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October 6, 2017

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

Re: MVP Health Insurance Company
1Q/2Q 2018 Small Group HIC Grandfathered Rate Filing
SERFF Tracking #: MVPH-131146158

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 2018 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 2018. 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 May 2017, 1,711 members were enrolled in the plans impacted by this rate filing. Of those 1,711 members, 1,125 members (66%) have a 1Q contract effective date, and 238 members (14%) 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	**1Q18**	**2Q18**
Medical + Rx	-2.4%	1.3%

The requested quarterly rate changes, 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:

Annual Rate Change							
Small Group PPO/EPO	**2Q17**	**3Q17**	**4Q17**	**1Q18**	**2Q18**	**Annual 1Q18**	**Annual 2Q18**
Medical + Rx	2.3%	1.8%	2.4%	-2.4%	1.3%	4.2%	3.1%

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 AR42 claim data for the period from January 2016 through December 2016 and paid through May 2017 as the base period experience. Groups that terminated coverage as of May 2017 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 the accompanying adjustments applied in deriving the rates for 1Q17.

   From the historical medical 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 pooling charge of 18% is supported in the file "Rolling 12 Medical and Rx Data - SG HDHP.xlsx" provided in the initial filing submission.

   The adjusted medical claims were projected forward to the midpoint of the rating period using an annual paid medical trend assumption of 3.9% (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 leveraging[1]. The prescription claims were projected forward to the midpoint of the rating period using an annual paid Rx trend of 15.3% (elaborated further in item 3 below).

   The trended cost was adjusted to reflect the impact of enrollment growth/termination. The experience period begins in January, while some groups have their renewal date later in the year. The proposed rates will be effective for an entire year for all groups electing coverage, so an adjustment is necessary. 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. As the experience period coincides with the renewal date for 66% of members, this adjustment was less than 0.1%. This adjustment is clearly documented and appears to be actuarially sound.

[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.

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

The proposed expected claim cost PMPM was also adjusted for the single conversion factor[2] change (derived using May 2017 membership distribution) to derive the gross claim cost for 1Q18. 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 May 2017 is 1.3 years older than the average during the experience period, resulting in a 1.7% increase in the proposed rates.

The required premium revenue PMPM for 1Q18 was compared to the 4Q17 premium rates for the membership underlying the experience period to determine the required quarterly rate change of -2.4%. MVPHIC developed the 2Q18 premium by applying one more quarter of trend to the experience period claims resulting in required quarterly rate change of 1.3%.

2. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVPHIC's provider network. Utilization trends reflect observed increases in utilization anticipated to continue into the rating period.

Medical Trend	Unit Cost Trend	Utilization Trend	Allowed Trend	Paid Medical Trend
2017	2.4%	0.6%	3.0%	3.6%
2018	3.0%	0.6%	3.6%	4.3%

The allowed cost trends 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 3.9% 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-four 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:

	2017 Trend		2018 Trend	
	Unit Cost	Utilization	Unit Cost	Utilization
Generic	-4.1%	2.9%	1.3%	3.3%
Brand	13.9%	1.5%	13.8%	-1.0%
Specialty	6.8%	6.7%	8.6%	7.3%

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

[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.

book of business.

The annualized effective paid trend derived from the requested allowed trends in the chart above is 15.3%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (by modeling 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 the same as the previous filing on this block. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 3Q/4Q17 filing, such as the ACA Insurer fee and VT Paid Claim Tax, that are itemized 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 2.0% for coverage dates in calendar year 2018,
    - VT vaccine pilot charge of 0.5%,
    - Patient-Centered Outcomes Research Institute (PCORI) Fee of $0.21 PMPM.

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 five 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 and is consistent with MVP's other filings.

We note that MVPHIC's loss ratio for this block in the experience period (January 2016 through December 2016) was 89.3%, which exceeds the minimum loss ratio requirement. The federal MLR used to determine if this block is required to pay a rebate for calendar year 2016 is 101.9%.

MVPHIC's 2018 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 2018	84.8%	89.7%

The single conversion factor increased by 1.3%, and the age factor increased by 2.4%. These two factors combined reflect the expected changes to claims and premiums due to observed enrollment shifts since the experience period. We believe that both adjustments are appropriate and reflect real, observed population changes. The combined impact of these two changes is to increase the rates by approximately 3.6%.

We find all other adjustments to the projected claim 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 3.9% 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.

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

Service Category	2017	2018
Inpatient	4.2%	5.0%
Outpatient & Other Medical	3.9%	4.7%
Physician	-2.4%	-2.6%
Total Unit Cost Trend	**2.4%**	**3.0%**

   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.

   In this filing, MVP is assuming average annual utilization increases of 0.6%. This assumed increase reflects an observed increase in outpatient and physician services. MVP provided historical utilization data that shows utilization of all major service categories increased noticeably between 2015 and 2016, even after normalizing for changes in member age. MVP chose to use a logarithmic regression, which implicitly assumes that trend will normalize to zero over time. This methodology resulted in an assumed 0.6% annual utilization trend on average.

   In addition, market data available from other filings indicates that an increase in medical utilization is being observed across the individual and small group market. Based on all information available at this time, the utilization trend included in this filing appears 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 account for MVPHIC's Vermont specific book of business. The assumed annual paid claim trend is 15.3%. Unlike in the past, the PBM provided only a "best estimate" of allowed Rx trends, rather than providing multiple scenarios of possible outcomes. MVPHIC relied on these assumptions without modification and incorporated the experienced distribution by drug tier and cost sharing provisions to develop the paid trend.

   MVPHIC provided historical claims data demonstrating that the groups included in the experience period have experienced extremely high Rx trends in recent years. In light of this experience and the projections reflecting the best estimate of the PBM, these assumptions appear to be reasonable.

4. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.4% is lower than the actual expense of 8.8% for the small group AR42 and AR44 markets as illustrated in MVPHIC's 2016 Supplemental Health Care Exhibit. 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	$410.60	$38.11	9.3%
2015	53,993	$416.49	$34.04	8.2%
2016	60,883	$431.29	$38.07	8.8%

The proposed contribution to surplus is 2.0%. In past 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.

MVP has stated that the billback stipulated by 18 V.S.A § 9374 (h)(1) and HCA assessment should be counted as claims for loss ratio purposes. L&E is not opining on the appropriateness of this methodology at this time, as it does not impact the rates for this filing. The projected loss ratio is in excess of the required minimum, both including and not including the billback as a claims expense. We note that if the billback expense is removed from claims in the numerator of the Federal MLR calculation, it should be added to the denominator as an assessment.

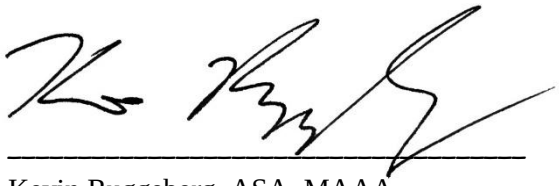
The assumed Health Insurer Fee payment for 1Q and 2Q 2018 is 2%. Due to the moratorium for coverage year 2017, the previously approved rates reflected less than the full fee amount. The assumed 2.0% is consistent with past filings and support numerically in the file "Support for L&E Objection #1.xlsx" provided by MVP on August 31, 2017. 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,



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Associate Actuary
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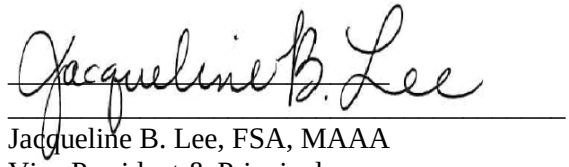

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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[3], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[4], 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 6, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 6, 2017.

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.