%
Contribution to Reserves (CTR)	1.5%	2.0%
Total Retention	**13.0%**	**13.0%**

[7] Equivalent to 0.3% of premium, or 365 divided by 366, minus one.

Administrative Expenses

The projected administrative expense of 7.8% of premium is consistent with the average expense for the last three years. The following table summarizes data taken from the Supplemental Health Care Exhibits in recent years:

Administrative Expense Summary for Large Group Products				
	Member Months	**Premium PMPM**	**Admin PMPM**	**Expense Ratio**
2019	22,511	$499.97	$46.35	9.3%
2020	23,424	$540.97	$38.45	7.1%
2021	25,201	$568.90	$47.93	8.4%
2022	22,029	$584.72	$43.89	7.5%
2023	18,033	$679.85	$50.78	7.5%

The administrative load appears to be reasonable and appropriate.

Other Expenses

The breakdown of the other expenses is as follows:

Other Expenses	Approved 2024 Retention	Proposed 2025 Retention
Broker Load	2.4%	2.1%
VT Vaccine Pilot	0.6%	0.5%
Bad Debt	0.3%	0.3%
Comparative Effectiveness Research Fee	0.0%	0.0%
18 VSA 9374(h) Billback	0.3%	0.3%
Total Other Expenses[8]	**3.7%**	**3.2%**

Contribution to Reserves (CTR)

The proposed contribution to reserves (CTR) is 2.0%, which is consistent with historically proposed CTR. In past orders, the Board has reduced the proposed CTR.

The target loss ratio is decreasing from the approved 87.05% 1Q 2024 to 87.02% for 2025. This change is the result of an increase in the billback amounts, an increase in the CTR, and a decrease to the broker load. The federal loss ratio for MVP in 2023 was 99.9%, and the rolling three-year average (2021-2023) is 97.6%.

[8] The sum of the individual components may not equal the total shown due to rounding.

MVP's actual gain/(loss) compared to the ordered risk margin for the most recent four years is as follows.

Year	Actual Gain/(Loss)	Expected Risk Margin (As Ordered)
2020	-8.6%	1.0%
2021	-6.2%	1.0%
2022	5.3%	1.5%
2023	-3.2%	1.0%

MVP's historical risk-based capital (RBC) ratio for the last four years is as follows.

Year	RBC Ratio
2020	429%
2021	354%
2022	369%
2023	417%

It is slightly concerning that MVP has experienced an overall negative profit in the last several years; however, MVP's RBC has been steadily increasing in recent years. Vermont business accounts for approximately 9% of MVP's overall business[9]. L&E recognizes that this is a small part of MVP's overall business, which contributes to the increasing RBC despite consistent losses observed for the VT business. However, actuarially sound rates are sustainable without other subsidization. L&E notes that it is not sustainable to have long-term losses. L&E also notes that the filed CTR assumption of 2.0% is slightly higher than the expected CTR in prior years. Given this information, L&E believes the filed CTR assumption is reasonable.

[9] Based on direct written premium amounts as reported in the 2023 SHCE.

Recommendation
L&E recommends that the proposed rates be modified to reflect:

- *Green Mountain Care Board (GMCB) Hospital Budget:* L&E recommends revising the medical unit cost trends to reflect the final orders regarding FY2025 hospital budgets. This will decrease the 2025 first quarter rates by 2.4%

- *COVID-19 Vaccinations:* MVP initially used an incorrect value for the adjustment for COVID-19 vaccinations. Correcting the adjustment, as supported by the data provided by MVP, has no material impact to the requested rates.

The recommended rate increase is as follows:

Reason for Change	1Q '25 Manual Rate Change
Base Rate Change	3.5%
Change in Retention	0.1%
Total Manual Rate Change	***3.6%***

Quarter	1Q '25 Annual Manual Rate Change
2Q '24 / 1Q '24	1.5%
3Q '24 / 2Q '24	1.5%
4Q '24 / 3Q '24	1.5%
1Q '25 / 4Q '24	3.6%
Membership Distribution Shift[10]	0.2%
Total Annual Rate Change	***8.5%***

Quarter	Quarterly Rate Change
2Q '25 / 1Q '25	0.9%
3Q '25 / 2Q '25	0.9%
4Q '25 / 3Q '25	0.9%

Quarter	Membership as of Apr '24	Recommended Annual Total Manual Rate Change
1Q24	1,445	8.5%
2Q24	0	7.9%
3Q24	0	7.3%
4Q24	144	6.7%

L&E believes that, if modified as described above, this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.

[10] The difference in the in membership between the experience period and April 2024, which was the current membership at the time of rate development.

Sincerely,

Traci L. Hughes, FSA, MAAA
Vice President & Principal
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Jacqueline B. Lee, FSA, MAAA
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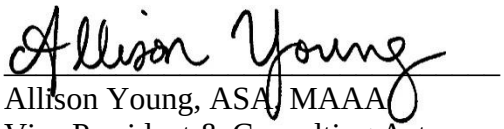

Allison Young, ASA, MAAA
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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[11], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[12], 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 Actuary
The responsible actuaries are:

- Traci Hughes, FSA, MAAA, Vice President & Principal at Lewis & Ellis, LLC
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, LLC
- Allison Young, ASA, MAAA, Vice President & Consulting Actuary at Lewis & Ellis, LLC

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents
The date of this document is October 14, 2024. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 4, 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 Lewis & Ellis, LLC (L&E), under any theory of law, related in any way to this material.
- L&E is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing 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 the issuers for reasonableness, but we have not audited it. 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, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are 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.
- The findings of this report are enclosed herein.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

[11] 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.

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

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions, and data used by the actuary 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 an applicable ASOP.