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April 8, 2016

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

Re: MVP Health Insurance Company
 3Q/4Q 2016 Small Group HIC Grandfathered rate filing
 SERFF Tracking #: MVPH-130435575

The purpose of this letter is to provide a summary and recommendation regarding the proposed small group filing submitted by MVP Health Insurance Company (MVPHIC) for its grandfathered high deductible EPO/PPO products for the third and fourth quarters of 2016 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. This filing demonstrates the premium rate development of MVPHIC's small group grandfathered EPO/PPO product portfolio comprising high deductible health plans (HDHP) and includes proposed rates for both the third and fourth quarters of 2016. Small groups who hold grandfathered products have coverage issued prior to March 23, 2010 and have not had substantial changes to their benefits.
2. This is a closed block of business. As of January 2016, 1,950 members were enrolled in the plans impacted by this rate filing. Of those 1,950 members, 134 members have a 3Q contract effective date, and 233 members have a 4Q contract effective date.
3. This rate filing is requesting a quarterly rate change of:

Quarterly Rate Change		
Small Group PPO/EPO	3Q16	4Q16
Medical + Rx	9.6%	0.4%

The requested quarterly rate increases, seen above, would result in the following annual rate changes for

1st quarter group renewals and 2nd quarter group renewals, when combined with prior approved filings:

Small Group PPO/EPO	Annual Rate Change						Annual 3Q16	Annual 4Q16
	4Q15	1Q16	2Q16	3Q16	4Q16			
Medical + Rx	1.7%	-2.9%	1.0%	9.6%	0.4%	9.3%	7.9%	

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

MVPHIC provided the methodology used in premium rate development (Exhibit 3) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim and membership summary for 34 months grouped into rolling 12 month periods, pricing trend assumptions (Exhibit 2), conversion factor and tier ratios (Exhibit 4), retention expenses (Exhibit 5), and additional supporting exhibits as requested during review of the filing.

Company's Analysis

1. ***HDHP Rate Development:*** MVPHIC utilized grandfathered small group HDHP claim data for the period from November 2014 through October 2015 and paid through December 2015 as the base period experience.

Exhibit 3 illustrates both the claim projection from the experience period to the rating period and also the accompanying adjustments applied in deriving the rates for 3Q16.

From the historical experience, claims in excess of \$100,000 were replaced with a pooling charge. The pooling charge reflects the average cost of claims in excess of \$100,000 and is based on historical experience. In addition, one member's utilization of the Hepatitis C drug, Harvoni, was removed from the data. Including these claims would result in a rate increase that is 2.2% higher than the requested increase.

The adjusted claims were projected forward to the midpoint of the rating period using an annual paid medical trend assumption of 3.5% (elaborated further in item 2 below). The paid medical trend is derived from the proposed allowed cost trend rates and the impact of cost share leveraging¹. The prescription claims were projected forward to the midpoint of the rating period using an annual paid Rx trend of 16.3% (elaborated further in item 3 below).

The trended cost was adjusted to reflect the impact of enrollment growth/termination. The experience period begins in November, while many groups have their renewal date in January. A number of groups or individuals did not renew their coverage, resulting in a disproportionately large share of the experience covering the months of November and December. The proposed rates will be effective for an entire year for all groups electing coverage, so an adjustment is necessary. The months of November and December are generally more expensive than the rest of the year, so the experience period claims were reduced by approximately 0.5%. This adjustment is clearly documented and appears actuarially sound.

The adjusted and trended claim cost was further increased to reflect fees and administrative costs (elaborated in item 4 below):

¹ 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.

- Fees and surcharges representing 1.25% of expected claims,
- Retention expenses of 10.25% (made up of
 - General administrative expense of 8.0%,
 - Bad debt expense of 0.25%, and
 - Contribution to surplus of 2.0%.
- Premium taxes of 2.0%,
- ACA Insurer tax of 2.0% during 2016 and 0% in 2017,
- VT vaccine pilot charge of 0.5%,
- Transitional reinsurance fee of \$2.25 PMPM for 2016 and \$0.00 PMPM for 2017, and
- Patient-Centered Outcomes Research Institute (PCORI) Fee of \$0.18 PMPM.

The proposed expected claim liability PMPM was also adjusted for the single conversion factor² change (derived using January 2016 membership distribution) to derive the gross claim cost for 3Q16. The required premium revenue PMPM for 3Q16 was compared to the 2Q16 premium rates for the membership underlying the experience period to determine the required quarterly rate change of 9.6%.

This filing is the first MVPHIC small group grandfathered filing to include an adjustment for population aging. The average age in January 2016 is 0.2 years older than the average during the experience period. The weighted average HHS age factor was used to adjust for this change, resulting in a 1.02% increase in the proposed rates.

MVPHIC developed the 4Q16 premium by applying one more quarter of trend to the experience period claims resulting in required quarterly rate change of 0.4%.

2. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVPHIC's provider network. Consistent with recently submitted filings, MVPHIC is utilizing a 0% utilization trend to its data. MVPHIC opines that based on regression analysis of its utilization data in the past, the predictive ability of the historical utilization trends was weak and not reliable.

The table below illustrates the trend factors for various benefit categories:

Annual Allowed Cost Trend			
Service Category	2015	2016	2017
Inpatient	5.3%	5.1%	5.1%
Outpatient & Other Medical	4.7%	4.0%	4.0%
Physician	2.9%	0.0%	0.0%
Total Medical Trend	4.2%	2.9%	2.9%

The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims paid by the carrier and the policyholder) and do not reflect effective paid trends, which reflect the actual claim payment by carrier only. MVPHIC adjusted the allowed cost trends illustrated above to account for the impact of cost share leveraging and derived the annual effective paid medical trend factor of 3.5% from the experience period to the rating period. This effective paid trend factor is used to trend the claim experience from the experience period to the rating period in calculating the projected claim cost for the

² The conversion factor adjusts premium that is developed on a PMPM basis to be on a tiered (single, double, parent/children, family) 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.

rating period. For this filing, twenty months of trend were used to trend the experience period claims forward.

3. *Rx Trend:* MVPHIC is requesting the annual allowed trends illustrated in the chart below:

	2015 Trend		2016 Trend		2017 Trend	
	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Generic	4.30%	3.40%	3.00%	2.20%	3.00%	2.40%
Brand	13.50%	-11.40%	13.50%	-4.40%	13.50%	-6.00%
Specialty	16.00%	5.00%	12.00%	6.00%	12.00%	4.00%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 16.3%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (through the use of deductible, copay and coinsurance).

MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor and did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is relatively new.

4. *Administrative Expenses:* As in the prior approved filing, projected taxes, assessments and retention are added to projected net claims to develop the gross cost for the projection period. The retention charges include 8.0% of premium for general administrative expense. This is consistent with the 1Q/2Q filing. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 1Q/2Q16 filing, such as the ACA Insurer fee and VT Paid Claim Tax.

L&E Analysis

1. *Rate Development:* During our analysis of MVPHIC's rate development methodology, we reviewed the assumptions and adjustments made to the experience data set for large claims and expense loads. We also reviewed the projected loss ratios and how these amounts compared to the company's historical experience.

The base period experience used in this filing has only two months of claims run-out, whereas previous filings have generally used three months of run-out. This necessitated a modification to the IBNR (Incurred but Not Reported) reserve factor. The updated base period was used consistently in both this filing and the 3Q/4Q Large Group filing, and the IBNR adjustment appears to be actuarially sound. Using only two months of run-out allows MVP to use the most current claims data. This change in methodology appears to be reasonable and appropriate.

We note that MVPHIC's loss ratio for the small group market in the experience period (November 2014 – October 2015) was 98.3%, which exceeds the minimum loss ratio requirement of 80%. The unadjusted medical loss ratio for this grandfathered group for the experience period is 95.0%.

MVPHIC's 2015 anticipated traditional loss ratio and federal medical loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) for this grandfathered block, as illustrated below, exceed the

minimum loss ratio requirement. The projected loss ratio has increased due to the reduction in insurer taxes and phasing out of the reinsurance fee.

Projected MLR		
Projection Period	Traditional Loss Ratio	Federal Loss Ratio
3Q 2016	86.5%	90.2%

We note that MVPHIC has modified their rating methodology to use current snapshots of enrollment distribution by age and tier to adjust for changes in enrolled population characteristics since the experience period. The single conversion factor increased by 0.41%, and the age factor increased by 1.02%. We believe that both of these adjustments are appropriate and reflect real, observed population changes. We anticipate that this new methodology will be used on all future filings for this block.

We find all other adjustments to the projected claim costs to include benefit mandates, taxes, and ACA related costs to be reasonable and appropriate.

MVPHIC's rate development methodology appears to be reasonable and appropriate.

2. *Medical Trend:* The annual effective paid medical trend factor of 3.5% assumed in this filing represents the most up-to-date provider contracting information available at the time of the filing, resulting in slight changes from prior filings. In particular, there is more run-out in the underlying claims data, and MVP has negotiated new provider contracts since the Exchange filing.

We consider the development of 2016 medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. Projected 2017 trends are assumed to be equal to 2016 trends. Given the lack of new information, we find this assumption to be reasonable as well. However, we expect future filings to update this assumption as 2017 provider reimbursement is finalized.

The methodology for combining multiple years of trend, however, did not take into account the changing mix of services over time due to trend. At L&E's recommendation, MVP has decided to make a slight modification to their trend methodology to reflect this change. The impact to this filing is an increase in the proposed rates of 0.1%.

Given that MVPHIC is assuming a 0% utilization trend, we note that if higher utilization is actually materialized in the rating period, then future rate increases could be higher than anticipated. With the modification above, the proposed medical trends appear to be reasonable and appropriate.

3. *Rx Trend:* MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor and did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor began in 2015. We consider MVPHIC's approach of using Rx trends from its vendor without accounting for its Vermont specific block of business to be a limitation on the appropriateness of their proposed Rx trend assumption.

The pharmacy vendor provides low, best, and high estimates of Rx trends. MVP has chosen to use the "low" estimates. In recent years, actual MVP drug trends have been observed to exceed even the high estimate from the PBM in many cases. For this reason, while we believe that MVP specific trend calculations would be more accurate, we do not think that using the PBM's low estimate national trend projections lead to

unreasonable premium rates. MVP has indicated that their historical data will be used to calculate Rx trends for the 2017 Exchange filing. It is our opinion that this methodology should be used in all filings from that point forward.

As a result of our review of another MVP filing, it was discovered that the 2015 Rx trends used in this filing did not include an intended adjustment for the conversion to the new vendor in 2015. If this adjustment were included, the annual paid Rx trend would decrease by approximately 0.3%, resulting in a decrease in the overall proposed rates of approximately 0.1%.

We recommend that MVP make this change to the Rx trend assumption.

4. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.0% to be lower than the actual expense of 8.5% for all markets as illustrated in MVPHIC's 2014 Supplemental Health Care Exhibit. If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

The assumed administrative load of 8.0% of premium is consistent with the previously approved 1Q/2Q 2016 filing. We assessed that MVPHIC's assumed general administrative load to be slightly lower than the actual expense ratio for the small group products, as illustrated in the Supplemental Health Care Exhibits:

Administrative Expense Summary for Small Group Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2010	186,297	\$344.28	\$39.71	11.5%
2011	209,126	\$348.79	\$34.17	9.8%
2012	190,795	\$365.29	\$37.24	10.2%
2013	178,794	\$394.67	\$46.56	11.8%
2014	64,143	\$411.16	\$33.39	8.1%

If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

The proposed contribution to surplus is 2.0%. In recent orders, the Board has reduced the proposed contribution to surplus. We recommend that the solvency analysis performed by DFR be considered if changes are made to this assumption.

The administrative expense assumptions appear 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:

- Modify the allowed trend assumption to incorporate the year-over-year change in cost distribution resulting from category-specific cost trends. This modification would add approximately 0.1% to the 3Q16 rate change and have no material impact on the 4Q16 rate change.
- Modify the Rx trend assumptions to reflect the one-time cost savings associated with switching to a new PBM in 2015. This modification would decrease in the overall proposed rates by approximately 0.1%.

The above changes effectively offset each other, and result in a minimal impact on the proposed rates. The anticipated rate changes with these modifications are outlined below and will likely be equal to the original proposed rate changes.

Modified Quarterly Rate Change		
Small Group PPO/EPO	3Q16	4Q16
Medical + Rx	9.6%	0.4%

Modified Annual Rate Change		
Small Group PPO/EPO	3Q16	4Q16
Medical + Rx	9.3%	7.9%

Sincerely,



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



David M. Dillon, FSA, MAAA, MS
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations³, 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 Conduct⁴, 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:

- 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 April 8, 2016. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 17, 2016.

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.
- 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.

³ 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.

⁴ These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

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.