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November 7, 2016

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

Re: MVP VT LG HMO Filing 1Q/2Q 2017 - Abbreviated Report  
 SERFF #: MVPH-130720563

The purpose of this letter is to provide an abbreviated summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP) for its existing HMO products for the first and second quarters of 2017 and to assist the Board in assessing whether to approve, modify, or disapprove the request. We are performing an abbreviated review because currently no policyholders are affected by this filing.

***Filing Description***

1. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio, and includes proposed rates for both the first and second quarters of 2017.
2. There are currently no members enrolled in these plans. The proposed rate increase would only affect Vermont large groups which purchased HMO coverage from MVP during the first half of 2017.
3. The requested change in the manual rate is not based on the most recent experience. The proposed manual rates are equal to the prior manual rates plus one year of trend. The prior manual rate was approved for 3Q/4Q 2016.
4. The requested first and second quarter manual rate changes are seen below, as well as other changes to premium calculations that affect the overall revenue change.

Reason for Quarterly Change	1Q17 / 4Q16	2Q17 / 1Q17
<b>Manual Rate Change</b>	1.1%	1.1%
<b>Age/Gender Factor Changes</b>	0.9%	0.0%
<b>Changes in Retention</b>	2.0%	0.0%
<b>Total Revenue Change</b>	<b>4.1%</b>	<b>1.1%</b>

The quarterly rate changes above result in annual revenue changes below.

Reason for Annual Change	1Q17 / 1Q16	2Q17 / 2Q16
<b>Manual Rate Change</b>	5.5%	6.6%
<b>Age/Gender Factor Changes</b>	3.9%	3.9%
<b>Changes in Retention</b>	-1.3%	-1.3%
<b>Total Revenue Change</b>	<b>8.2%</b>	<b>9.3%</b>

### ***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 in premium rate development (Exhibit 2a-2d, Exhibit 3a, and Exhibit 3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes the experience rating formula and all applicable rating factors, including industry factors and plan design factors.

### ***Company's Analysis***

1. *Rate Development:* MVP utilized large group HMO claim data for the period from May 1, 2015 through April 30, 2016 and paid through June 30, 2016 as the base period experience. This data set included 1,399 member months.

The adjusted claims were projected forward to the midpoint of the 1Q17 rating period using an annual paid medical trend assumption of 2.7%, and prescription claims were projected forward to the midpoint of 1Q17 rating period using an annual paid Rx trend of 10.3%.

The trended claim cost was further adjusted to develop the projected claim costs as of 1Q17. These adjustments include projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting all of these adjustments, the manual rate change suggested by the data is a 19.0% increase. Due to credibility concerns, MVP has requested that the manual rates increase by one quarter of trend, or 1.1%, relative to the previously approved 4Q 2016 rates.

MVP developed the 2Q17 manual rate by applying one more quarter of trend to the experience period claims. This results in a rate increase of 1.1% in 2Q17.

2. *Age/Gender Factor Changes:* There is no current enrollment on this block, and the age/gender factors from the 1Q/2Q 2017 PPO filing were used. These factors are 0.9% higher than the factors previously approved for the HMO products.
3. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Consistent with recently submitted filings, MVP is utilizing a 0% utilization trend to its data. MVP 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 allowed cost trends illustrated 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. MVP adjusted the allowed cost trends to account for the impact of cost share leveraging and derived a total effective paid medical trend factor of 2.7% annually.

4. *Rx Trend:* MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

Tier	2016 Trend		2017 Trend		2018 Trend	
	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
<b>Generic</b>	-11.2%	3.4%	-2.7%	3.2%	-2.7%	3.2%
<b>Brand</b>	15.8%	-5.2%	17.1%	-2.2%	17.1%	-2.2%
<b>Specialty</b>	8.2%	9.5%	9.1%	8.1%	9.1%	8.1%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 10.3%, 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.

MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVP'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. *Retention Assumptions:* Retention incorporates all non-claim expenses built into the proposed rates, including administrative costs and contribution to surplus. As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The Experience Rating Addendum contains all expenses that will be added to the projected claims to calculate total premium. The retention charges include 9.7% of premium for general administrative expense. This is a rate increase of 2.0% from the 3Q/4Q16 filing. A line item has been added for the Health Care Advocate assessment, accounting for \$0.49 PMPM. 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. These three changes have an approximate net rate impact of 0%. In total, the premium impact of all changes to retention is an average increase of 2.0%.

### ***L&E Analysis***

1. *Rate Development:* During our analysis of MVP's rate development methodology, we reviewed the assumptions and adjustments made to the experience data set for large claims and expense loads.

The base period experience used in this filing has two months of claims run-out. 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 methodology appears to be reasonable and appropriate.

2. *Age/Gender Factor Changes:* The age/gender factors proposed in this filing are 0.9% higher than the previously approved factors, due to changes in the enrollment mix of members enrolled in the PPO product. MVP has stated that they wish to use the same factors for the HMO and PPO product. However, this factor change would result in a premium increase that is not actuarially supported. A similar change occurred in

the previous filing, when the age/gender factors were increased by 2.9%. Combining these two factor changes, the rates are being increased by a total of 3.9%. In response to a Lewis & Ellis objection, MVP acknowledged that the re-normalization of the age/gender factors in this filing and in the previous filing have contributed to proposed rate increases on this block that are higher than the assumed trend.

To illustrate this impact, we consider a situation where there is no trend. In this case, the premium rate should not change. The age/gender factor for a single female aged 28 was 0.86 in the 1Q 2016 manual rate calculation. In this filing, the proposed factor is 0.893. This factor is applied to the manual rate to determine projected claims. If the manual rate was \$300 PMPM, the impact on the projected claims for a 28-year-old female would increase by from \$258 to \$268. This increase is not caused by trend or any other change that would be expected to impact HMO claim costs. In this case, a change is necessary to return the claim cost to \$258.

We recommend that the HMO manual rate be reduced by 3.9% to offset the 3.9% increase in the age/gender factors over the last two filings. In the example above, this would mean reducing the \$300 manual rate to \$289. When the proposed age/gender factor is applied, the result is the correct rate of \$258. This change to methodology achieves MVP's stated goal of "quarterly manual rate increases equal to the paid medical and pharmacy combined trend."

3. *Medical Trend:* 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. We consider the 2.7% annual medical paid trend assumption to be reasonable and appropriate.
4. *Rx Trend:* MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVP's pharmacy vendor and account for MVP'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. *Administrative Expenses:* We observed MVP'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 recently filed PPO product, which makes up the majority of MVP's large group business. 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 large group 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**

After modification, 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 modification:

- Apply a reduction of 3.9% to the proposed base manual rate to counteract the age/gender normalization on this block in this filing and the previous filing.

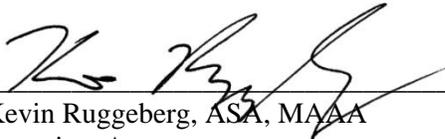
After this modification, the quarterly change to revenue would be as illustrated in the following table:

Reason for Quarterly Change	1Q17 / 4Q16	2Q17 / 1Q17
<b>Manual Rate Change</b>	-2.7%	1.1%
<b>Age/Gender Factor Changes</b>	0.9%	0.0%
<b>Change in Target Loss Ratio</b>	2.0%	0.0%
<b>Total Revenue Change</b>	<b>0.1%</b>	<b>1.1%</b>

The quarterly rate changes above result in annual revenue changes below.

Reason for Annual Change	1Q17 / 1Q16	2Q17 / 2Q16
<b>Manual Rate Change</b>	1.6%	2.7%
<b>Age/Gender Factor Changes</b>	3.9%	3.9%
<b>Changes in Retention</b>	-1.3%	-1.3%
<b>Total Revenue Change</b>	<b>4.1%</b>	<b>5.3%</b>

Sincerely,



Kevin Rugeberg, 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 organizations<sup>1</sup>, 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 Conduct<sup>2</sup>, 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 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 November 7, 2016. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is November 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.

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<sup>1</sup> 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.

<sup>2</sup> 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.