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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 Grandfathered Small Group EPO/PPO Rates
(SERFF #: MVPH-129389265)

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 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 the small and large group markets in New York and Vermont.
2. 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 third and fourth quarters of 2014. Small groups who hold grandfathered products represent those groups issued coverage prior to March 23, 2010 that have not made substantial changes to their benefits.
3. The proposed rates in this filing will affect approximately 4,600 Vermonters:
 - HDHP Groups: 4,200
 - Non-HDHP Groups: 400

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

	Small Group PPO/EPO	3Q14	4Q14
HDHP	Medical + Rx	4.8%	3.3%
Non-HDHP	Medical + Rx	6.3%	5.1%

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

	Small Group PPO/EPO	3Q14	4Q14
HDHP	Medical + Rx	6.3%	1.2%
Non-HDHP	Medical	6.3%	1.1%
	Rx Riders	6.3%	2.1%

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 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 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 3Q14 rating period using a 7.2% annual effective medical trend (elaborated further in item 2 below) assumption for Non-HDHP products and an 8.0% 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 leveraging¹. The prescription claims were projected forward to the midpoint of 3Q14 rating period using a 7.5% annual effective Rx trend (elaborated further in item 3 below) for Non-HDHP products and a 7.8% annual effective Rx trend for HDHP products.

The trended claims were adjusted to develop the required premium revenue. These adjustments were made to reflect the projected costs of benefit mandates, taxes, ACA related costs, and retention charges. The retention charges include 9.5% for general administrative expenses.

The required premium revenue PMPM for 3Q14 was compared to the 2Q14 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 13.9% was then blended (using weights based on December 2013 membership) with the calculated quarterly rate change of 5.1% for HDHP products to arrive at an average proposed rate change of 6.3%.

The trend factor used to derive the 4Q14 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 4Q rating period and adjusted for any fee changes between 3Q and 4Q).

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 MVPHIC's provider network.

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 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.

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 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%	8.9%	4.5%

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 8.0% 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 requested Rx trend reflected is 7.5% for Non-HDHP and 7.8% for HDHP products.

L&E Analysis

1. *HDHP and Non-HDHP Rate Development:* 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 and appropriate 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.

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.

MVPHIC's 2014 anticipated traditional loss ratio for the entire small group market is 90.1% and the equivalent federal loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) is 95.1%. The adjusted loss ratio exceeds the minimum loss ratio requirement of 80% for the small group market.

The historical loss ratios for the preceding 12-month periods were:

- August 2010 – July 2011: 83.1%
- August 2011 – July 2012: 88.0%
- August 2012 – July 2013: 91.2%

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

In the 1Q/2Q14 rate filing, the Commissioner of the Department of Financial Regulation had recommended reducing the 3.0% contribution to surplus to 2.0%. After reading the Commissioner's recommendations, MVPHIC, in addition to other changes, reduced the contribution to surplus from 3.0% to 1.0%. The assumed contribution to surplus in this filing is 2%, which is equivalent to the 2% contribution to surplus recommended by the Commissioner in the prior filing.

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

2. *Medical Trend:* 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. MVPHIC provided a provider utilization-weighted distribution of allowed cost increases that illustrated the development of the aggregate 16.6%.

The revised contractual arrangement between MVPHIC 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.

- 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 2.6% to 20.6% for Non-HDHP and 1.4% to 17.6% for HDHP products). An average of the rolling 12-month Rx trends experienced from August 2012 through July 2013 is 13.5% for Non-HDHP and 7.4% for HDHP products.

We believe that MVPHIC's approach of using the Rx trend rates provided by Express Scripts is a reasonable and appropriate approach. We find the Rx trend rates of 7.5% for Non-HDHP and 7.8% for HDHP products 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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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations², 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 Conduct³, 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.

² 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.

³ 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.