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May 22, 2018

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05620

Re: MVP Health Plan, Inc.
3Q/4Q 2018 Small Group HMO Grandfathered Rate Filing
SERFF #: MVPH-131432994

The purpose of this letter is to provide a summary and recommendation regarding the small group filing submitted by MVP Health Plan (MVP) for its grandfathered high deductible HMO products for the third and fourth quarters of 2018 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP is a non-profit health benefit plan provider. MVP provides small and large group coverage to employers in Vermont as well as individual and small group coverage sold on Vermont Health Connect (VHC).

2. This filing demonstrates the premium rate development of MVP's small group grandfathered HMO product portfolio comprising high deductible health plans (HDHP) and includes proposed rates for both the third and fourth 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.

3. This is a closed block of business. As of January 2018, there were approximately 1,361 members enrolled in MVP Small Group HMO plans. Of these 1,361 members, 120 (9%) have a third quarter effective date, and 144 (11%) have effective dates in the fourth quarter. The remaining members (80%) have effective dates in the first or second quarter.

4. The average requested quarterly manual rate changes are seen below, alongside previously approved rate changes. The annualized rate changes for 3rd quarter group renewals and 4th quarter group renewals are in the second chart.

Reason for Change	4Q17 / 3Q17	1Q18/ 4Q17	2Q18/ 1Q18	3Q18/ 2Q18	4Q18/ 3Q18
Change in Claims	1.8%	-2.7%	1.3%	5.2%	1.4%
Change in Retention	0.6%	0.4%	0.0%	-4.1%	-0.3%
Total Revenue Change	2.4%	-2.4%	1.3%	0.9%	1.1%

Reason for Change	3Q18 Annual	4Q18 Annual
Change in Claims	5.5%	5.1%
Change in Retention	-3.2%	-4.0%
Total Revenue Change	***2.1%***	***0.9%***

5. This filing was amended on March 29, 2018. MVP removed base plan VT3HDH54AXS and accompanying preventative pharmacy rider from the filing. As stated in the Actuarial Memorandum, MVP was still determining the best course of action to replace plan VEHD2-49 from the previous filing. MVP has decided to transition grandfathered members purchasing VEHD2-49 to VT3HMO049XSG upon renewal. Therefore, MVP has removed the other alternative for these members (VT3HDH54AXS) from its form and rate filing. MVP has also added the following riders to the filing: YV3HMB312S, MV3HMB307S, and GV3HMB700S. Since MVP has filed a non-qualified plan on this block of business, MVP also needs to file rider versions that can attach to the HMO Certificate of Coverage (COC) as well as the HDHP COC. These riders are exactly the same as the corresponding HDHP rider and have been priced as such.

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 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 and membership summary for 36 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:* MVP utilized grandfathered small group AR42 claim data for the period from November 2016 through October 2017 and paid through January 2018 (with incurred estimates updated through February 2018) as the base period experience. Groups that had terminated coverage as of January 2018 were removed from the experience period data, as they will not be eligible to renew coverage in the rating period.

   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 3Q18.

   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 run out for the experience period is three months.

   The adjusted claims were projected forward to the midpoint of the rating period using an annual paid medical trend assumption of 3.3% (elaborated further in item 2 below). The paid medical trend is derived from proposed allowed cost trend rates and the impact of cost share leveraging[1]. The prescription claims were

[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.

projected forward to the midpoint of the rating period using an annual paid Rx trend of 16.8% (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 most groups have their renewal date earlier in the year. 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 0.1%. 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 in item 4 below).

The proposed expected claim cost PMPM was also adjusted for the single conversion factor[2] change (derived using January 2018 membership distribution) to derive the gross claim cost for 3Q18. Consistent with the prior filing, rates were also adjusted for observed changes in the covered population's average age since the experience period resulting in a 0.6% increase in the proposed rates.

The required premium revenue PMPM for 3Q18 was compared to the 2Q18 premium rates for the membership underlying the experience period to determine the required quarterly rate change of 0.9%. MVP developed the 4Q18 premium by applying one more quarter of trend to the experience period claims resulting in required quarterly rate change of 1.1%.

2. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. The assumed utilization trend is 0.0%. Due to concerns with the large impact that membership growth in other blocks of business was having on the total utilization trend for Vermont, MVP elected to reflect no utilization trend.

Medical Trend	Unit Cost Trend	Utilization Trend	Allowed Trend	Paid Medical Trend
2017	2.3%	0.0%	2.3%	2.8%
2018	2.8%	0.0%	2.8%	3.3%
2019	2.9%	0.0%	2.9%	3.4%

The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims cost 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 illustrated above to account for the impact of cost share leveraging and derived a total effective paid medical trend factor of 3.3% 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, 20 months of trend were used to trend the experience period claims forward to 3Q18.

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

[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.

and by drug tier:

	2017 Trend		2018 Trend		2019 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-8.3%	0.8%	-0.4%	2.7%	4.6%	3.1%
Brand	9.9%	-4.4%	14.9%	2.5%	12.5%	1.4%
Specialty	10.9%	9.6%	6.9%	7.5%	10.6%	7.4%

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.

The annualized effective paid trend derived from the requested allowed trends in the chart above is 16.8%, 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 reserve and other miscellaneous charges similar to the 1Q/2Q18 filing 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 reserve of 2.0%.
    - ACA Insurer tax of 1.0% 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 MVP'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 these amounts compared to the company's historical experience.

   The base period experience used in this filing has three months of claims run-out and therefore, needed to be adjusted for claims incurred but not reported ("IBNR"). The IBNR factor also includes several large claims for the experience period that were received in February 2018. The IBNR adjustment appears to be actuarially sound and is consistent with MVP's other filings.

   We note that MVP's loss ratio for this block in 2017 was 94.6%, which exceeds the minimum loss ratio requirement. The federal minimum loss ratio is 80% for small group policies. MVP did not rebate customers for this block in 2015 or 2016, and does not anticipate having to pay an MLR rebate for the 3-year average of 2015-2017. Therefore, no adjustments need to be made to base period experience to reflect the impact of premium rebates.

   MVP's 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 removal of the VT premium tax.

Projection MLR		
Projection Period	**Traditional LR**	**Federal LR**
3Q 2018	88.4%	90.1%

The single conversion factor decreased by 2.1%, and the age factor increased by 0.6%. 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 decrease the rates by approximately 1.5%.

We find all other adjustments to the projected claim costs to be reasonable and appropriate.

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

2. *Medical Trend:* The annual effective paid medical trend factor of 3.3% 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	2019
Inpatient	4.2%	5.0%	5.0%
Outpatient & Other Medical	3.9%	4.7%	4.7%
Physician	-2.4%	-2.6%	-2.6%
Total Allowed Trend	**2.3%**	**2.8%**	**2.9%**

   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 using a 0.0% utilization trend. MVP had concerns with the large impact that membership growth in other blocks of business was having on the total utilization trend for Vermont. Because removing the other blocks would result in a block that was not considered credible, MVP elected to reflect no utilization trend. Based on all information available at this time including a review of historical utilization data provided by MVP, the utilization trend included in this filing appears to be reasonable and appropriate.

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

	2017 Trend		2018 Trend		2019 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-8.3%	0.8%	-0.4%	2.7%	4.6%	3.1%
Brand	9.9%	-4.4%	14.9%	2.5%	12.5%	1.4%
Specialty	10.9%	9.6%	6.9%	7.5%	10.6%	7.4%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 16.8%, 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). This blended annualized figure is used to trend the experience period claim costs to the projection period.

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. The Rx trend assumptions appear to be reasonable and appropriate.

4. *Administrative Expenses:* We assessed that MVP'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 MVP'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
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 reserve is 2.0%. In past orders, the Board has reduced the proposed contribution to reserve. We recommend that the solvency analysis performed by the Department of Finaicial Regulation be considered if changes are made to this assumption.

The rate adjustment reflecting the Health Insurer Fee moratorium for 2019 appears to be reasonable and appropriate.

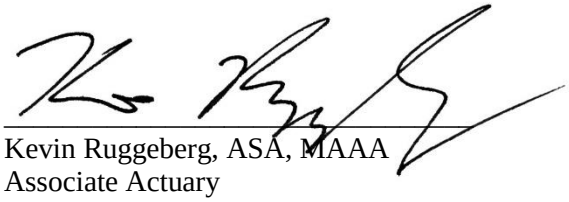
MVP has stated the billback stipulated by 18 V.S.A § 9374 (h)(1) and HCA assessment as a claims expense for loss ratio purposes. During the 1Q/2Q 2018 HMO filing review, in accordance with guidance received from CMS, GMCB provided direction that MVPHP must include such amounts within its administrative expenses, consistent with the treatment of other taxes and fees imposed by the state and federal governments. L&E notes that this instruction was not implemented in the 3Q 2018 filing and recommends that this be addressed in the filing of 2019 Vermont Health Connect rates. However, as with previous filings, this reporting issue does not materially impact the rates under review.

Notwithstanding the Billback mischaracterization, 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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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 J. Ruggeberg, 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 May 22, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is May 22, 2018.

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.