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March 25, 2014

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

Re: 3Q14 – 4Q14 MVPHIC Large Group EPO/PPO Rates
SERFF #: MVPH-129389053

The purpose of this letter is to provide a summary and recommendation regarding the proposed large group filing submitted by MVP Health Insurance Company (MVPHIC) for its EPO/PPO products for the third and fourth quarters of 2014 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVPHIC provides PPO and EPO products to individuals and employers in New York and Vermont.
2. 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 2014.
3. The proposed rates in this filing will affect approximately 7,600 Vermonters:
 - HDHP Groups: 3,700
 - Non-HDHP Groups: 3,900

4. The proposed rates, broken out by quarter and product category, reflect an annual rate change for 3rd quarter group renewals and 4th quarter group renewals of:

Table 1 – Annual Rate Change

Large Group PPO/EPO		3Q14	4Q14
HDHP	Medical + Rx	1.3%	1.1%
Non-HDHP	Medical + Rx	0.3%	0.3%

The requested quarterly rate changes from 2Q 2014 to 3Q 2014 and from 3Q 2014 to 4Q 2014 are presented below:

Table 2 – Quarterly Rate Change

Large Group PPO/EPO		3Q14	4Q14
HDHP	Medical + Rx	-2.6%	1.4%
Non-HDHP	Medical	-2.6%	1.3%
	Rx Riders	-2.6%	1.2%

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), experience rating formula (Exhibits A and B), addendum and appendices describing rating factors and additional supporting exhibits as requested during review of the filing.

Company's Analysis

1. *HDHP and Non-HDHP Manual Pure Premium Changes:* MVPHIC utilized large group claim data for the period from August 1, 2012 through July 31, 2013 and paid through October 31, 2013 as the base period experience.

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 3rd quarter of 2014 rating period using a 7.9% annual effective medical trend (elaborated further in item 2 below) assumption for Non-HDHP products and an 8.2% annual effective 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 leveraging¹. The prescription claims were projected forward to the midpoint of 3rd quarter of 2014 rating period using a 4.6% annual effective Rx trend (elaborated further in item 3 below) for Non-HDHP products and a 6.0% annual effective Rx trend for HDHP products.

The trended claims were adjusted to develop the required premium revenue. These adjustments include projected costs of benefit mandates, non-FFS claim expenses, and Rx rebates.

The required 3Q14 manual claim cost was calculated by further adjusting the above projected claim cost to normalize² for the impact of:

- Age/Gender
- Industry

The required premium revenue PMPM for the 3rd quarter of 2014 was compared to the 2nd quarter 2014 premium rates for the membership underlying the experience period to determine the required rate change of -2.6%.

The trend factor used to derive the 4th quarter rate table reflects 3 months of the assumed 2015 paid trend (i.e., the experience period data was projected an extra 3 months to the midpoint of the 4th quarter rating period and adjusted for any fee changes between third and fourth quarters).

2. *Medical Trend:* 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 assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network.

MVPHIC analyzed total utilization by provider for all fully insured Vermont membership (MVP Health Insurance Company and MVP Health Plan) combined to increase the credibility of the projection and provide a consistent projected trend for group rating regardless of product type (EPO/PPO, HMO etc.). Additionally, it assumes the same distribution of claims by benefit category (inpatient/outpatient hospital, physician services) for both large group PPO/EPO products administered by MVP Health Insurance Company and large group HMO products administered by MVP Health Plan in developing the medical trend.

The facility trend factors reflect the 2014 hospital budget approved by the Board. MVPHIC developed the medical cost trends shown in table below by calculating the projected unit cost change at each facility weighted by utilization by facility. The physician trend factors below reflect the revised contract with a major provider group following the termination of its

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 weighted average demographic/industry factor for the group. This step in the rate change 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 (Non-HDHP, HDHP).

contract on April 1, 2014. MVPHIC states that the revised rates represent a significant physician unit cost increase that drives the overall unit cost increase proposed in this rate filing.

The table below illustrates the comparison of the realized annual trend for 2013, the approved trend for 1Q/2Q 2014, and the assumed trends for 3Q/4Q 2014 and 2015:

Table 3 – Annual Allowed Cost Trend

	2013 Annual Trend	1Q/2Q 2014 Approved	3Q/4Q 2014	2015 Annual Trend
Inpatient	8.8%	8.8%	5.4%	5.4%
Outpatient & Other Medical	4.6%	4.6%	5.4%	5.4%
Physician	2.5%	2.5%	16.6%	2.5%
Total Medical Trend	4.8%	4.8%	9.1%	4.4%

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 7.9% for Non-HDHP and 8.2% for HDHP products) as indicated in item 1 above.

3. *Rx Trend:* MVPHIC analyzes its pharmacy data by product type (HDHP vs. Non-HDHP) and drug category (Traditional vs. Specialty). Annual trend factors by drug category, as supplied by MVPHIC’s pharmacy vendor (Express Scripts), were used in projecting the base period prescription drug costs to the rating period.

The overall annual effective prescription drug trend reflected is 4.6% for Non-HDHP and 6.0% for HDHP products, as indicated in item 1 above.

4. *Experience Rating Formula:* As in the previously approved filing, retention charges (including 9.5% for general administrative expenses) are added to the blended pure premium in deriving the group required pure premium.

MVPHIC is making the following changes to the experience rating formula effective 7/1/2014:

- HSA/HRA funding factor - reflects the additional risk charge attributed to anticipated increase in utilization when a group funds a portion of or the entire plan deductible;
- Movement of prior period adjustment factor - used to account for experience differences between the most recent experience period and prior periods. The adjustment factor was moved up in the experience rating formula so that it would apply before the pooling charge instead of after;
- Renewal rate cap guarantee factor - a group’s next renewal premium will be capped by a maximum agreed upon renewal increase; and
- Group risk assessment factor - reflects specific characteristics of the group.

L&E Analysis

1. *HDHP and Non-HDHP Manual Pure Premium Changes:* During our analysis of the 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.

Handling of large claims (in excess of \$100K) has been changed in this filing by removing such large claims from the historical fee for service claims in the base period experience and replacing those claims with a pooling charge. We find the use of the pooling charge to be reasonable given the continued drop in membership and significant differences in high cost claim PMPMs and PMPM trends between the non-HDHP products and HDHP products.

MVPHIC's 2014 anticipated traditional loss ratio for the large group market is 83.9%, and the equivalent federal loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) is 89.8 %. The adjusted loss ratio exceeds the minimum loss ratio requirement of 85% for the large group market. This anticipated loss ratio is consistent with the preceding 12-month periods:

- August 2010 – July 2011: 95.1%
- August 2011 – July 2012: 93.8%
- August 2012 – July 2013: 88.6%

The assumed contribution to surplus in this filing is 2%. This is consistent with the 2% contribution to surplus approved in the prior filing.

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

2. *Medical Trend:* MVPHIC combines data from MVP Health Insurance Company and MVP Health Plan approach to reduce volatility in the distribution of claims between providers. Additionally, since MVPHIC's provider contracts and networks within MVPHIC's footprint are the same for MVP Health Plan products and MVP Health Insurance products, MVPHIC's rationale that aggregating the data results in a more credible set of data is reasonable.

Additionally, we note that MVPHIC aggregates its small group and large group data in deriving the weights (% of allowed claims) applied to providers in determining the aggregate hospital and physician trends. We asked for further clarification regarding this approach since this approach could result in cross-subsidization between markets. MVPHIC opined that it follows this approach to increase statistical credibility and to reduce volatility in the distribution of claims between providers. Since MVPHIC's provider network and reimbursement are the same for small group and large groups, we find MVPHIC's rationale for aggregating the data to be reasonable and appropriate.

The assumed physician trend of 16.6% for 3Q/4Q is materially higher than what is typically assumed in such products. MVP provided a provider utilization-weighted distribution of allowed cost increases that illustrated the development of the aggregate 16.6%.

The revised contractual arrangement between MVP and a major provider group at materially higher rate levels appears to be the driver of the increased physician trend. For comparison purposes, we calculated that if the contracts were settled at a historically consistent unit cost

trend of 5% instead of the actual finalized contract levels, the aggregate physician trend level would reduce from 16.6% to 2.4%. This would be in line with the assumed 2013 physician trend level of 2.5%. If the 2014 physician cost trend was reduced from 16.6% to 2.5%, the overall 2014 medical trend (weighted by percent of allowed costs spent on inpatient, outpatient, and physician services) would reduce from 9.1% to 4.4%. This revised contractual arrangement has a significant impact on the required rate increase.

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.

We find the development of facility trend level and outpatient trend level to be appropriate and justified by the support provided.

3. *Rx Trend:* MVPHIC uses the best estimates of trend factors, split by drug category, from Express Scripts in developing its Rx trend. MVPHIC does not use historic claim experience to form assumptions for future Rx trend as it believes that prior experience is not indicative of future trends. We believe that the annual trend factors for generic/brand drugs and specialty drugs, as provided by Express Scripts, are reasonable. However, in analyzing the reasonableness of this trend assumption, historical Rx trend experience was reviewed for comparison purposes. Rolling 12 month Rx trend derived from base period experience shows high volatility (ranging from -0.2% to -13.7% for Non-HDHP and -9.4% to 1.1% for HDHP products). An average of the rolling 12-month Rx trends experienced from August 2012 through July 2013 is -7.1% for Non-HDHP and -6.5% for HDHP products.

Given the volatility of historical Rx trend experience and the diminishing membership³, we believe that MVP's approach of using the Rx trend rates provided by Express Scripts is a reasonable approach. We find the Rx trend rates of 4.6% for Non-HDHP and 6.0% for HDHP products to be reasonable and appropriate.

4. *Experience Rating Formula:* We assessed that MVPHIC's assumed general administrative load of 9.5% to be lower than the actual expense of 11.7% as illustrated in MVPHIC's 2012 NAIC statutory statement (for all markets). MVPHIC's rationale for this lower expense load assumption is that they are working to reduce administrative spending and have undergone several cost cutting measures as well as strategically positioning the company for membership growth through participation in the individual and group exchange market and Medicaid expansion. MVPHIC recognizes that the administrative load could still fall short relative to actual expenses in 2014; however, MVPHIC is committed to offering a product that provides value to its members with competitive non-claim expense charges. If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

We assessed the changes to the experience rating formula and find them to be reasonable and appropriate.

³ We note that total large group PPO membership decreased from an average of 9,527 members per month in 2012 to an average of 7,923 members per month in 2013.

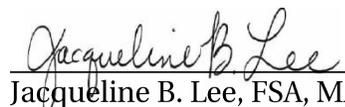
Recommendation

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.

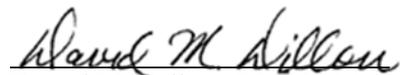
Sincerely,



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



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



David M. Dillon, FSA, MAAA, MS
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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:

- 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 25, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 24, 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.

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.

- 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.

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.