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October 4, 2016

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

Re: MVP Health Insurance Company
1Q/2Q 2017 Small Group HIC Grandfathered rate filing
SERFF Tracking #: MVPH-130681893

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 first and second quarters of 2017 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 first and second quarters of 2017. In order to be considered a grandfathered plan, the small groups must have their 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 June 2016, 1,933 members were enrolled in the plans impacted by this rate filing. Of those 1,933 members, 1,263 (65%) members have a 1Q contract effective date, and 305 (15%) members have a 2Q contract effective date. The remaining members (20%) have contract effective dates in 3Q and 4Q.
3. This rate filing is requesting a quarterly rate change of:

| Quarterly Rate Change | | |
|-----------------------|-------|------|
| Small Group PPO/EPO | 1Q17 | 2Q17 |
| Medical + Rx | -0.8% | 2.3% |

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 1Q17 | Annual 2Q17 |
|------------------------|--------------------|------|------|-------|------|------|----------------|----------------|
| | 2Q16 | 3Q16 | 4Q16 | 1Q17 | 2Q17 | | | |
| Medical + Rx | 1.0% | 8.3% | 0.4% | -0.8% | 2.3% | 9.0% | 10.5% | |

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 28 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 AR42 claim data for the period from May 2015 through April 2016 and paid through June 2016 as the base period experience. Groups that have terminated coverage as of June 2016 were removed from the experience period data, as they will not be eligible to renew coverage in the rating period.

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 1Q17.

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 3.5% 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 3.1% (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 16.7% (elaborated further in item 3 below).

The trended cost was adjusted to reflect the impact of enrollment growth/termination. The experience period begins in May, while many groups have their renewal date in January. The proposed rates will be effective for an entire year for all groups electing coverage, so an adjustment is necessary. The experience period claims were increased by approximately 0.2%. This adjustment was based on the expected variation in claims by policy month. MVP updates these factors periodically to reflect the relationship between claims trend and deductible suppression. This adjustment is clearly documented and appears to be actuarially sound.

The adjusted and trended claim cost was further increased to reflect fees and administrative costs (elaborated

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.

in item 4 below):

- Fees and surcharges representing 1.25% of expected claims,
- Retention expenses of 10.65%:
 - General administrative expense of 8.4%,
 - Bad debt expense of 0.25%, and
 - Contribution to surplus of 2.0%.
- Premium taxes of 2.0%,
- ACA Insurer tax of 0.0% for 1Q renewals and 0.75% for 2Q renewals,
- VT vaccine pilot charge of 0.5%,
- Patient-Centered Outcomes Research Institute (PCORI) Fee of \$0.20 PMPM.
- Health Care Advocate assessment of \$0.49 PMPM

The proposed expected claim liability PMPM was also adjusted for the single conversion factor² change (derived using June 2016 membership distribution) to derive the gross claim cost for 1Q17. Consistent with the prior filing, rates were also adjusted for observed changes in the covered population's average age since the experience period. The average age in January 2016 is 0.3 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 1.01% increase in the proposed rates.

The required premium revenue PMPM for 1Q17 was compared to the 4Q16 premium rates for the membership underlying the experience period to determine the required quarterly rate change of -0.8%. MVPHIC developed the 2Q17 premium by applying one more quarter of trend to the experience period claims resulting in required quarterly rate change of 2.3%.

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 unit cost trend factors for various benefit categories:

| Service Category | 2016 | 2017 |
|---------------------------------------|-------------|-------------|
| Inpatient | 4.1% | 5.1% |
| Outpatient & Other Medical | 3.5% | 4.4% |
| Physician | -3.1% | 1.4% |
| Total Medical Trend | 1.4% | 3.5% |

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 3.1% 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 rating period. For this filing, twenty months of trend were used to trend the experience period claims

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.

forward.

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

| | 2016 Trend | | 2017 Trend | |
|------------------|------------|-------------|------------|-------------|
| | Unit Cost | Utilization | Unit Cost | Utilization |
| Generic | -12.6% | 3.4% | -3.2% | 3.1% |
| Brand | 10.4% | -2.2% | 17.3% | -1.9% |
| Specialty | 10.9% | 10.3% | 11.7% | 7.9% |

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 account for MVPHIC's Vermont specific book of business.

The annualized effective paid trend derived from the requested allowed trends in the chart above is 16.7%, 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).

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 8.4% of premium for general administrative expense. This is a slight increase over the 3Q/4Q filing's assumption of 8.0%. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 3Q/4Q16 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 and therefore, needed to be adjusted for claims incurred but not reported ("IBNR"). 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 and is consistent with MVP's other recent filings, including the prior filing for this block.

We note that MVPHIC's loss ratio for the small group market in the experience period (May 2015 through April 2016) was 94.8%. The federal MLR used to determine if this block is required to pay a rebate for calendar year 2015 is 97.0%.

MVPHIC's 2017 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 |
| 1Q 2017 | 86.7% | 89.9% |

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 0.4%, and the age factor increased by 1.0%. 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 3.1% 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 medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. L&E has reviewed the methodology used to combine the assumptions by service category and year into a single trend assumption, and found it reasonable.

The 20 months of trend used for 1Q rates is reasonable, as most first quarter renewals occur on or near January 1st. However, renewals during 2Q are distributed throughout the quarter, resulting in an average coverage date that is more than 3 months after that of 1Q renewals. MVP has applied only 3 months of trend to 1Q rates to obtain 2Q rates, which is reasonable. However, we note that it would also be reasonable to apply 4.2 months of trend, equal to the average period of time between the first and third quarter renewal dates. MVP has indicated that this would correspond to a 0.6% increase to 2Q rates and has chosen not to implement this methodology. As such, L&E does not recommend this modification at this time. We recommend that MVP consider making this modification in the future to ensure adequate premium for second quarter renewals.

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. Experience on this block will have limited credibility for trend calculation purposes. MVP has provided experience on the Exchange population demonstrating that utilization trend appears to be approximately zero for all service categories. The use of 0% utilization trend is reasonable.

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 account for MVPHIC's Vermont specific book of business. These drug trends differ noticeably from the PBM's national assumptions, which were used in prior filings for this block. In particular, the generic cost trends are substantially lower than assumed previously. We believe this is indicative of the value in using carrier-specific data in projecting Rx trends.

In support of previous filings, the pharmacy vendor has provided low, best, and high estimates of Rx trends. MVP has chosen to use the best estimates. In recent years, actual MVP drug trends have been observed to exceed even the high estimate from the PBM in many cases.

4. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.4% is higher than the actual expense of 8.2% for the small group AR42 and AR44 markets as illustrated in MVPHIC's 2015 Supplemental Health Care Exhibit. Because this is a closed block, MVP anticipates that administrative costs will increase relative to premiums due to declining membership. We note that the 8.2% expense ratio achieved in 2015 was the result of material efforts to decrease expenses in recent years, (see table below) and believe the projected 8.4% of premium is reasonable.

| Administrative Expense Summary for Small Group Products | | | | |
|---|---------------|--------------|------------|---------------|
| | Member Months | Premium PMPM | Admin PMPM | Expense Ratio |
| 2012 | 190,795 | \$365.29 | \$37.24 | 10.2% |
| 2013 | 178,794 | \$394.67 | \$46.56 | 11.8% |
| 2014 | 87,545 | \$3410.60 | \$38.11 | 9.3% |
| 2015 | 53,993 | \$416.49 | \$34.04 | 8.2% |

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 1Q17 rates do not include an allowance for the Health Insurer fee, due to the one-year moratorium for 2017. The assumed 0.75% Insurer Fee for 2Q 2017 reflects a 2.0% of premium assumption for coverage months in 2018. As the average 2nd quarter enrollment date is approximately May 11th, approximately 4.37 months of the policy year will take place in 2018, when the fee is expected to be reinstated. The insurer fee assumption is supported and reasonable.

The administrative expense assumptions appear to be reasonable and appropriate.

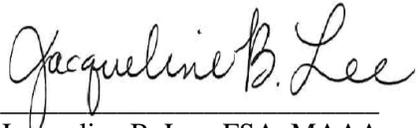
Recommendation

L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing as proposed.

Sincerely,



Kevin Ruggeberg, ASA, MAAA
Associate Actuary
Lewis & Ellis, Inc.



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



David M. Dillon, FSA, MAAA, MS
Vice President & Principal
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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:

- Kevin Ruggeberg, ASA, MAAA, Associate Actuary at Lewis & Ellis, Inc. (L&E)
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal 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 October 4, 2016. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is October 4, 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.