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March 31, 2015

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

Re: 3Q15 – 4Q15 MVPHIC Large Group EPO/PPO Rates
 SERFF #: MVPH-129877690

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 third and fourth quarters of 2015 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 third and fourth quarters of 2015.
2. The proposed rates in this filing will affect approximately 6,115 Vermonters. Of these 6,115 members, 99 members have a contract effective date in the 3rd quarter, and 529 have contract effective date in the 4th quarter.
3. This rate filing is requesting a quarterly rate change of:

Quarterly Rate Change			
	Large Group PPO/EPO	3Q15	4Q15
HDHP	Medical + Rx	7.9%	1.8%
	Medical	7.9%	1.8%
Non-HDHP	Rx Riders	7.9%	1.8%

The requested quarterly rate increases, seen above, would result in the following annual rate changes for 3rd quarter group renewals and 4th quarter group renewals, when combined with prior approved filings:

Annual Rate Change			
	Large Group PPO/EPO	3Q15	4Q15
HDHP	Medical + Rx	3.1%	3.5%
Non-HDHP	Medical + Rx	17.5%	18.0%

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 (Exhibits 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 September 1, 2013 through August 31, 2014 and paid through November 30, 2014 as the base period experience.

Exhibit 3a illustrates both the claim projection from the experience period to the rating period and also the accompanying adjustments applied in deriving the rates for 3Q15.

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 three months.

The adjusted claims were projected forward to the midpoint of the 3Q15 rating period using an annual effective medical trend assumption of 6.8% (elaborated further in item 2 below). The effective medical trend reflects MVPHIC's paid trend and is derived from its proposed allowed cost trend rates and the impact of cost share leveraging¹. The prescription claims were projected forward to the midpoint of 1Q14 rating period using an annual effective Rx trend of 20.7% (elaborated further in item 3 below).

The trended claim cost was further adjusted to develop the projected claim costs as of 3Q15. These

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

adjustments include projected cost of benefit mandates, capitation and non-FFS claim expenses, Rx rebates, and deductible suppression² factors.

The required 3Q15 manual claim cost was calculated by further adjusting the projected claim cost to normalize³ for the impact of age/gender and industry.

The required premium revenue PMPM for the 3rd quarter of 2015 was compared to the 2nd quarter 2015 manual premium rates for the membership underlying the experience period to determine the required rate change of 7.9%.

MVPHIC developed the 4Q15 premium by applying one more quarter of trend to the experience period claims.

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 trend factors for various benefit categories:

Annual Allowed Cost Trend		
Claim Category	2014 Annual Trend	2015 Annual Trend
Inpatient	5.8%	6.7%
Outpatient & Other Medical	5.4%	5.9%
Physician	15.3%	3.5%
Total Medical Trend	8.6%	5.3%

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 6.8% as indicated in item 1 above. 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.

² Due to deductibles, paid claims are lesser in early months of a member's contract and are higher than average in later contract months. Deductible suppression factor is used to make an adjustment to reflect the anticipated claim costs for a 12-month contract period as the experience period membership is not evenly distributed by contract month.

³ In developing the manual pure premium which will be charged to groups, group-specific demographic and industry factor will be applied and is based on the weighted average demographic/industry factor for the group. This step in the rating methodology removes the effect of demographics and industry from the average claim cost by using the reciprocal of the weighted average demographic/industry factor for each product type.

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

Annual Rx Allowed Cost Trend⁴		
2014	2015	2016
14.5%	16.9%	16.3%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 20.7%, 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).

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 did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is new. MVPHIC's rationale for using unadjusted trends includes the following:

- The new PBM (contracted on January 1, 2015) does not have enough MVPHIC data to provide a credible Rx trend forecast based on MVPHIC's experience.
- The historic trends do not reflect the constantly changing Rx market and do not account for drugs coming off patent, changes in average wholesale price, new drugs being released to the market and price competitiveness amongst generic and brand drug manufacturers.

3. *Experience Rating Formula:* 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 9.5% of premium for general administrative expense, 2% for contribution to surplus, and other miscellaneous charges similar to the 1Q/2Q15 filing. MVPHIC provided the filed and approved experience rating formula and addendum as part of this filing.

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.

We note that MVPHIC's loss ratio for the small group market in the experience period (September 2013 – August 2014) exceeded the minimum loss ratio requirement of 85%. The unadjusted medical loss ratio for this block is illustrated below:

Historic Period	Unadjusted MLR
September 2013-August 2014	89.7%
January 2014 – October 2014	90.6%

⁴ MVPHIC has proposed same utilization and unit cost trends by drug tier in all three MVP filings (SERFF #: MVPH-129866393, MVPH-129877690, MVPH-12877747). Due to varying utilization by drug tier in these filings, the total allowed trends as illustrated in this chart will not exactly match in all three filings.

MVPHIC’s 2015 anticipated traditional loss ratio and federal loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) for this block, as illustrated below, exceed the minimum loss ratio requirement.

Projection Period (3Q 2015)		
Projection Period	Traditional Loss Ratio	Federal Loss Ratio
3Q 2015	79.4%	85.8%

The prior 1Q/2Q 2015 filing had requested non-uniform rate change due to revision of benefit relativities. With the benefit relativity correction now in place, MVPHIC’s rate methodology in this filing evaluates the entire block as a whole instead of by product category (HDHP versus Non-HDHP).

Since MVPHIC has used credible experience from its own block of business in creating its updated pricing model, we consider the pricing methodology to be reasonable and appropriate.

2. *Medical Trend:* We consider the development of 2015 medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be appropriate. We consider the 6.8% annual medical paid trend assumption to be reasonable and appropriate.

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.

Rx Trend: We consider MVPHIC’s approach of using Rx trends from its vendor without accounting for its Vermont specific block of business to be a limitation on the reasonableness of their proposed Rx trend assumption.

In a response to an inquiry, MVPHIC provided a comparison of calendar year 2014 Rx allowed claims by category compared to calendar year 2013 Rx allowed claims by category.

Drug Category	Calendar Year 2013	Calendar Year 2014	Allowed Trend
Generic	\$16.36	\$15.08	-7.8%
Brand	\$18.51	\$17.45	-5.7%
Specialty	\$14.11	\$21.89	55.1%
Aggregate	\$48.97	\$54.43	11.1%

As illustrated in the chart above, specialty drugs are having a significant impact on the total Rx trend. This is consistent with industry experience where the cost of hepatitis C drugs is driving high specialty drug trends in recent years.

We do not agree with the Company only utilizing the unadjusted trends from the PBM. We considered MVPHIC’s historic experience, the PBM’s recommendation, and the impact of new high cost specialty drugs. To maintain consistency across all MVP filings and account for factors outside of historic experience, we opine that the requested Rx paid trend of 20.7% is reasonable and appropriate.

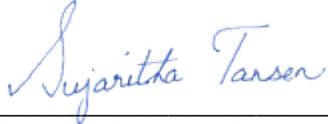
3. *Experience Rating Formula:* We assessed that MVPHIC's assumed general administrative load of 9.5% to be lower than the actual expense of 10.8% as illustrated in MVPHIC's 2013 Supplemental Health Care Exhibit (for all markets). If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

There were no changes to the experience rating formula other than updated fees related to ACA (such as federal reinsurance assessment). We find the development to be reasonable and appropriate.

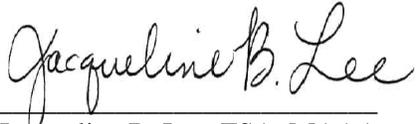
Recommendation

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 requested.

Sincerely,



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Associate Actuary
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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations⁵, 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 Conduct⁶, 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:

- Sujaritha Tansen, ASA, MAAA, MS, 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 March 31, 2015. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is March 13, 2015.

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.

⁵ 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.

⁶ 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.