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July 30, 2014

Green Mountain Care Board
State of Vermont
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: MVP Health Plan 2015 Exchange Filing (SERFF # MVPH-129560321)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2015 Exchange Filing for MVP Health Plan, Inc. (MVP) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP provides individual and small group coverage to be sold on Vermont Health Connect (VHC).

2. This filing develops premiums to be used on VHC beginning January 1, 2015.

3. This filing addresses MVP individual members and small groups. There are approximately 5,000 lives affected.

4. The overall impact of this filing is a proposed average 15.3% or $87.95 per member per month (PMPM) increase in premiums. This average increase broken down by metal level is:

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	11.0%	$21.99	2.1%
Bronze	17.1%	$79.20	44.6%
Silver	14.4%	$85.71	35.1%
Gold	15.5%	$118.33	5.2%
Platinum	13.2%	$122.29	13.0%
Overall	***15.3%***	***$87.95***	***100.0%***

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.

Summary of the Data Received
MVP provided the methodology used to calculate the proposed 2015 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including manual rate development and adjustments, trend, administrative costs, taxes and fees.

Exhibit 2a illustrates the assumed allowed medical cost trend by benefit category for 2014 and 2015, annual paid trend that accounts for leveraging impact, and the utilization/unit cost trends for prescription drugs by drug category.

Exhibit 2b illustrates the application of pharmacy trends by drug category to experience period Paid PMPM in development of projected pharmacy Paid PMPM.

Exhibit 3 shows the index rate development starting from MVP's experience period claims (encompassing 204,962 total member months from small group EPO, small group PPO, small group HMO, small group HDHPs, and individual indemnity products). Adjustments were made for incurred but not reported paid claims, pooling charge, paid medical trend, benefit changes (such as expanded benefits due to EHB requirements and mandates), and population morbidity changes.

Exhibit 4 shows the development of single conversion factor of 1.165 using tier distribution and average contract size by tier derived from the experience period.

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

MVP provided additional exhibits in quantitative support as requested during the rate review process.

L&E Analysis
The average proposed 15.3% increase to the 2014 premiums is attributed to several factors including trend, contract tier distribution assumptions, and changes to federal programs. To create a consistent comparison for both companies filing VHC products, we categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component[1]	Percentage Change[2]	PMPM Change[3]
1. 2013 Actual/Projected Claims Experience	2.1%	$8.34
2. Difference in trend from 2013 to 2014	1.2%	$4.80
3. Trend from 2014 to 2015	6.6%	$27.38
4. Change to Population Risk Adjustment	0.0%	$0.00
5. Change to Other Factor	-0.9%	-$4.03
6. Changes to the Federal Transitional Reinsurance Recoveries	-0.2%	-$0.70
7. Changes in Administrative Costs	0.4%	$1.83
8. Changes in Contribution to Reserves	1.1%	$5.00
9. Changes in Taxes & Fees	0.3%	$1.31
10. Changes in Single Contract Conversion Factor	0.6%	$2.70
11. Changes in all other Pricing AV factors	3.3%	$14.92

1. *2013 Actual/Projected Claims Experience:* To project future claims, MVP used the same general approach in 2015 as in 2014 in developing the starting point for the projected claims. Adjustments to the starting point included changes applicable to the 2015 filing, such as removal of non-applicable groups and using a pooling charge for large claims.

   The 2015 Exchange filing used the 2013 experience claims data from MVP's small group EPO, small group PPO, small group HMO, small group HDHPs, and Individual Indemnity products. This year, MVP excluded the Catamount and Agriservices groups because these members will not be on VHC for 2015. In 2015, MVP made an adjustment to the experience period claims to account for large claims. This adjustment stabilizes the experience claims to ensure that any catastrophic claims do not skew projections. This process has been used in other non-Exchange filings this year.

   The claims experience from the 2014 Exchange filing to the 2015 Exchange filing represents a 2.1% increase in 2015 premiums. Before the application of trend, morbidity, and other factors, we believe the starting claims experience and these adjustments to be reasonable and appropriate.

2. *Difference in trend from 2013 to 2014:* The trend from 2013 to 2014 in the 2015 URRT is 6.6%. This trend is higher than the projected trend from 2013 to 2014 utilized in the 2014 URRT by 1.2%. We note that the facility trend factors reflect the 2014 hospital budget approved by the Board. The higher trend from 2013 to 2014 in this rate filing can be attributed partly to higher physician trend factors, which reflect the revised contract with a major provider group

[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 increases are multiplicative and do not sum to the requested 15.3% premium increase.

[3] The PMPM changes do not add up to the overall average PMPM of $87.95 quoted on Page 1 because the PMPM changes seen in this table incorporate the Single Contract Conversion Factor change.

following the termination of its contract in April 2014. We find the development of this trend to be reasonable and appropriate.

3. *Trend from 2014 to 2015:* Medical trend and pharmacy trend will be outlined in the following sections:

   - *Medical Trend:*

     The Company projected a 6.6% allowed medical trend. To evaluate the reasonableness of the Company's trend development, we combined all of the allowed medical claims for the prior 36 months and modeled 12-month rolling PMPM claims using an exponential regression.

     Our analysis resulted in an allowed medical trend of 7.4%, which is higher than the Company's requested allowed medical trend. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. Our estimated allowed trend range is 6.7% to 8.2%. Each of the numbers within our estimated range are not equally likely, that is, the trends on the low and high end are not as likely to occur as the trends in the middle of the range.[4]

     The Company's proposed value of 6.6% is lower than our best estimate and falls slightly below the estimated range. Since actual results will vary from projected amount due to random fluctuations and unpredictable changes in the market, we consider the Company's requested allowed medical trend to be reasonable and appropriate.

     The effective medical trend reflects MVP's paid trend and is derived from its proposed allowed cost trend rates and the impact of cost share leveraging[5]. The medical claims were projected forward to the midpoint of the rating period using a 7.7% annual effective medical trend. We consider the Company's assumed effective medical trend to be reasonable and appropriate.

   - *Pharmacy Trend:*

     MVP uses the best estimates of pharmacy trend factors, split by drug category (Traditional vs. Specialty), as supplied by its pharmacy vendor in developing its effective pharmacy trend of 9.0%. The annual trend factors for generic/brand drugs and specialty drugs, as provided by MVP's new pharmacy vendor, did not account for MVP's Vermont specific book of business, given the partnership with this vendor is new. We consider this to be a limitation on the reasonableness of their trend assumption.

[4] For example, the probability that the actual trend will be centered on the best estimate (between 7.3% and 7.5%) is 50% higher than being near the low end of the range (between 6.4% and 6.6%).

[5] 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

As in prior non-Exchange filings, MVP has not used historic pharmacy claim experience to form assumptions for future pharmacy trends as they believe prior experience is not indicative of future trends. For comparison purposes, we analyzed 36 months of MVP's historic pharmacy trend experience. An average of the rolling 12 month allowed pharmacy trends experienced from January 2013 through December 2013 is -1.9%[6]. We recognize due to other factors, such as shifts in generic dispensing rates, drugs losing patents, and changes in pharmacy vendors, historical trends may not be indicative of future trends.

In absence of better information, we recommend using a Vermont-specific pharmacy trend of 8.4%[7].

4. *Change to Population Risk Adjustment:* The Company is applying a 2% morbidity improvement factor (consistent with GMCB's decision and order from MVP's 2014 Exchange filing) to its projection of experience period data. In absence of statistically credible data to support modifying this assumption, we find using the same factor to be reasonable and appropriate.

5. *Change to Other Factor:* The Other Change projection factors reflect anticipated demographics, benefits being removed (such as optional riders for coverage of elective abortion and vision benefits), addition of new EHB benefits, and the impact of pooling claims in excess of $100,000. The overall change from the prior filing results in a 0.9% rate decrease.

   We note that the change in demographics between the experience period and the projected 2015 rating period was not accounted for in the Other Change projection factors. We find the lack of demographic adjustment to be inappropriate because it does not comply with the definition of index rate as defined in 45 CFR Part 156.80(d)[8]. We note that the Company does not agree with our opinion regarding this issue.

   Given MVP's 2014 actual enrollment is the basis for the 2015 projected enrollment, we believe it is appropriate to incorporate this information in the development of the index rate. We recommend applying a demographic adjustment factor of 1.028. This will result in an overall Other Factor adjustment of 1.8%. Please note as a result of this recommendation, the calculation of the single contract conversion factor will also be modified (see #10 below).

[6] This reflects allowed pharmacy cost trend and not paid pharmacy claim cost trend that reflects net plan payment after copays and other member cost-sharing.

[7] This Rx trend is used by Vermont's largest carrier based on state-specific experience.

[8] 45 CFR Part 156.80(d) requires that a health insurance issuer establish an Index Rate for each (or combined) market annually. The Index Rate for a market is based on the total combined claim costs for providing Essential Health Benefits within the single risk pool for that state market. In the URRT, the index rate should reflect the EHB portion of projected allowed claims divided by all *projected* single risk pool lives.

6. *Changes to the Federal Transitional Reinsurance Recoveries:* MVP developed the anticipated payments from the reinsurance pool by analyzing claims in the reinsurance corridor from the calendar years 2011, 2012, and 2012, after trending claims to the projection period. MVP's reinsurance recovery development incorporates the proposed, but not official, attachment point of $45,000 in the Final Rule, dated May 27, 2014.

   The average reinsurance, as percentage of FFS claims, is lower for 2015 partly due to change in reinsurance parameters. Since the Company will only receive reinsurance payment for individual members, the assumed percent of individual members can also affect the reinsurance recovery assumption. As of April 2014, 61.3% of enrollees in ACA-compliant plans were individuals, which is higher than the 33.4% assumed in the 2014 rate development. Based on these two changes, the Company expects the net reinsurance recoveries to increase in 2015. As a result, the 2015 premiums will decrease by -0.2%. The following chart illustrates the differences in reinsurance recovery development in 2014 and 2015:

	2014 Rate Filing	2015 Rate Filing
Lower Attachment Point	$60,000	$45,000
Higher Attachment Point	$250,000	$250,000
% of claims reinsured between attachment points	80%	50%
Average reinsurance as % of FFS Claims	-11.0%	-7.6%
Projected % of individual membership	33.4%	61.3%
Impact of Reinsurance Pool	-3.7%	-4.7%

   As a result of the likelihood and the history[9] of HHS implementing modified reinsurance parameters, we find the use of the proposed parameters to be reasonable and appropriate.

7. *Changes in Administrative Costs:* The general administrative load (including quality improvement expenses) of 9.75% (or $39.10 PMPM) is equal to the administrative load assumed in the 2014 Exchange filing. In addition to the general administrative load, MVP added a $1.50 PMPM in 2015 as an access fee associated with a rental network. The rental network was added to provide an expanded network to members purchasing exchange products in VT. As a result of this additional network fee, the 2015 premiums increased 0.4%. We consider the administrative cost changes to be reasonable and appropriate.

8. *Changes in Contribution to Reserves:* MVP's assumed contribution to surplus of 1.5% in this rate filing is higher than the 0.5% approved by the Board for MVP's 2014 Exchange filing. As stated in the reinsurance section, the Company utilized the proposed, but not

[9] The original attachment point in 2014 was $60,000, but was later reduced to $45,000 after the 2014 premiums were finalized.

official, reinsurance parameters in the Final Rule. If these parameters are not ultimately adopted by HHS, the Contributions to Reserves would be negatively impacted. We do not recommend any changes to the Contribution to Reserves, but the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

9. *Changes in Taxes & Fees:* The total change for taxes and fees is 0.3%. This increase is due to the VT vaccine pilot assessment increasing slightly from 2014 by0.3%. No other changes were made in the other taxes and fees. These assumptions appear to be reasonable and appropriate.

10. *Other Changes:* The single conversion factor[10] used in the 2014 rate filing was 15.8%. For this year's filing, MVP utilized 2013 enrollment to calculate the 2015 single conversion factor of 16.5%.

    We do not believe the change in enrollment should be included in the conversion factor (calculation. As indicated in #5 above, we believe that the projected demographic change should be included in the index rate calculation. Based on the 2014 actual enrollment, we calculated a single conversion factor of 9.8%. The actual 2014 enrollment shows there are lesser parent/child(ren) and family tier enrollment, when compared to the experience period. The average contract size has reduced from 1.79 in the experience period to 1.53 in the projected period, resulting in a decrease to the single conversion factor. We recommend that the single conversion factor be changed to 9.8%. We note that the Company does not agree with our opinion regarding this issue.

11. *Changes in all other Pricing AV factors:* This reflects other Pricing AV changes such as changes in Metal AVs of plans and changes in projected enrollment among plans. The assumed 2015 distribution is more heavily weighted towards richer plans. Since the 2015 plan distribution is based on actual 2014 Exchange enrollment, we find this to be reasonable and appropriate.

Recommendation

After modifications, 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:

- Reduce Pharmacy trend from 9.0% to 8.4%;
- Increase the projected index rate by 2.8% to account for changes in demographics;
- Reduce the single contract conversion factor from 1.165 to 1.098.

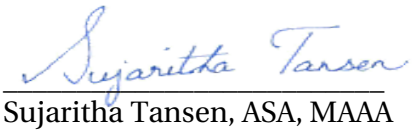
[10] The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, the tiered premiums require the base premium to be for a single adult.

After the modifications, the anticipated overall rate increase will reduce from 15.3% to 11.6% (or $66.45 PMPM).

Plan	**Proposed Rate Change**	Modified Rate Change	Percent of Membership
Catastrophic	11.0%	7.5%	2.1%
Bronze	17.1%	13.4%	44.6%
Silver	14.4%	10.8%	35.1%
Gold	15.5%	11.8%	5.2%
Platinum	13.2%	9.5%	13.0%
Overall	***15.3%***	***11.6%***	***100.0%***

Plan	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	$21.99	$14.88	-$7.11	2.1%
Bronze	$79.20	$61.66	-$17.54	44.6%
Silver	$85.71	$63.87	-$21.85	35.1%
Gold	$118.33	$90.12	-$28.21	5.2%
Platinum	$122.29	$88.56	-$33.73	13.0%
Overall	***$87.95***	***$66.45***	***-$21.50***	***100.0%***

Sincerely,



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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations11, 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 Conduct12, 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:

- Rita Tansen, ASA, MAAA, Associate Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents
The date of this document is July 30, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 17, 2014.

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 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.
- Lewis & Ellis 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.

[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.

- 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.

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