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September 24, 2015

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

Re: 1Q16 – 2Q16 MVPHIC Large Group EPO/PPO Rates – REVISED
 SERFF #: MVPH-130178700

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 2016 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 2016.
2. The proposed rates in this filing will affect approximately 2,755 Vermonters. The rest of MVPHIC's large group members will transition to the Vermont Health Exchange in 2016 (51-100 groups). Of these 2,755 members, 1,611 have a first or second quarter policy effective date.
3. This rate filing is requesting quarterly manual rate changes of:

Quarterly Rate Change				
	2014 Enrollment	Large Group PPO/EPO	1Q16	2Q16
HDHP	62%	Medical + Rx	6.7%	1.4%
Non-HDHP	38%	Medical	6.7%	1.4%
		Rx Riders	6.7%	1.4%

The requested quarterly manual rate increases, 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					Annual	Annual
	Large Group PPO/EPO	2Q15	3Q15	4Q15	1Q16	2Q16	1Q16	2Q16
HDHP	Medical + Rx	1.5%	7.9%	1.8%	6.7%	1.4%	18.9%	18.8%
Non-HDHP	Medical	1.5%	7.9%	1.8%	6.7%	1.4%	18.9%	18.8%
	Rx Riders	1.9%	7.9%	1.8%	6.7%	1.4%	19.4%	18.8%
Total Manual Rate Change							18.9%	18.8%
Age Gender Table Normalization							-7.3%	-7.3%
Impact of Changes in Target Loss Ratio							-0.9%	-0.9%
Proposed Annual Rate Change							9.2%	9.1%

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 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 January 1, 2014 through December 31, 2014 and paid through April 30, 2015 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 1Q16.

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 four months.

The adjusted claims were projected forward to the midpoint of the 1Q16 rating period using an annual paid medical trend assumption of 4.3% (elaborated further in item 2 below). The paid 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 1Q16 rating period using an annual paid Rx trend of 15.8% (elaborated further in item 3 below).

The trended claim cost was further adjusted to develop the projected claim costs as of 1Q16. These adjustments include projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates.

In prior filings, the required manual claim cost was calculated by further adjusting the projected claim cost to normalize² for the impact of age/gender and industry. The age/gender normalization methodology has changed in this filing which resulted in an increase to the manual rate by 7.9% and an offsetting decrease of 7.3% in the age/gender factors³. This new method is actuarially equivalent to the previous method and has no impact on the final premium.

Additionally, MVP increased its target loss ratio from 81.6% to 82.5%, which reduced premiums by 0.9%.

The manual rate PMPM for the 1st quarter of 2016 was compared to the 4th quarter 2015 manual rates for the membership underlying the experience period to determine the required manual rate change of 6.7%.

MVPHIC developed the 2Q16 manual rate 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		
Service Category	2015	2016
Inpatient	5.4%	5.5%
Outpatient & Other Medical	4.8%	4.6%
Physician	2.9%	0.0%
Total Medical Trend	4.3%	3.2%

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

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

² 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.

³ Note that a 7.9% increase and a 7.3% decrease cancel each other out because $(1 + 7.9\%)(1 - 7.3\%) = 100\%$. So while these changes appear to be different in magnitude, there is no change in the final premium for this methodology change.

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 4.3% annually from 2014 to 2016 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. For this filing, two years 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, split between 2015 and 2016 and by tier:

Annual Rx Allowed Cost Trend	
2015	2016
9.0%	16.3%

Annualized Rx Allowed Cost Trend by Tier		
Tier	Unit Cost	Utilization
Generic	4.2%	3.0%
Brand	14.0%	-2.8%
Specialty	17.0%	7.0%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 15.8%, 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, two years 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 and did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is new.

4. *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 8.0% of premium for general administrative expense. This is a reduction of 1.5% from the 3Q/4Q15 filing. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 3Q/4Q15 filing, such as the ACA Insurer fee and VT Paid Claim Tax.

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.

Projection Period (LG in 1Q 2016)	
Period	Traditional MLR
1Q 2016	82.5%

The pooling charge used in the proposed rate development is based on experience not only for groups to which the filing is applicable but also on the 51-100 member block and groups transitioning to ASO. This results in an increase in the pooling charge from 8.0% to 9.2%. In response to an inquiry, MVPHIC argued

that the inclusion of this data generates a more credible estimate of the appropriate pooling charge. While the method incorporates groups not applicable to this filing, we agree that the inclusion of additional groups creates a larger and more credible data set for this analysis and is a generally accepted actuarial practice. We reviewed the experience for other similar blocks to add even more credibility and stability to this data set, and these inclusions would have likely increased the pooling charge more than what is proposed. We are not making any recommendations at this time, but we will monitor this assumption closely in future filings.

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).

The change in the age/gender normalization methodology was performed on a revenue neutral basis with a corresponding change to the manual rate.

The rate development appears to be reasonable and appropriate.

2. *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 4.3% 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.

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 did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is new. 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.

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 does 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. This includes new drugs like PCSK-9 Inhibitors that have been approved for use recently and would not be reflected by the company's historical experience.

The Rx trends used in this filing are materially higher than those in the recently approved Exchange filing. Both estimates are taken from forecasts provided by MVPHIC's PBM. For the Exchange filing, the Company used the "Low Estimate" from the PBM, whereas they have proposed using the "Best Estimate" for this filing. In response to an inquiry, MVPHIC provided insufficient justification for modifying the trend assumptions between these two filings. We recommend that the requested trend assumption be reduced to be consistent with the approved trend that was assumed for Exchange products. This change would result in a decrease in the requested rate change of 0.5%. The change is summarized below. Note that due to benefit and tier distribution differences, the effective trend differs slightly between the two blocks, even using the same trend assumptions.

Tier	2016 Trend in Exchange Filing		2016 Trend Proposed in SG GF Filing	
	Unit Cost	Utilization	Unit Cost	Utilization
Generic	3.3%	2.1%	4.2%	3.0%
Brand	13.5%	-4.5%	14.0%	-2.8%
Specialty	14.0%	6.0%	17.0%	7.0%

4. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.0% to be lower than the actual expense of 8.5% for all markets as illustrated in MVPHIC's 2014 Supplemental Health Care Exhibit. If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

The proposed contribution to surplus is 2.0%. In the last two orders, the Board has reduced the proposed contribution to surplus from 2.0% to 1.0%. We recommend that the solvency analysis performed by DFR be considered when making changes to this assumption.

We find the administrative assumptions to be reasonable and appropriate.

Recommendation

After modifications, 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:

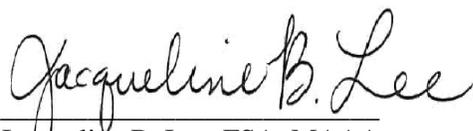
- Modify the Rx trend assumptions to reflect the “Low Estimate” from the PBM, as MVPHIC chose this as an appropriate assumption for the recently approved Exchange filing. This change would reduce the requested rate change by 0.5% for 1Q16 and by 0.1% for 2Q16.

The above change will decrease the 1Q16 quarterly manual rate change from 6.7% to 6.2% and the 2Q16 quarterly manual rate change from 1.4% to 1.3%

Quarterly Rate Change			
Large Group PPO/EPO		1Q16	2Q16
HDHP	Medical + Rx	6.2%	1.3%
Non-HDHP	Medical	6.2%	1.3%
	Rx Riders	6.2%	1.3%

Annual Rate Change			
Large Group PPO/EPO		1Q16	2Q16
HDHP	Medical + Rx	18.4%	18.1%
Non-HDHP	Medical	18.4%	18.1%
	Rx Riders	18.9%	18.1%
Total Manual Rate Change		18.4%	18.1%
Age Gender Table Normalization		-7.3%	-7.3%
Impact of Changes in Target Loss Ratio		-0.9%	-0.9%
Proposed Annual Rate Change		8.8%	8.5%

Sincerely,



Jacqueline B. Lee, FSA, MAAA
Vice President
Lewis & Ellis, Inc.



David M. Dillon, FSA, MAAA, MS
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations⁴, 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 Conduct⁵, 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:

- 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 September 24, 2015. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is September 24, 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.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

⁴ 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.

⁵ These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

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.