Contact Information

Company Information

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ACTUARIAL MEMORANDUM

2017 Vermont Exchange Filing

Purpose and Scope of Filing

This memorandum details the methods and assumptions underlying the proposed 2017 premium rates for the State of Vermont's Individual and SHOP Exchange. These products will be issued by MVP Health Plan, Inc. (MVP), a non-profit subsidiary of MVP Health Care, Inc. The rate filing has been prepared to satisfy the requirements of 8 V.S.A §5104 as well as the requirements of the Federal ACA including 45 CFR Part 156, §156.80. The premium rates are effective between 1/1/2017 and 12/31/2017. There are no benefit plans being retired, and there are no new plans being offered. MVP made uniform modifications to a number of the benefits being offered, and the updated forms have been submitted in a separate SERFF filing. The proposed rates reflect an average rate adjustment to prior rates of 8.8%, ranging from 3.5% to 13.5%.

Drivers of Rate Increase

The proposed premium rates reflect an increase over the prior rates due to medical inflation, experience period data not reflecting a full 12-month contract, and an aging population. Premium rate increases are varying by plan due to uniform benefit modifications of a number of benefits being offered as well as the impact of fixed PMPM non-claim costs on premiums that vary based on benefit level.

Market/Benefits

All benefit plans and rates included in this rate filing are available to both individuals and small employer groups. A description of benefits is included in Exhibit 1 of the rate filing. Exhibit 1A of the filing provides an overview of benefit changes for renewing plans from 2016 to 2017. All Essential Health Benefits (EHBs) are covered. Only one EHB substitution was made as required by the Department of VHA, a substitution for the $2,000 annual Private Duty Nursing benefit limit in the benchmark plan. MVP contracted Milliman to determine an actuarially equivalent visit limit. The supporting memorandum is included with the documents supplementing this filing.

The non-standard plans proposed by MVP and included in this rate filing include a wellness benefit in excess of the EHBs. This wellness benefit is included in all non-standard products and is filed as a mandatory rider, Form: FRVT-301.

To inform consumers of the availability and details of the products included in this filing, MVP will provide community outreach support as well as offer web and print product content and other printed product materials for VT plans. MVP will also have a mass media presence to further educate health care customers in Vermont.

The book of business affected by this rate filing is 2,987 policyholders, 4,354 subscribers and 6,614 members based on March 2016 membership.

Experience Period Premium and Claims (Worksheet 1, Section 1 of Unified Rate Review Template)

Worksheet 1, Section 1 of the Unified Rate Review Template contains MVP Health Plan, Inc. Small Group and Individual HMO Data for Vermont members over the time period 1/1/2015 – 12/31/2015, completed through 3/31/2016. All of the members included in this section are enrolled in ACA compliant plans.

MVP does not project to rebate consumers for 2015 dates of service, and therefore no adjustments were made to the earned premium amount reflected on Worksheet 1, Section 1 of the Unified Rate Review Template. The earned premium shown reflects the amount of premium MVP collected from groups and individuals over the experience period.

Allowed claim data includes claims from our fee for service (FFS) claim warehouse along with additional medical expenses not captured in the claim warehouse such as: payments associated with medical home, physician incentive payments, FFS write-offs and net reinsurance expenses.

An allowance for incurred but not reported paid claims (IBNR) was added to the experience period fee-for-service (FFS) medical claims. IBNR files were supplied directly from MVP's reserving actuary. MVP uses a combination PMPM and completion factor method to develop IBNR estimates, and Vermont specific data for the experience period was used to develop the factors. The fee-for-service experience period claims were reconciled with the IBNR lag triangles to ensure accuracy.

A summary of experience period claims processed through MVP's claim system, experience period costs not processed through MVP's claims system, as well as an estimate of IBNR are summarized below for the claims shown in Worksheet I, Section I of the URRT.

	Allowed	**Incurred**
Claims Processed Through Claim System	$28,763,920	$22,523,130
Experience Period Costs Not Processed Through Claims System	$921,644	$883,478
IBNR	$572,941	$455,543
Total	$30,258,505	$23,862,151

<u>Benefit Categories (Worksheet 1, Section 2 of Unified Rate Review Template)</u>

MVP determines benefit category based on the type of claim form submitted in conjunction with the code and type of code attached to the claim form (i.e. ICD-9, Diagnosis Code, or HCPCS). Member encounter data is used to determine utilization for claims falling under the "Other" category.

<u>Projection Factors (Worksheet 1, Section 2 of Unified Rate Review Template)</u>

Other Adjustment for Experience Period vs Projection Period Membership Characteristics

This adjustment represents the change in the HHS age factor for March 2016 membership enrolled in ACA compliant plans compared to the experience period ACA compliant enrollment. MVP is assuming the projection period enrollment will equal March 2016 enrollment. As a result, an adjustment is being made to the claim projection to account for changes in the average HHS age factor between the experience period and the current snapshot.

<u>Medical Trend Factors</u>

The assumed unit cost trends reflect known and assumed price increases from MVP's provider network. Consistent with recently submitted filings, MVP is applying 0% utilization trend to its data. Regression analysis has been performed on MVP's utilization data in the past, and it was concluded that the predictive ability of the historical utilization trends was weak and not reliable.

<u>Rx Trend Factors</u>

Annual allowed Rx trend factors split by generic, brand, and specialty drugs are provided by MVP's PBM and were determined using MVP specific data over the experience period by drug class. The forecast provided by MVP's PBM account for drugs coming off patent, changes in average wholesale price, new drugs being released to the market, and price competitiveness amongst generic and brand drug manufacturers.

<u>Credibility Manual Rate Development (Worksheet 1, Section 2 of Unified Rate Review Template)</u>

MVP Health Plan, Inc. and MVP Health Insurance Co. historical claim data was the basis of the premium rate development. Non-ACA compliant and ACA compliant individual and small employer group data, association data, and large employer groups with 51-100 employees are included in the experience period data set used to develop premium rates. MVP combined the experience of these separate pools of data to form a more credible experience

base. In aggregate, the claim data is assumed to be fully credible. The experience period data complies with the single risk pool requirement of the Federal ACA.

Because MVP's experience period membership shown in Worksheet 1, Section 1 does not fully reflect this population, the claims not reflected in that section which are being used in MVP's premium rate development are reflected in the credibility manual.

MVP determined the credibility weights between the two sections of URRT data based on the membership enrolled in each of these populations over the experience period.

A portion of the index rate claims are covered under a capitation arrangement. The cost associated with these claims reflects the PMPM payment MVP will owe its capitated vendors in 2017.

Paid-to-Allowed Ratio and Membership Projection (Worksheet 1, Section 3 & Worksheet 2, Section 4 of Unified Rate Review Template)

MVP projects a 77.5% paid-to-allowed ratio in 2017. MVP's projection period membership equals the March 2016 enrollment of the population eligible to purchase these products, or 9,730 members. On Worksheet 2 of the URRT, members currently enrolled in non-ACA compliant plans are mapped to ACA compliant plans using the actuarial value of the member's current plan using MVP's benefit relativity model and the product type of the member's current benefit (QHDHP vs non-QHDHP). Members were then mapped to the ACA compliant plan of the same product type with the actuarial value closest to their current plan.

After mapping members to products in the projection period, MVP then computed the weighted average projected claim expense PMPM. The resulting PMPM was compared the projection period Allowed Experience Period Claims PMPM to derive the paid to allowed ratio for 2017.

Federal Risk Adjustment Program

For 2014 dates of service, MVP paid $44.58 PMPM into the risk adjustment program. MVP compared its 2014 ACA compliant membership to its 2015 ACA compliant membership and determined that 80.6% of the 2015 members were enrolled in MVP's ACA compliant plans in 2014. Additionally, MVP reviewed VHC enrollment figures from December 2014 and December 2015 and determined that the overall market has not changed substantially; there were 67,677 members enrolled in VHC in December 2014 vs 68,045 members in December 2015. Because MVP's membership in ACA compliant plans has not changed materially and the total market membership has not changed substantially between 2014 and 2015, MVP does not anticipate its relative risk position to change from being a payer to a receiver from 2014 to 2015 dates of service. That being said, it is worth noting that risk scores are heavily influenced by months of enrollment, and 2014 data is heavily skewed by the extended open enrollment period where many members did not enroll until May. Because of the factors described above and the uncertainty caused by the extended open enrollment period in 2014, MVP is assuming a risk adjustment payment equal to 2/3 of the 2014 risk adjustment payment PMPM, or $29.42.

Index Rate and Premium Rate Development

The experience period index rate of $466 is equal to AR44 small group and individual HMO allowed claim data for the time period, 1/1/2015 – 12/31/2015, completed through 3/31/2016. The single risk pool projection period index rate is $506.60. These amounts reflect the cost of EHBs over the applicable time periods. The projection period index rate reflects the market-wide adjustment discussed above in the section labeled, "Projection Factors".

The market adjusted index rate for the projection period equals $543.63. This value was computed by adjusting the projection period index rate for the federal risk adjustment program and marketplace user fees. Please see above for

details on the computation of the projected value of the risk adjustment program. The market adjusted index rate reflects the average demographic characteristics of the single risk pool.

Plan Adjusted Index PMPM rates

Plan adjusted index rates are calculated by multiplying the market adjusted index rate times the AV pricing value. The AV pricing value reflects the impact of benefit value, induced utilization, benefits in addition to EHBs, the catastrophic plan adjustment, and the value of non-claim expenses. Please see below for details regarding actuarial values, induced utilization, and non-claim expenses reflected in 2017 premium rates.

Note the AV pricing value does not reflect the expected actuarial value of benefits being offered. Because the market adjusted index rate does not reflect the impact of administrative costs and the AV pricing value accounts for these costs, many of the AV pricing values seen on Worksheet 2 are greater than 1.00.

Actuarial Values and Induced Utilization Factors

The AV Metal Level for each plan was determined using the Federal prescribed Actuarial Value Calculator. Adjustments for aggregate deductibles, the VT Rx OOPM, and safe harbor prescription Rx benefits were made to the calculator results for the non-standard gold HDHP and non-standard bronze HMO plans. The actuarial certification of these adjustments has been included.

The Benefit Actuarial Value for each plan was determined using MVP's in house benefit pricing tools. The pricing tools value the expected net paid claim cost associated with unique benefit plan designs from a starting single risk pool allowed amount. The AV is the ratio of the expected paid to allowed amount for each plan design. MVP did not reflect any induced utilization in the projection of the net paid amounts for each unique benefit plan.

The induced utilization factors used to set premium rates and compute the average inforce induced utilization factor are sloped to comply with the HHS prescribed induced utilization factors of 1.00 for Bronze, 1.03 for Silver, 1.08 for Gold, and 1.15 for Platinum.

Non Claim Expense Plan Level Adjustments

Non claim expenses include both percent of premium loads and PMPM loads. The loads do not vary by plan. Each Standard and Non Standard plan is being loaded with the same PMPM and Percent of Premium loads. The loads are outlined below.

Federal Taxes PMPM based

A total of $0.33 PMPM is added for fees MVP must pay to the Federal Government per ACA regulations on a PMPM basis and includes the following taxes: $0.13 HHS risk adjustment user fee and $0.20 Patient Centered Outcome Research Fee.

State Taxes PMPM based – Assessment to Fund Health Care Advocate

Recent legislation has been proposed which will assess carriers and hospitals to fund the Health Care Advocate. The total assessment equals $510,000 with 24.2%, or $123,420, of it being funded by health insurance companies licensed under 8 V.S.A. Chapter 101. The assessment will be allocated amongst carriers under this license based on earned premium. MVP reviewed the earned premium reported on the 2015 Supplemental Health Care Exhibits for carriers under this license and estimates that MVP will be responsible for 56.7% of the assessment, or approximately $70,000. Based on MVP's March 2016 total commercial enrollment in the State of Vermont, $0.49 PMPM is being added to the proposed premium rates for this assessment.

Federal Taxes Premium based
The ACA Insurer Tax is being suspended for 2017 dates of service. Due to the one year suspension of this fee, there is no charge reflected in the proposed 2017 premium rates for this tax.

State Taxes Premium based – VT Vaccine Assessment
This load reflects a Vermont state assessment based on plan premiums used to fund immunizations provided by the state. The load of 0.5% is based on MVP's current charge for this program.

General Administrative Expense Load (Including QI component)
The total administrative expense load included as a plan level adjustment is unchanged from the 2016 Exchange filing and equals $36.60 PMPM. This amount includes $1.50 PMPM to provide an expanded network to members purchasing exchange products in VT through a partnership with PHCS. The remaining $35.10 PMPM is used to cover SG&A expenses as well as Quality Improvement/Cost Containment Programs (QI). Based on an analysis of MVP's 2015 expenses, 10% of MVP's total administrative expense was spent on QI. Therefore, $3.51 PMPM of the $35.10 PMPM administrative expense is attributable to QI.

The following table summarizes the administrative expenses for small group and individual lines of business from the 2013, 2014, and 2015 Statutory Supplemental Health Care Exhibits (SHCE).

Combined VT AR42 and AR44	Year	SHCE Admin PMPM*
Individual	2013	$39.37
Small Group	2013	$47.28
Combined	2013	$46.57
Individual	2014	$45.43
Small Group	2014	$43.01
Combined	2014	$43.87
Individual	2015	$36.66
Small Group	2015	$34.04
Combined	2015	$35.15

**Reflects lines 1.07, 6.6, 8.3, 10.1, and 10.4 of SHCE, Part 1*

Contribution to Reserves/Risk Charge
MVP is building a 1% contribution to reserves/risk charge into the VT Exchange premium rates for 2017. This charge is added to premium rates to meet statutory reserve requirements for MVP's VT block of business and protect against adverse experience relative to pricing assumptions.

Bad Debt Expense
A plan level adjustment equal to 0.40% of premium was added to account for non-payment of premium risk. This charge is unchanged from the 2016 Exchange filing and is consistent with MVP's historical experience for this block.

Rider FRVT-301 (Wellness Benefit in Addition to EHBs)
Members purchasing a non-standard plan will receive MVP's Member Wellness Incentive (Form: FRVT-301). This benefit provides adult members with up to $50 per year in incentives. MVP projects the net cost of this benefit to equal $0.07 PMPM and is unchanged from the cost of this rider in 2016.

Catastrophic Plan Adjustment
An additional plan level adjustment was applied to the catastrophic plan to account for the unique age eligibility requirements as permitted by the Federal ACA Rules. MVP did not reflect the fact that individuals facing financial

hardship could also qualify to enroll in this plan. As of March 2016, 43 of the 45 members enrolled in this plan meet the age qualification for enrollment (< 30 years old).

MVP determined the adjustment factor for this plan by calculating the HHS Age factor for the eligible population and comparing it to the HHS Age factor of the experience period membership. The eligible population was assumed to be any member under the age of 30 that was not attached to a subscriber age 30 or older. It was assumed that a member under the age of 30 and attached to a subscriber age 30 or older would enroll as a dependent in a non-catastrophic plan. The eligibility adjustment factor is equal to 0.642.

Catastrophic Plan Level Adjustment	
	HHS Age Factor
Ages 0-29, Meeting Subscriber Qualifications	1.039
Single Risk Pool Total	1.619
Catastrophic Adjustment	0.642

Per Contract Premium Rates

The Plan Specific Gross Claim Cost PMPMs are converted to per contract premium rates using the computed single conversion factor and the prescribed standard load ratios.

The single conversion factor (SCF) was calculated using subscriber and member data by contract type for the eligible population enrolled with MVP as of March 2016. The SCF = weighted average contract size/ weighted average load ratio.

Loss Ratio Information

The traditional target loss ratio (claims cost / premium) for the rates proposed in this rate filing is 90.3%. After making adjustments for taxes/assessments and expenses associated with quality improvements, the Federal target loss ratio for the rates proposed in this filing is 91.6%.

Target Loss Ratio for 2017 VT Exchange	
A) Claims Expense	$433.34
B) Taxes/Assessments	$3.22
C) Quality Improvement	$3.51
D) Premium	$479.87
E) Traditional Loss Ratio *= A) / D)*	90.3%
F) Federal Loss Ratio *= [A) + C)] / [D) - B)]*	91.6%

Terminated Products

There are no products being terminated.

Warning Alerts

There are no Warning Alerts being generated.

Actuarial Certification

I, ███████████, am a Member of the American Academy of Actuaries. The projected Index Rate and Adjusted Paid Amount used in the development of these proposed premium rates is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and developed in compliance with the applicable Actuarial Standards of Practice. I have examined the assumptions and methods used in determining MVP's requested rates. Based on my review and examination, it is my opinion that the proposed premium rates are reasonable in relation to the benefits provided and that they are not excessive, nor inadequate, nor unfairly discriminatory. They are developed using only the permitted rating classifications. The Adjusted Paid Amount and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The Standard AV Calculator was used to determine the Metal AV Value to be show in Worksheet 2 of the Part I Unified Rate Review template for all the plans. The EHB portion of premium reflected in Worksheet 2, Sections 3 and 4 was calculated in accordance with actuarial standards of practice.

The URRT does not demonstrate the process that was used to develop premium rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases and for certification that the Index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I certify that I am knowledgeable as to the Vermont laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits.

I am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the PPACA and the HCERA of 2010.

I certify that each rate filing has been prepared in accordance with the following Actuarial Standards of Practice; ASOP #5, ASOP#8, ASOP #12, ASOP #23, ASOP #25, ASOP#41, ASOP#42, ASOP#45, and ASOP#50.

MVP Health Care, Inc.