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April 22, 2016

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

Re: 3Q16 – 4Q16 MVPHIC Large Group EPO/PPO Rates
SERFF #: MVPH-130454426

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 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 third and fourth quarters of 2016.

2. The proposed rates in this filing will affect approximately 2,256 Vermonters. Of these 2,256 members, 45 have a third or fourth quarter policy effective date.

3. The average requested third and fourth quarter 2016 manual rate changes are seen below, alongside previously approved rate changes. The annualized rate changes for 3rd quarter group renewals and 4th quarter group renewals are in the second chart.

Reason for Change	4Q15 / 3Q15[1]	1Q16 / 4Q151	2Q16 / 1Q161	3Q16 / 2Q16	4Q16 / 3Q16
Manual Rate Change	1.8%	6.3%	1.2%	-8.1%	1.2%
Age/Gender Factor Changes	0.0%	-7.3%	0.0%	2.9%	0.0%
Change in Administrative Expenses	0.0%	-0.9%	0.0%	-3.8%	-0.7%
Total Revenue Change	***1.8%***	***-2.3%***	***1.2%***	***-9.0%***	***0.5%***

[1] Previously approved rate changes.

Reason for Change	3Q16 Annual	4Q16 Annual
Manual Rate Change	0.6%	0.0%
Age/Gender Factor Changes	-4.6%	-4.6%
Change in Administrative Expenses	-4.7%	-5.3%
Total Revenue Change	***-8.6%***	***-9.6%***

Due to plan design changes described below, the manual rate change varies between plans. The third quarter 2016 manual rate change is -8.6% for all plans except VEHD-02 and VPHD-03, which have a requested manual rate change of -5.9%. These correspond to quarterly revenue decreases ranging from approximately -9.5% to -6.9% for the third quarter of 2016. The rate increase for fourth quarter 2016 does not vary by plan.

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 (Appendices 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 November 1, 2014 through October 31, 2015 and paid through December 31, 2015 as the base period experience. Certain groups were excluded from this analysis because they are not eligible to purchase this product in the future or did not purchase this product in 2016.

   Exhibit 3a illustrates both the claim projection from the experience period to the rating period and the accompanying adjustments applied in deriving the rates for 3Q16.

   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 two months.

   The adjusted claims were projected forward to the midpoint of the 3Q16 rating period using an annual paid medical trend assumption of 3.4% (elaborated further in item 3 below). MVPHIC's paid medical trend is derived from its proposed allowed cost trend rates and the impact of cost share leveraging[2]. The prescription claims were projected forward to the midpoint of 3Q16 rating period using an annual paid Rx trend of 14.0%

[2] 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.

(elaborated further in item 4 below).

The trended claim cost was further adjusted to develop the projected claim costs as of 3Q16. These adjustments included projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting all of these adjustments, the manual rate change suggested by the data was -16.1%. MVPHIC has requested that only half of this manual rate change (-8.1%) be implemented in order to maintain rate stability.

Two plans in this block, VEHD-02 and VPHD-03, are undergoing slight benefit modification to comply with HHS' single member out-of-pocket maximum regulation. The effect of this increase is projected to be 3% for affected plans. So, for the small number of enrollees in VEHD-02, the rate increase will be 3% higher than the average rate increase for the block.

MVPHIC developed the 4Q16 manual rate by applying one more quarter of trend to the experience period claims. This results in a rate increase of 1.2% in 4Q16.

2. *Age/Gender Factor Changes:* The rates for this product depend on the demographics of the covered population. The base manual rate projection described above does not take into account changes in demographics. Therefore, it does not reflect the change in the average demographic factor that results from a younger or older enrolled population. Since the prior filing, the demographics of this block have been observed to deviate from past expectations. The demographic factors were re-normalized to reflect the updated experience and increased by 2.9%.

3. *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**	**2017**
Inpatient	5.3%	5.1%	5.1%
Outpatient & Other Medical	4.7%	4.0%	4.0%
Physician	2.9%	0.0%	0.0%
Total Medical Trend	**4.2%**	**2.8%**	**2.8%**

   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 3.4% annually. 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, twenty months of trend were used to trend the experience period claims forward.

4. *Rx Trend:* MVPHIC is requesting the annual allowed trends illustrated in the chart below, split by calendar

year and by drug tier:

	2015 Trend		2016 Trend		2017 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	4.3%	3.4%	3.0%	2.2%	3.0%	2.4%
Brand	13.5%	-11.4%	13.5%	-4.4%	13.5%	-6.0%
Specialty	16.0%	5.0%	12.0%	6.0%	12.0%	4.0%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 14.0%, 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, twenty months 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 relatively new.

5. *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 VT Paid Claim Tax. The assumed expenses reflect the one-year moratorium on the ACA Insurer Tax in 2017 and removal of the Temporary Reinsurance Pool fee for 2017 dates of service.

   The decrease in administrative expenses and the federal fees result in a rate change of -3.8% in 3Q 2016, and an additional -0.7% in 4Q 2016.

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 3Q 2016)		
Period	Traditional MLR	Federal MLR
3Q 2016	84.4%	88.1%

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%. MVPHIC has 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 are not making any recommendations at this time, but we will monitor this assumption closely in future filings.

The base period experience used in this filing has only two months of claims run-out, whereas previous filings have generally used three months of run-out. This necessitated a modification to the IBNR (Incurred but Not Reported) reserve factor. The updated base period was used consistently in both this filing and the

3Q/4Q Small Group filing, and the IBNR adjustment appears to be actuarially sound. Using only two months of run-out allows MVP to use the most current claims data. This change in methodology appears to be reasonable and appropriate.

The prior 1Q/2Q 2016 filing requested a uniform rate change. In this filing, the benefit relativities are being modified to reflect a change in the out-of-pocket maximum design for one plan, VEHD-02L. This corresponds to a 3% increase to members in this plan. All other plans have lower than average increases. The -8.1% quarterly manual rate change for 3Q 2016 reflects a -5.9% rate change for members of VEHD-02L (about 21% of members), and a -8.6% manual rate change for all other members. This change in the benefit relativities is based on MVPHIC's benefit pricing tool and is consistent with the benefit relativities for all other plans. The change in pricing to account for the out-of-pocket maximum modification appears to be reasonable and appropriate.

The experience data, trend projections, and other claim cost projections support a much more substantial rate decrease than is being proposed in this filing. While we concur with MVP that minimizing the decrease in this filing will reduce the necessary rate increases in the future, we do not believe the proposed 8.1% decrease is adequate to achieve actuarially justified rates for 3Q and 4Q renewals. In order to reduce future rate volatility, we propose that MVPHIC implement a decrease of 11.8% to the manual rate. This change was calculated by assuming all else being equal and that the total 16.1% decrease was implemented for this filing, the next filing would result in a rate increase of the current trend assumptions. Therefore, we have increased the rate change of -16.1% by the total paid trend assumption of approximately 5.2%. This change would result in a manual rate decrease of 11.8%, rather than 8.1%.

When a group requests a quote for plans affected by this filing, the manual rate calculated in this filing may be overridden, depending on their recent experience. According to the experience rating manual, all groups of 100 subscribers are subject to a "manual rate cap." This cap increases or reduces the manual rate to be within 15% of the group's experience. This is equivalent to assigning very high credibility to any group with outlier experience, even if the group's size would not generally warrant a high credibility factor.

L&E has concerns that this methodology could result in higher premium volatility than traditional credibility methods. The manual rate cap is new for 2016 and has yet to have an impact on any covered groups. At this time, we believe that the manual rate cap should be closely monitored in future filings to determine whether it results in unreasonable or unfairly discriminatory rates for MVP policyholders.

2. *Age/Gender Factor Changes:* The methodology used by MVPHIC is not typical in its approach to adjusting for age/gender factor changes. However, the result is mathematically equivalent to more standard methods of reflecting changes in demographics. Therefore, the age/gender normalization methodology appears to be reasonable and appropriate.

3. *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 3.4% annual medical paid trend assumption to be reasonable and appropriate.

   The methodology for combining multiple years of trend did not take into account the changing mix of services over time due to trend. At L&E's recommendation, MVP has decided to make a slight modification to their trend methodology to reflect this change. The impact to this filing is an increase in the proposed rates of 0.1%.

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. With the modification above, the proposed medical trends appear to be reasonable and appropriate.

4. *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 appropriateness of their proposed Rx trend assumption.

   The pharmacy vendor provides low, best, and high estimates of Rx trends. MVP has chosen to use the "low" estimates. In recent years, actual MVP drug trends have been observed to exceed even the high estimate from the PBM in many cases. For this reason, while we believe that MVP-specific trend calculations would be more accurate, we do not think that using the PBM's low estimate national trend projections lead to unreasonable premium rates. MVP has indicated that their historical data will be used to calculate Rx trends for the 2017 Exchange filing. It is our opinion that this methodology should be used in all filings from that point forward.

   As a result of our review of another MVP filing, it was discovered that the 2015 Rx trends used in this filing did not include an adjustment for the conversion to the new vendor in 2015. If this adjustment was included, the annual paid Rx trend would decrease by approximately 0.3%, resulting in a decrease in the overall proposed rates of approximately 0.1%.

   We recommend that MVPHIC make this change to the Rx trend assumption.

5. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.0% to be lower than the actual expense of 8.2% for all markets, as illustrated in MVPHIC's 2015 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.

   The reduction in the estimated federal fees appears to be reasonable and appropriate, given the guidance for 2016 and 2017. For policies issued in 4Q 2016, a larger portion of the contract year is in 2017, resulting in a greater impact from the Insurer Fee moratorium. If the Insurer Fee resumes for 2018, the rates will probably increase at that time to cover the added expense.

   The administrative expense assumptions appear 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 medical trend calculation to reflect the change in cost distribution over time. This change would increase the requested rate change by approximately 0.1%.
- Modify the Rx trend assumptions to reflect the one-time cost savings related to switching to a new PBM in 2015. This change would decrease the requested rate change by approximately 0.1%
- Implement an average manual rate change of -11.8%, rather than one-half of the indicated rate change. This change would result in a decrease of approximately -4.0% in the proposed rates.

The above changes would decrease the 3Q16 quarterly manual rate change from -8.1% to approximately -11.8% and have minimal impact on the 4Q16 quarterly manual rate change of 1.2%. When combined with the changes in normalization of the age/gender table and administrative changes, the quarterly revenue changes have been estimated in the table below:

Quarterly Changes	MVPHIC Proposal		Recommended	
	3Q16 / 2Q16	4Q16 / 3Q16	3Q16 / 2Q16	4Q16 / 3Q16
Manual Rate Change	-8.1%	1.2%	-11.8%	1.2%
Age/Gender Factor Changes	2.9%	0.0%	2.9%	0.0%
Change in Administrative Expenses	-3.8%	-0.7%	-3.8%	-0.7%
Total Revenue Change	***-9.0%***	***0.5%***	***-12.7%***	***0.5%***

Annual Rate Changes	MVPHIC Proposal		Recommended	
	3Q16 / 3Q15	4Q16 / 4Q15	3Q16 / 3Q15	4Q16 / 4Q15
Manual Rate Change	0.6%	0.0%	-3.5%	-4.0%
Age/Gender Factor Changes	-4.6%	-4.6%	-4.6%	-4.6%
Change in Administrative Expenses	-4.7%	-5.3%	-4.7%	-5.3%
Annual Revenue Change	***-8.6%***	***-9.6%***	***-12.3%***	***-13.3%***

Sincerely,

Jacqueline B. Lee, FSA, MAAA
Vice President
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David M. Dillon, FSA, MAAA, MS
Vice President & Principal
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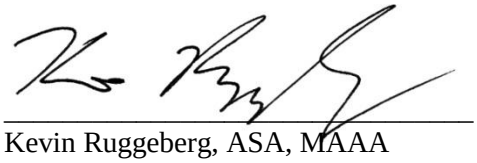

Kevin Ruggeberg, ASA, MAAA
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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[3], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[4], 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).
- Kevin J. Ruggeberg, ASA, MAAA Associate Actuary 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 April 22, 2016. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 17, 2016.

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.

[3] 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.

[4] 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.