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Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan
Vermont Health Connect 2023 Individual Rate Filing
SERFF # MVPH-133238186 (Individual)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2023 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, 2023.

2. As of February 2022, there were 15,026 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
2018	10,868	
2019	14,491	33.3%
2020	16,137	11.4%
2021	15,371	-4.7%
2022	15,026	-2.2%

3. For the 2022 rating year, the Small Group and Individual markets were separated for rating purposes. In accordance with Act 137, Section 9, the markets will continue be to separate for rating year 2023. 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 with 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 17.4%. The tables below illustrate the approved premium rate changes for last year's 2022 QHP filing and the proposed premium rate increase for the 2023 QHP filing.

2022 APPROVED INDIVIDUAL RATE CHANGES

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM[1]	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$339.18	$360.82	6.4%	$21.64	0.1%
Bronze	$475.60	$549.91	15.6%	$74.31	33.4%
Silver Loaded	$656.63	$724.66	10.4%	$68.03	33.6%
Silver Reflective	$510.26	$581.27	13.9%	$71.01	5.5%
Gold	$637.28	$714.78	12.2%	$77.50	22.5%
Platinum	$741.01	$848.75	14.5%	$107.74	5.0%
Overall	**$587.86**	**$662.25**	**12.7%**	**$74.38**	**100.0%**

2023 PROPOSED INDIVIDUAL RATE CHANGES

Plan Type	Average 2022 Premium PMPM	Average 2023 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$360.82	$409.74	13.6%	$48.92	0.0%
Bronze	$548.38	$633.48	15.5%	$85.09	30.8%
Silver Loaded	$726.27	$825.29	13.7%	$99.02	35.6%
Silver Reflective	$584.60	$687.00	17.6%	$102.40	3.4%
Gold	$723.88	$891.86	23.2%	$167.98	24.5%
Platinum	$855.79	$1,046.97	22.3%	$191.18	5.6%
Overall	**$673.33**	**$790.28**	**17.4%**	**$116.95**	**100.0%**

[1] These values do not match the values in the next table for 2022 premiums because these reflect averages based on 2021 plan selections, whereas the next table reflects actual 2022 plan selections.

STANDARD OF REVIEW

Pursuant to *8 V.S.A. §4062, 18 V.S.A. §9375(6),* and Green Mountain Care Board *Rule 2.000: Health Insurance Rate Review*, this letter is to assist the Board in determining whether the 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 2023 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 2022 versus 2023.

Exhibit 2a illustrates the assumed annual allowed and paid medical cost trends by benefit category for 2022 and 2023 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 180,000 individual member months) from ACA-compliant individuals. Adjustments were applied to adjust for incurred but not reported (IBNR) claims, pooling charges, paid medical/Rx trend, and other factors.

Exhibit 4 shows the development of the individual market single conversion factor of 1.044 using the distribution and the average contract size by tier derived from February 2022 enrollment data.

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

Exhibit 6 shows the calculations for the load on the On-Exchange Silver Plan to account for the defunding of the Cost Sharing Reductions (CSRs). The CSR adjustment is applicable for the individual market only. Exhibit 7 calculates final PMPM premiums based on the assumptions in the prior exhibits.

The "Loss Ratio Information" section of the Actuarial Memorandum demonstrates that the expected claims and premiums produce a projected traditional loss ratio of 91.0% for the individual market. After adjusting for taxes, fees, and Quality Initiatives, the 2023 federal MLR is projected to be 91.9% 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 2023 individual market rate increase of 17.4% 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 2023 PROPOSED RATE CHANGE

Rating Component[2]	Percentage Change[3]
1. 2021 Actual/Projected Claims Experience	+13.6%
2. Difference in Trend from 2021 to 2022	+0.2%
3. Trend from 2022 to 2023	+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	-0.5%
8. Changes to Risk Adjustment	-3.8%
9. Changes in Actuarial Value	+1.4%
10. Changes in Administrative Costs	-0.6%
11. Changes in Taxes & Fees	-0.1%
12. Changes in Contribution to Reserves	+0.4%
13. Changes in Single Contract Conversion Factor	-0.5%
Total Proposed Individual Rate Change	**+17.4%**

1. 2021 ACTUAL/PROJECTED CLAIMS EXPERIENCE: Actual 2021 claims experience for the individual market was about approximately 13.6% higher than the two-year-trended 2019 costs, projected in the 2022 filing. Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate.

2. DIFFERENCE IN TREND FROM 2021 TO 2022: In the 2022 filed rates, the assumed 2021 to 2022 trend was approximately 6.3%. MVP now projects a 2021 to 2022 allowed trend rate of approximately 6.6%. The primary driver of the increase is an increase in the assumed pharmacy trend, which increased from 8.6% in the final 2022 URRT to approximately 10.9% in the 2023 URRT.

   The trend development is discussed further in the next section.

3. TREND FROM 2022 TO 2023: The Company requested a total allowed trend for 2022 to 2023 of approximately 6.1%.

[2] 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.

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

2022 TO 2023 ALLOWED TRENDS

Cost Category	Total Allowed Trend
Medical	5.5%
Pharmacy	10.9%
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 5.5%, which is comprised 4.5% for unit cost changes and 1.0% for utilization changes.

MEDICAL UNIT COST TREND

MVP computed its allowed trend as a weighted average 2022 medical claim unit cost trends for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network. This approach is consistent with prior rate filings. These increases reflect the changes to the unit cost increases ordered by the Green Mountain Care Board during the Hospital Budget Review.

GMCB HOSPITAL BUDGET REVIEW

The overall unit cost medical trend of 4.5% includes:

1) a trend of 5.0% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and

2) a trend of 4.3% for other medical facilities and providers that are not subject to the Hospital Budget Review.

Since the fiscal year 2023 Hospital Budget Review is not yet finalized, MVP has assumed that hospital increases will match the fiscal year 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 40% 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 2023.

L&E believes utilizing recent hospital budget figures for the assumed unit cost trends is reasonable and appropriate. Once 2023 hospital budget requests are submitted, L&E recommends that this new information be considered.

MEDICAL UTILIZATION TREND

For the 2023 filing, MVP ran simulations in which trend values were aggregated at the service category level and adjusted for age/gender differences. This approach produced a very wide range

of forecasted utilization trends with a 10th percentile of -3.5%, a mean trend of 3.4%, and a 90th percentile of 10.3%. Since the simulation produced a volatile and wide range, MVP decided to assume a utilization trend of 1%, which is consistent with the 2021 and 2022 approved filings.

L&E performed a series of independent trend calculations using MVP's monthly normalized allowed medical claims cost PMPM data. L&E's analyses also resulted in a wide range of forecasted utilization trends, ranging from -4.6% to 12.5%. While MVP's membership has been more stable in recent years than in the past, L&E believes that the instability of market utilization due to the COVID-19 pandemic over 2020 (shutdown) and 2021 (recovery) has created an unreliable dataset for forecasting future 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 5.5% 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 2023 premium rate calculations.

PHARMACY TREND: The Company projected a 10.9% 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	-2.5%	2.6%	0.1%
Brand	5.2%	2.1%	7.4%
Specialty	5.0%	10.8%	16.3%
***Total*[4]**			***10.9%***

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.

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

[4] 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.

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.

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
2017/2016	11.1%	5.2%	+5.3%
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%
4-year Average	7.7%	10.8%	
3-year Average	6.2%	12.6%	

L&E notes the unusually large 2020 pharmacy trend, for which the largest driver was a large spike in specialty tier utilization of approximately 20%. L&E believes 2020 was an outlier year that should be mitigated and accounted for when considering future trends.

Based on recent historical trends and striking an appropriate balance for smoothing outlier years, L&E concludes that MVPs assumed Rx trend of 10.9% 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 0.0% morbidity adjustment, which is due to the projected impacts of COVID-19 vaccination and an expected decline in COVID-19 services (i.e., treatment, office visits, testing). The morbidity adjustment and its components for the 2022 and 2023 QHP filings are shown below.

BREAKDOWN OF POPULATION MORBIDITY ADJUSTMENT

	2022 QHP Filing (As Ordered)	2023 QHP Filing
ARPA	-0.2%	--
Increased Telehealth Utilization	0.3%	--
High-Cost Pooling	-0.8%	--
Decline in COVID-19 Services	--	-0.6%
COVID-19 Vaccinations	--	0.6%
Total Morbidity Adjustment	**-0.9%**	**0.0%**

AMERICAN RESCUE PLAN ACT (ARPA): 0.0%
Effective April 2021, federal legislation (ARPA) included a provision extending eligibility for ACA health insurance subsidies to households whose incomes are above 400% of the federal poverty level. The legislation states that this provision applies through 2022. This particularly impacted 2022 enrollment since open enrollment for 2021 had already expired when the legislation was enacted. Therefore, an adjustment was made in the prior filing regarding the morbidity impact of this legislation. Without any new legislation, this provision will expire prior to the onset of the 2023 rating year. Therefore, no adjustment is proposed for the impact of morbidity between the 2021 and 2023 rating years. L&E considers this to be reasonable. This results in a 0.2% increase to the rates

INCREASED TELEHEALTH UTILIZATION: 0.0%
In the prior filing, MVP applied an adjustment for increases in telehealth utilization that were remaining even after in-person services resumed. This was considered reasonable and was approved. Since the 2021 experience is used as the base period for 2023 rate development, the increased level of telehealth utilization is reflected in the base period experience. Therefore, no adjustment is proposed for any further increase in telehealth utilization between the 2021 and 2023 rating years. L&E considers this to be reasonable. This results in a 0.3% decrease to the rates

HIGH-COST POOLING: 0.0%
Historically, MVP has removed claims in excess of $100,000 and replaced them with a pooling charge based on a reinsurance contract. MVP is no longer engaged in this reinsurance contract due to the increased costs of the pooling charge compared to the level of high-cost claims. Therefore, there is no longer an adjustment for high-cost claims pooling. This is considered reasonable and appropriate based on the removal of the contractual arrangement. This produces a 0.8% rate increase.

DECLINE IN COVID-19 SERVICES: -0.6%
MVP analyzed the total expense in the experience period associated with COVID treatment, visits, and testing. After consultation with MVP's medical team, MVP assumed a 30% reduction in COVID costs in the projection period compared to the experience period. The total claims expenses PMPM for COVID-19 services in 2021 was $12.76, therefore a 30% reduction results in a removal of $3.83 PMPM. This produces a 0.6% rate decrease.

Additionally, costs are reduced for COVID-19 cost sharing changes included within section 9 of this report. Ultimately, the $12.76 PMPM observed in the experience period is decreased to an assumed $7.29 for the rating period. This is approximately a 43% reduction to COVID-19 treatment, visit, and testing costs overall. This is considered reasonable and appropriate.

COVID-19 VACCINATIONS: +0.6%
MVP assumed that in 2023 members will utilize the COVID-19 vaccine at a rate of 52%, receiving 1.4 vaccines per utilizing member and a unit cost of $104 per shot, based on CMS

projections[5]. These assumptions result in a projected PMPM cost of $6.31[6]. The PMPM cost of COVID vaccinations in the experience period was $2.65 PMPM. Therefore, the projection results in an additional cost of $3.66 PMPM for the projection period compared to the experience period. This produces a +0.6% rate increase.

MVP provided further information that the $2.65 PMPM cost of COVID-19 vaccinations in the experience period represented a utilization rate of 37%, 1.7 vaccines per utilizing member, and a unit cost of $39.31 per shot. L&E believes that the CMS source cited pertains specifically to the Medicare population and is not a more appropriate predictor for MVPs population than MVPs own experience and population behavior. L&E believes that the experience period cost of COVID-19 vaccinations, which gets trended to the rating period as part of the rating development, is a reasonable projection of COVID-19 vaccination costs for the rating period without an additional upward adjustment.

L&E recommends that the COVID-19 vaccine cost adjustment be removed. This recommendation decreases the rates by approximately 0.6%.

5. **DEMOGRAPHIC SHIFT:** The Company did not make any adjustments for demographic shifts in 2023. 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
2019	1.73
2020	1.75
2021	1.78
2022	1.79

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

6. **PLAN DESIGN CHANGES:** The plan design changes factor addresses any rate changes that are needed because members purchase products with different plan designs versus the prior year. This filing includes a 0.0% plan design adjustment which is consistent with the prior filing. Therefore, the estimated impact from plan design changes is 0.0%.

MVP is assuming no plan design changes from 2021 to 2023 that materially impact allowed costs. L&E considers MVP's assumptions to be reasonable and appropriate.

[5] https://www.cms.gov/files/document/2023-announcement.pdf

[6] (0.52*1.4*$104)/12=$6.31

7. **CHANGES TO OTHER FACTORS:** Last year's 'Other Factor' was 5.9% in total. This was listed in the 2022 filing as being comprised of 5.8% 'COVID-19 normalization factor' and 0.1% combined impact of the leap-year and the National High-Cost Risk Pool (HCRP). During the rate review process, MVP clarified that this breakdown was erroneous, and the factor actually consisted of a 0.1% combined impact of the leap-year and HCRP, -0.6% 'COVID-19 normalization factor', and a 6.4% 'paid-to-allowed normalization factor'. L&E outlines the prior year ordered 'Other Factor' breakdown, the prior year ordered/revised 'Other Factor' breakdown, and this year's filed 'Other Factor' breakdown in the following table.

BREAKDOWN OF OTHER FACTOR

	2022 QHP Filing (Ordered)	2022 QHP Filing (Ordered/Revised)	2023 QHP Filing	Report Section
HCRP Fee	+0.4%	+0.4%	+0.4%	7
HCRP Recovery	--	--	-0.8%	7
Leap Year	-0.3%	-0.3%	--	7
COVID-19 Normalization	5.8%	-0.6%	--	1
Paid-to-Allowed Normalization	0.0%	+6.4%	+9.7%	9
Total Other Factor	**+5.9%**	**+5.9%**	**+9.2%**	
Section 7 Total	**+0.1%**	**+0.1%**	**-0.4%**	

L&E included the COVID-19 normalization factor as part of the projected 2021 experience per the 2022 filing discussed in Section 1 of this report. This factor was intended to adjust for the fact that MVP developed rates using the 2019 base period trended an extra year rather than use the 2020 base period due to the impact of COVID-19 and was an approved methodology in the 2022 filing.

MVP's intention for the 'paid-to-allowed normalization factor' is to reflect the difference between MVP's actual paid to allowed ratio and what is implied by the actuarial value (AV) and induced demand used in rate development. MVP's pricing AVs and induced demand used in rate development are not intended to project true paid to allowed ratios, they are intended to represent the relativities between two or more benefit plans by the difference in their value. Since MVP prices using paid claims instead of allowed claims, the actual paid-to-allowed ratio is reflected in the paid claims. This normalization factor is a necessary adjustment to accurately populate the URRT.

During the rate review process, MVP proposed that this 'paid-to-allowed normalization factor' was more appropriately reflected in Worksheet 2 of the URRT, within the 'AV and Cost Sharing Design' line item. Per the URRT instructions, the Market Adjusted Index Rate in Worksheet 1 of the URRT should reflect a true expectation of allowed cost. Therefore, the AVs on Worksheet 2 should be adjusted such that they reflect the true projected paid-to-allowed ratios. L&E believes this revision is appropriate and notes that it has no impact on the

final rates. It only changes how this factor is reflected in the URRT, and therefore where this piece of the rate increase should be reflected in this report. In accordance with the movement of the 'paid-to-allowed normalization factor' to worksheet 2 of the URRT, this piece of the rate increase will be reflected as part of the change in actuarial value discussed in Section 9 of this report.

NATIONAL REINSURANCE POOL: +0.4%

The National High-Cost Reinsurance Pool (HCRP) reimburses carriers for 60% of members' paid claims above $1M in a given plan year. The program is aggregated at a nationwide level and a percentage of premium charge to each issuer is determined for the program. Based on a national study performed by Wakely Consulting Group, the estimated load for MVP individual market is approximately 0.4%. This is consistent with the HCRP load applied in the prior filing. This appears to be reasonable and appropriate.

EXPERIENCE PERIOD NATIONAL REINSURANCE POOL RECOVERY: -0.8%

MVP is expecting a recovery from the National High-Cost Reinsurance Pool (HCRP) for the 2021 base period for one member with incurred claims above the national threshold of $1M. This factor is decreasing the experience period allowed claims by approximately -0.8%. This appears to be reasonable and appropriate.

LARGE CLAIMS ADJUSTMENT: 0.0%

The following table outlines the total amount of claim dollars for claims greater than $200K from 2018 to 2021, before accounting for any HCRP recoveries.

HISTORICAL LARGE CLAIMS

Year	Large Claims (>$200K) Prior to HCRP Reimbursement	Members	PMPM
2018	$209,939	10,868	$19.34
2019	$399,199	14,491	$27.54
2020	$2,826,865	16,137	$175.18
2021	$4,237,835	15,371	$275.70
4-year Average	$1,918,440		
3-year Average	$2,487,940		

Since 2021 is the base period used for rate development, $4.2M in large claims is represented in the base period, $978K is removed via the adjustment HCRP recovery as discussed above. Therefore $3.3M remains in the base period and is projected forward into the rating period. Given the high level of large claims in 2020 and 2021 compared to 2018 and 2019, L&E believes it would be appropriate to adjust the base period claims to account for the higher-than-average amount of large claims. L&E recommends the $3.3M remaining after the expected HCRP reimbursement be reduced further to the 3-year unadjusted historical average of $2.5M. The three-year average strikes an appropriate balance for smoothing outlier years but still accounting for any recent changes that may be causing increased large claims that may remain into 2023. This is an additional reduction of approximately $4.29 PMPM which represents an approximate 0.7%

decrease to the rates.

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 needed to be collected from MVP members. MVP projected the expected 2021 risk adjustment transfer payment based on the most recent data available, which was CMS's interim risk adjustment report published in March 2022[7].

   Actual risk adjustment transfers were published[8] by CMS on June 30, 2022. Based on the report, MVP owes $13,209,383 in risk adjustment payments for the 2021 individual market benefit year.

   Prior to the publication of the recent report from CMS, L&E requested that both VHC carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports to compile them confidentially and to provide both carriers with an updated risk adjustment estimate for the unmerged market. This calculation indicated the following risk transfer payments for the unmerged individual market.

2021 ESTIMATED RISK ADJUSTMENT TRANSFERS (PAYMENTS)

Market	MVP Estimate	CMS Report
Individual	($13,300,000)	($13,205,875)
Catastrophic	($3,307)	($3,508)

   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 0.1% decrease to the 2023 premium rates.

9. **CHANGES IN ACTUARIAL VALUE:** The Change in Actuarial Value (AV) assumption reflects Pricing AV changes, such as changes in Metal AVs, induced utilization, and changes in projected enrollment among plans. This factor also reflects any changes to the Pricing AVs calculated by MVP. As discussed in section 7, this includes any adjustment to the Pricing AVs such that the true paid-to-allowed ratio is reflected rather than only what is implied by the AV and induced demand. The changes in actuarial value result in a 1.4% 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. For Silver plans, the actuarial value is adjusted for CSR funding. The adjustment is based on the experience period federal CSR funding PMPM. This is then adjusted for IBNR

[7] https://www.cms.gov/files/document/interim-ra-report-by2021.pdf

[8] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf

and trend, as a percentage of net claim costs. The induced utilization assumptions are sloped consistently with HHS's induced utilization factors.

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 0.00% to 0.07% depending on the specific plan. L&E considers this to be an immaterial impact to overall rates.

After this modification, L&E considers this methodology to be reasonable and appropriate.

10. **CHANGES IN ADMINISTRATIVE COSTS:** MVP is projecting 2023 general administrative costs to be $51.46 PMPM, which is an increase relative to the 2022 assumption of $47.10. However, the projected 2023 PMPM represents 6.5% of premium while the 2022 PMPM represents 7.1% of premium. Therefore, the overall rate impact is a decrease of 0.6%.

    MVP provided the actual 2021 administrative expenses, projected (approved) 2022 administrate expenses, proposed 2023 administrative expenses, per member per month, by expense category. This information is shown in the table below.

EXPENSES PMPM

Expense Category	2021 Actual Admin PMPM	2022 Projected Admin PMPM	2023 Proposed Admin PMPM
Personnel Expenses	$30.30	$26.17	$29.01
Software	$4.10	$3.60	$4.39
Consulting/Project Expenses	$6.53	$4.90	$5.15
All Other Admin	$10.78	$12.42	$12.91
Total	***$51.71***	***$47.10***	***$51.46***

    The assumed 2023 administrative costs are $8.74 PMPM higher than MVP's recent individual administrative costs as reported in the Company's 2019 to 2021 Supplemental Health Care Exhibits (SHCE). Over that three-year period, the administrative costs PMPM have averaged $42.72. In 2022, MVP began managing the billing and payment processing functions, which added an estimated $6.61 to the administrative expenses, as provided last year. When this additional PMPM is added to the three-year historical average, the resulting amount is consistent with the 2023 proposed administrative costs PMPM. L&E considers the assumed 2023 administrative costs to be reasonable and appropriate.

11. **CHANGES IN TAXES & FEES:** The expected rate change due to taxes and fees is a 0.1% decrease. 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 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 risk margin and a provision for bad debt. The CTR and its components for the 2022 and 2023 QHP filings are shown below.

BREAKDOWN OF CONTRIBUTION TO RESERVES

	2022 QHP Filing (As Ordered)	2023 QHP Filing
Bad Debt	0.4%	0.3%
Risk Margin	0.5%	1.5%
Total CTR	**0.9%**	**1.8%**

MVP provided the bad debt as a percentage of premium for each of the last 3 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 2023 rates, which is consistent with the 2022 rate filing.

The proposed risk margin of 1.5% is consistent with the risk margin that was proposed in the 2022 filing, but an increase from the ordered 2022 risk margin of 0.5%. The 2023 projected federal loss ratio using this CTR is 91.9%, which exceeds the statutory minimum MLR of 80%.

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

HISTORICAL RISK MARGIN

Year	Actual	Expected (As Ordered)
2019	-1.0%	1.5%
2020	4.4%	1.0%
2021	-11.1%	0.5%
Total	-7.7%	3.0%

As a reasonableness check of the proposed CTR provision, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs). In 2022, there were 442 carriers who submitted individual or small group ACA filings nationally. The filed CTR varied from -17% 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 2.4%. MVP's filed CTR of 1.5% would place it at around the 27th percentile for all QHP carriers.

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
2019	433.6%
2020	429.4%
2021	354.0%

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 5% of MVP's overall business[9]. 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[10] 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 2022 rate filing was 1.049. For this year's filing, MVP utilized February 2022 enrollment to calculate the 2023 single conversion factor of 1.044.

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

[9] Based on direct written premium amounts as reported in the 2021 SHCE.

[10] 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 2023 hospital budget requests are submitted, L&E recommends that this new information be considered in the unit cost assumption.

- **REMOVE COVID-19 VACCINATION ADJUSTMENT:** L&E believes that that COVID-19 vaccination costs included within the experience period data is a sufficient predictor of the rating period COVID-19 vaccination costs, without further adjustment. L&E recommends that the COVID-19 vaccine cost adjustment be removed. This recommendation decreases the rates by approximately 0.6%.

- **MOVE THE PAID-TO-ALLOWED NORMALIZATION FACTOR TO WORKSHEET 2 OF THE URRT:** L&E recommends that the paid-to-allowed normalization currently reflected in the 'other factor' on worksheet 1 of the URRT be moved to the 'AV and Cost Sharing Design' line item of worksheet 2 of the URRT, in accordance with the URRT instructions. This has no impact on the proposed rates.

- **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 0.1%.

- **LARGE CLAIM ADJUSTMENT:** L&E recommends that the base period claims be adjusted to account for the higher-than-average amount of large claims. This represents an approximate 0.7% decrease to the rates.

After the modifications, the anticipated rate change for the individual market is roughly +16.0%,[11] plus any impact from updated hospital budget information

[11] 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.

2023 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[12]	Percentage Change[13]
1. 2021 Actual/Projected Claims Experience	+13.6%
2. Difference in Trend from 2021 to 2022	+0.2%
3. Trend from 2022 to 2023	+6.1%
4. Changes to Population Morbidity Adjustment	+0.3%
5. Demographic Shift	+0.0%
6. Plan Design Changes	+0.0%
7. Changes to Other Factors	-1.2%
8. Changes to Risk Adjustment	-3.7%
9. Changes in Actuarial Value	+1.4%
10. Changes in Administrative Costs	-0.6%
11. Changes in Taxes & Fees	-0.1%
12. Changes in Contribution to Reserves	+0.4%
13. Changes in Single Contract Conversion Factor	-0.5%
Total Proposed Individual Rate Change	**+16.0%**

[12] 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.

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

Sincerely,

Traci Hughes, FSA, MAAA
Vice President & 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[14], 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[15], 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 & 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, 2022. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is June 29, 2022.

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,

[14] 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.

[15] 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 body of this report.

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

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

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