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September 25, 2014

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

Re: 1Q15 – 2Q15 MVPHIC Grandfathered Small Group EPO/PPO Rates
SERFF #: MVPH-129662230

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 EPO/PPO products for the first and second 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 small group grandfathered 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 2015. Small groups, who hold grandfathered products, have coverage issued prior to March 23, 2010 that have not made substantial changes to their benefits.

2. The proposed rates in this filing will affect approximately 3,000 Vermonters:
   - HDHP Groups: 2,800
   - Non-HDHP Groups: 200

3. This rate filing is requesting a quarterly rate change of:

Quarterly Rate Change			
	Small Group PPO/EPO	**1Q15**	**2Q15**
HDHP	Medical + Rx	0.9%	1.5%
Non-HDHP	Medical	0.9%	1.3%
	Rx Riders	0.9%	2.3%

The requested quarterly 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			
	Small Group PPO/EPO	**1Q15**	**2Q15**
HDHP	Medical + Rx	10.1%	10.2%
Non-HDHP	Medical + Rx	10.1%	10.2%

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 (split by HDHP and Non-HDHP products) 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 and Non-HDHP Rate Development:* MVPHIC utilized grandfathered and non-grandfathered small group claim data for the period from January 1, 2013 through December 31, 2013 and paid through May 31, 2013 as the base period experience.

   Exhibit 3 illustrates both the claim projection from the experience period to the rating period and also the accompanying adjustments applied in deriving the rates for 1Q15.

   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 five months.

   The adjusted claims were projected forward to the midpoint of the 1Q15 rating period using a 7.2% annual effective medical trend (elaborated further in item 2 below) assumption for Non-HDHP products and a 7.9% annual effective medical trend for HDHP products. 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 leveraging[1] . The prescription claims were projected forward to the midpoint of 1Q14 rating period using a 9.7% annual effective Rx trend (elaborated further in item 3 below) for Non-HDHP products and a 10.2% annual effective Rx trend for HDHP products.

[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 trended claim cost was further increased to reflect fees and surcharges representing 1.249% of expected claims, retention expenses of 11.75%, premium taxes of 2.00%, ACA Insurer tax of 2.0%, VT vaccine pilot charge of 0.6%, transitional reinsurance fee of $3.67 PMPM and Patient Centered Research Fee of $0.17 PMPM.

The proposed expected claim liability PMPM was also adjusted for the single conversion factor[2] change (derived using January 2013 – December 2013 membership distribution) to derive the gross claim cost for 1Q15. The required premium revenue PMPM for 1Q15 was compared to the 4Q14 premium rates for the membership underlying the experience period to determine the required rate change. The calculated quarterly rate change for the Non-HDHP products of 12.3% was then blended (using weights based on June 2014 membership) with the calculated quarterly rate change of -0.4% for HDHP products to arrive at an average proposed rate change of 0.9%.

MVPHIC developed the 2Q15 premium by applying one quarter of medical paid trend to the 1Q15 rates for each product type. Rx Riders were trended at 2.3%, which is equal to one quarter of Rx annual paid trend rate.

2. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVPHIC's provider network. The 2014/2015 unit cost trend factors are consistent with the unit cost trend factors used in MVPHIC's 2015 Exchange filing. 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		
Market Segment	**2014 Annual Trend**	**2015 Annual Trend**
Inpatient	6.0%	6.0%
Outpatient & Other Medical	5.4%	5.4%
Physician	15.3%	3.5%
Total Medical Trend	**8.6%**	**5.0%**

MVPHIC adjusted the allowed cost trends illustrated above to account for the impact of cost share leveraging and derived the effective paid medical trend factors (of 7.2% for Non-HDHP and 7.9% for HDHP products) as indicated in item 1 above.

Rx Trend: MVPHIC analyzes its pharmacy data by product type (HDHP vs. Non-HDHP) and 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

[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, given the partnership with this vendor is new.

MVPHIC felt that the data supplied by the vendor did not accurately reflect the impact of the drug Sovaldi[3] in the specialty trend. MVPHIC used its commercial book of business to analyze the impact of Sovaldi on specialty trend from January to April 2014. To account for the impact of Sovaldi on its specialty trend, MVP increased the 2015 specialty unit cost trend from 8.6% to 13.1%.

The overall annual requested Rx trend reflected is 9.7% for Non-HDHP and 10.2% for HDHP products.

L&E Analysis

1. *HDHP and Non-HDHP 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 (January 2013 – December 2013) exceeded the minimum loss ratio requirement of 80%. The medical loss ratio for the grandfathered group and the entire small group market (which includes non-grandfathered products) is illustrated below:

Experience Period (2013)			
Small Group Experience Period MLR			
Market Segment	**Incurred Claims**	**Earned Premium**	**MLR**
All Small Group	$347.75	$394.96	88.0%
Small Group Grandfathered	$355.37	$385.74	92.1%

   MVPHIC's 2014 anticipated traditional loss ratio and federal loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) for this grandfathered block and the entire small group market, as illustrated below, far exceed the minimum loss ratio requirement.

Projection Period (2014)		
Market Segment	Traditional Loss Ratio	Federal Loss Ratio
All Small Group	93.3%	99.5%
Small Group Grandfathered	98.5%	105.3%

[3] Sovaldi, a high cost prescription drug, approved for use in December 2013, is used to treat Hepatitis C.

The assumed administrative load of 9.5% of premium is same as what was assumed in the 2015 Exchange filing. We assessed that MVPHIC's assumed general administrative load to be lower than the actual expense ratio for the small group products, as illustrated in the Supplemental Health Care Exhibits:

Administrative Expense Summary for Small Group Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2010	186,297	$344.28	$39.71	11.5%
2011	209,126	$348.79	$34.17	9.8%
2012	190,795	$365.29	$37.24	10.2%
2013	178,794	$394.67	$46.56	11.8%

If MVPHIC's envisioned strategy to reduce its administrate expenses does not materialize, future rate increases could be higher than anticipated.

We note that MVPHIC utilized 2013 enrollment (combined grandfathered and on-grandfathered blocks) to project the age/gender assumptions for the needed rate change and to calculate the 2015 single conversion factors (1.192 for Non-HDHP and 1.208 for HDHP products). Considering the shift in membership of this closed block, we believe that it is more appropriate to use the most recently available contract distribution in developing the rate change and the single conversion factors.

If June 2014 enrollment was used instead of the experience period enrollment distribution, the change in the distribution of age/gender would increase the age factor from 1.553 to 1.559. This 1.004 increase should be incorporated in the rate change development. Additionally, the single conversion factor for Non-HDHP products increases from 1.192 to 1.222 and HDHP product decreases from 1.208 to 1.186. The demographic adjustment and revised contract conversion factors will reduce the recommended quarterly rate change from 0.9% to 0.0%.

We find all other adjustments to the projected claim costs to include benefit mandates, taxes, and ACA related costs to be reasonable and appropriate.

With the recommended changes to the demographic assumption in the rate change calculation and single conversion factor calculation, MVPHIC's rate development methodology appears to be reasonable and appropriate.

2. *Medical Trend:* We consider the utilization of recently approved allowed medical trends (filed in 2015 Exchange rate filing) to be reasonable and appropriate. We also note that the leveraging factors assumed for the Non-HDHP products and HDHP products are unchanged from the prior approved 3Q14/4Q14 filing for this product and consider this 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.

The 2Q15 rate change is based on this medical trend assumption. We consider the quarterly rate increase for 2Q15 to be reasonable and appropriate.

3. *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.

   We analyzed MVPHIC's development of assumed impact of Sovaldi on specialty unit cost trend. In the 2015 Exchange Rate filing, MVPHIC's PBM had assumed a lower projected impact (1.3% for 2014 and 1.6% for 2015) of Sovaldi on projected specialty claim forecast. MVPHIC had independently analyzed the impact of Sovaldi on specialty trend from its January to April 2014 Rx experience and determined that shortfall of Sovaldi projected impact was $0.76 PMPM. This translates to a 4.1% trend shortfall to the specialty allowed cost. We consider this to be within the range of our expectations and consider this reasonable.

   We recommend using the approved Rx trend from the 2015 Exchange filing as the starting point for the Rx trend. The adjustment to the specialty trend is still appropriate, since this analysis was based on MVPHIC's own experience. This will decrease the overall annual requested Rx trend from 9.7% to 9.1% for Non-HDHP and from 10.2% to 9.6% for HDHP products. This will results in a -0.1% change to the overall rate change for 1Q15 and the Rx riders rate change for 2Q15.

Recommendation

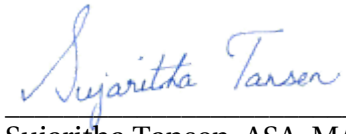
After modifications, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modification:

- Reflect updated enrollment in the rate change development and the single conversion factor calculation (-0.9% to 1Q15 rate change).
- Decrease the starting Rx trend to match the approved Rx trend in the 2015 Exchange filing (-0.1% to 1Q15 rate change and -0.1% to 2Q15 Rx rate change).

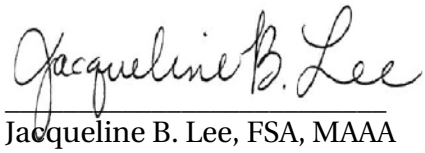
The above changes will decrease the 1Q15 quarterly rate change from 0.9% to -0.1%. The 2Q15 rate increase is based on the medical and Rx trends. Therefore, only the Rx riders are impacted due to the Rx trend reduction recommendation. The rate increase for Rx riders for 2Q15 will decrease from 2.3% to 2.2%.

Modified Quarterly Rate Change			
	Small Group PPO/EPO	**1Q15**	**2Q15**
HDHP	Medical + Rx	-0.1%	1.5%
Non-HDHP	Medical	-0.1%	1.3%
	Rx Riders	-0.1%	2.2%

Sincerely,



Sujaritha Tansen, ASA, MAAA, MS
Associate Actuary
Lewis & Ellis, Inc.



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

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[4], 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[5], 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 September 25, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 12, 2014.

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.

[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.

- 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.

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.