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October 7, 2016

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

Re: 1Q17 – 2Q17 MVPHIC Large Group EPO/PPO Rates
 SERFF #: MVPH-130682523

The purpose of this letter is to provide a summary and recommendation regarding the large group filing submitted by MVP Health Insurance Company (MVPHIC) for its existing EPO/PPO experience-rated 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 large group EPO/PPO product portfolio, comprising of both high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and includes proposed rates for both the first and second quarters of 2017.
2. The proposed rates in this filing will affect approximately 2,234 Vermonters. Of these 2,234 members, 2,179 have a first or second quarter policy effective date.
3. The average requested quarterly manual rate changes are seen below, alongside previously approved rate changes. The annualized rate changes for 1st quarter group renewals and 2nd quarter group renewals are in the second chart.

Reason for Change	2Q16 / 1Q16	3Q16 / 2Q16	4Q16 / 3Q16	1Q17 / 4Q16	2Q17 / 1Q17
Manual Rate Change	1.2%	-11.8%	1.3%	-4.0%	1.6%
Age/Gender Factor Changes	0.0%	2.9%	0.0%	0.9%	0.0%
Change in Target Loss Ratio	-1.2%	-1.6%	-0.8%	2.0%	0.9%
Total Revenue Changes¹	0.0%	-10.5%	0.5%	-1.1%	2.5%

¹ Due to rounding, the quarterly revenue changes are approximate.

Reason for Change	1Q17 Annual	2Q17 Annual
Manual Rate Change	-13.2%	-12.9%
Age/Gender Factor Changes	3.9%	3.9%
Change in Target Loss Ratio	-1.4%	0.6%
Total Revenue Change	-11.1%	-8.9%

For all medical plans, the quarterly manual rate change is the same. Some plans had benefit modifications in the previous filing and have correspondingly different annual revenue changes. Rider rates are decreasing by the same manual rate percentages, excluding a small number of riders which have never been purchased.

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 2a-2h, Exhibit 3a, and Exhibit 3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim data (split by HDHP and Non-HDHP products) and the membership summary for 36 months grouped into rolling 12 month periods, pricing trend assumptions, experience rating formula (Appendices A-C), and additional supporting exhibits, as requested during review of the filing.

Company's Analysis

1. *Rate Development:* MVPHIC utilized large group claim data (constituting HDHP and EPO/PPO products) for the period from May 1, 2015 through April 30, 2016 and paid through June 30, 2016 as the base period experience. Certain groups were excluded from this analysis because they are not eligible to purchase this product in the future or did not purchase this product in 2016.

Exhibit 3a illustrates both the claim projection from the experience period to the rating period and 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. The run out for the experience period is two months.

The adjusted claims were projected forward to the midpoint of the 1Q17 rating period using an annual paid medical trend assumption of 3.0% (elaborated further in item 3 below). MVPHIC's paid medical trend is derived from its proposed allowed cost trend rates and the impact of cost share leveraging². The prescription claims were projected forward to the midpoint of 1Q17 rating period using an annual paid Rx trend of 13.1% (elaborated further in item 4 below).

² 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.

The trended claim cost was further adjusted to develop the projected claim costs as of 1Q17. These adjustments included projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting all of these adjustments, the quarterly manual rate change suggested by the data was a decrease of 8.0%. MVPHIC has requested that only half of this manual rate change (-4.0%) be implemented. MVP stated in the actuarial memorandum that this proposal is based on the volatility generated by a high turnover rate and on a desire to reduce premium fluctuations. MVP also stated that their rates are materially lower than their primary competitor and that they would like the manual rate to be more reflective of the average market risk.

MVPHIC developed the 2Q17 manual rate by applying one more quarter of trend to the experience period claims. This results in a quarterly rate increase of 1.6% in 2Q17.

2. *Age/Gender Factor Changes:* The rates for this product depend on the demographics of the covered population. The base manual rate projection described above does not take into account changes in demographics. Therefore, it does not reflect the change in the average demographic factor that results from a younger or older enrolled population. Since the prior filing, the demographics of this block have been observed to deviate from past expectations. The demographic factors were re-normalized to reflect the updated experience and increased by 0.9%.
3. *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:

Service Category	2016	2017
Inpatient	4.1%	5.1%
Outpatient & Other Medical	3.5%	4.4%
Physician	-3.1%	1.4%
Total Medical Trend	1.3%	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 a total effective paid medical trend factor of 3.0% annually. 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 forward to 1Q17.

4. *Rx Trend:* MVPHIC is requesting the annual allowed trends illustrated in the chart below, split by calendar

year and by drug tier:

Tier	2016 Trend		2017 Trend	
	Unit Cost	Utilization	Unit Cost	Utilization
Generic	-11.2%	3.4%	-2.7%	3.2%
Brand	15.8%	-5.2%	17.1%	-2.2%
Specialty	8.2%	9.5%	9.1%	8.1%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 13.1%, which blends the allowed trends and accounts for cost sharing by the insured (through the use of deductible, copay and coinsurance). This blended annualized figure is used to trend the experience period claim costs to the projection period. For this filing, twenty months of trend were used to trend the experience period claims forward.

MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor. Those trend factors reflect MVP's business in the state of Vermont and are notably different from the nationwide trends provided by the PBM prior to using MVP's data.

5. *Change in Target Loss Ratio (Administrative Expenses)*: As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The retention charges include 9.7% of premium for general administrative expense. This is an increase of 1.7% from the 3Q16/4Q16 filing. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 3Q16/4Q16 filing, such as the VT Paid Claim Tax. The assumed expenses reflect the one-year moratorium on the ACA Insurer Tax in 2017 and removal of the Temporary Reinsurance Pool fee for 2017 dates of service.

The decrease in administrative expenses and the federal fees result in a rate change of -1.4% in 1Q 2017.

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 ratio and how the loss ratio compared to the company's historical experience. For this block, the 2015 Federal MLR is 90.0%. After a substantial manual rate increase in the first quarter of 2016, rates are being brought back down and should satisfy statutory requirements.

Projection Period (LG in 1Q 2017)		
Period	Traditional MLR	Federal MLR
1Q 2017	83.1%	86.4%

The pooling charge of 9.2% assumed in this filing is unchanged from the prior filing. Recent experience has had fewer catastrophic claims than are assumed in this charge. We agree with MVP's assessment that the assumption is reasonable given the long-term experience on this block. We also note that the percentage of claims over \$100,000 is expected to grow with time due to medical trend. We are not making any recommendations at this time, but we will monitor this assumption closely in future filings.

The adjustment to base period experience for IBNR (Incurred but Not Reported) reserves appear reasonable. Consistent with MVP's other recent filings, data with two months of runout was used in developing these

rates. 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.

The proposed rate increase is being applied equally to all medical plans. In effect, this means that the benefit relativities (i.e. the ratio of the premiums between MVP's plans) are based on data that is not current. MVP has indicated that the current relativities were calculated based on claims data from calendar year 2012. In response to an L&E inquiry on this topic, MVP stated that the factors are not being changed due to the size of the block and to minimize the impact on renewing groups. While we do not recommend a change to the benefit relativities in this filing, we note that it would be prudent for MVP to perform an analysis to determine if this approach is still appropriate after 5 years to limit the possibility of mispricing.

The experience data, trend projections, and other claim cost projections support a more substantial rate decrease than is being proposed in this filing. As in the 3Q/4Q filing, MVP is requesting that the rate decrease be reduced from what is suggested by the data due to volatility. MVP consistently excludes groups from rate calculations if they have terminated coverage with MVP since the base period. In recent years, the groups that have terminated coverage have had very different claims experience than groups that retained coverage with MVP. This may indicate that the experience period claims in this filing are not representative of the entire population that is eligible to purchase this product.

MVP also provided an analysis indicating that their primary competitor in this market pays substantially more in claims on a PMPM basis. Due to complicating factors like age, benefit/network differences, and experience rating, it is difficult to reach solid conclusions based on this comparison. However, we note that the proposed 2017 rates are materially lower than the 2016 rates and agree with MVP that the entire rate decrease suggested by the trended experience would increase the likelihood of significant premium fluctuations in subsequent filings. To address the concern of targeting manual rates representative of the market-wide average risk, we recommend MVP consider using the entire experience period in future filings, rather than excluding terminated groups. While we do not recommend any changes to the proposed methodology for this filing, we believe that MVP should perform an analysis for future filings to assess whether a reduced decrease approach is still appropriate.

When rating groups of certain sizes, MVP's current rate manual uses a "manual rate cap", which effectively applies greater credibility to the experience for groups with abnormally high or low claims. This approach is atypical, and we believe this methodology should continue to be monitored closely. Since the previous filing, no groups have been quoted with rates that relied on the manual rate cap. We do not recommend action until better information is available regarding the impact this methodology has on Vermonters.

2. *Age/Gender Factor Changes:* Since the previous filing, the average age/gender factor of the covered population has been observed to decrease by 0.9%. If this change were not corrected for, this would result in inadequate revenue being collected. To account for this change, MVP has increased all age/gender factors by the necessary 0.9% to maintain the necessary premium level. When combined with the normalization from the prior filing, this results in an annual increase to the age/gender factors of 3.9%. The age/gender normalization methodology appears to be reasonable and appropriate.
3. *Medical Trend:* We consider the development of medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. We consider the 3.0% annual medical paid trend assumption to be reasonable and appropriate.

MVP assumed no increases or decreases in the utilization of medical services. Experience on this block will have limited credibility for utilization 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.

4. *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.

In previous filings, the pharmacy vendor has provided low, best, and high estimates of Rx trends. MVP has chosen to use the low estimates in the past, while this filing incorporates the PBM's best estimates. In recent years, actual MVP drug trends have been observed to exceed even the high estimate from the PBM in many cases. In addition, the trends are now based on the unique distribution of drugs that MVP provides in Vermont. As such, we believe the use of the best estimate is appropriate and reasonable.

Due to data limitations, MVP is using the same average drug rebate in 2017 as in 2016. As prescription drugs continue to make up a greater portion of the total cost, more sophisticated analysis may be warranted in future filings.

5. *Change in Target Loss Ratio (Administrative Expenses)*: We observed that MVPHIC's assumed general administrative load of 9.7% to be higher than in the previous filing. This increase on a percentage basis is consistent with the decrease in revenue. The administrative load appears to be reasonable.

The proposed contribution to surplus is 2.0%. In some past orders, the Board has reduced the proposed contribution to surplus from 2.0% to 1.0%. Due to the relatively small size of the block, L&E recommends that the assumption not be reduced to protect the company from inherent volatility.

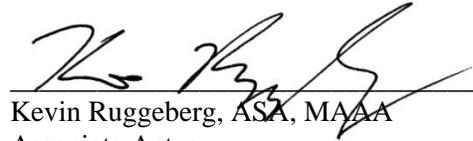
The reduction in the estimated federal fees appears to be reasonable and appropriate, given that the health insurer fee was reduced for 2017. For policies issued in 2Q 2017, the insurer fee will be non-zero due to the coverage including part of 2018. If the Insurer Fee resumes for 2018, rate increases can be expected as the result of the increased need for revenue.

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
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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 J. Rugeberg, 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 7, 2016. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is October 7, 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.