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May 22, 2018

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05620

Re: MVP Health Plan, Inc.
3Q/4Q 2018 Large Group HMO Rate Filing
SERFF #: MVPH-131435335, MVPH-131435409

The purpose of this letter is to provide a summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP or MVPHP) for its existing HMO products for the third and fourth quarters of 2018 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP is a non-profit health benefit plan provider. MVP provides small and large group coverage to employers in Vermont as well as individual and small group coverage sold on Vermont Health Connect (VHC).

2. This filing demonstrates the premium rate development of MVP's large group HMO 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 2018. MVP has migrated the entire product portfolio sold on the MVP Health Insurance Company (MVPHIC) license to MVP Health Plan and has retired the entire portfolio previously sold on MVP Health Plan.

3. This filing is supplemented by products on the MVP Health Insurance Company (MVPHIC) Large Group filing (SERFF#: MVPH-131435409). The products on the MVPHIC filing provide out of network coverage riders to the base major medical offerings in this filing. The products on the MVPHIC filing are not standalone products and must be purchased in conjunction with coverage on MVPHP. The rates for these riders are set as a percentage of premium to the combined medical and pharmacy manual rates under the Large Group HMO plan. The example below utilizing 3Q 2018 manual rates demonstrates this calculation.

a) Medical Benefit VT3HMO0872ZLN	$463.73	
b) Rx Benefit RXVT3HMB500ZL	$50.68	
c) Combined In-Network Manual Rate	$514.41	= a) + b)
d) POS Rider SV3HMB01L Percentage	3.60%	
e) Combined Manual Rate w/ POS Rider	$532.93	= c) * [1 + d)]

4. As of January 2018, there were approximately 2,275 members enrolled in MVP large group plans in

Vermont. Of these 2,275 members, 155 (7%) have a third quarter effective date and none have effective dates in the fourth quarter. The remaining members have effective dates in the first or second quarter.

5. The average requested quarterly 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	4Q17 / 3Q17	1Q18/ 4Q17	2Q18/ 1Q18	3Q18/ 2Q18	4Q18/ 3Q18
Manual Rate Change	1.8%	-3.1%	1.4%	8.3%	1.2%
Age/Gender Factor Changes	0.0%	-0.1%	0.0%	-1.0%	0.0%
Change in Retention	0.9%	0.3%	0.0%	-4.2%	-0.4%
Total Revenue Changes	2.7%	-2.9%	1.4%	2.6%	0.8%

Reason for Change	3Q18 Annual	4Q18 Annual
Manual Rate Change	8.3%	7.7%
Age/Gender Factor Changes	-1.1%	-1.1%
Change in Retention	-3.1%	-4.3%
Total Revenue Change	***3.8%***	***1.9%***

6. The filing was amended on March 29, 2018. The deductible and maximum OOP for plan VT3HDH41EXLE was updated from $2,600 to $2,700. No change to the rate was necessary as this change was already made in the previous filing. MVP added riders to ensure rider versions that attach to both the HMO Certificate of Coverage (COC) and the HDHP COC were available. MVP also added a wellness rider and a rider that adds a discount program for services such as Acupuncture, Chiropractic, Dietic, Exercise Center, Fitness Club, and Massage Therapy. Because MVP does not have utilization data for these services, the rate was added at $0.00.

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

MVP 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:* MVP utilized large group claim data (constituting HDHP and non-HDHP products) for the period from November 2016 through October 2017 and paid through January 2018 (with incurred estimates updated through February 2018) as the base period experience.

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 3Q18.

From the historical medical 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 3Q18 rating period using an annual paid medical trend assumption of 2.8% (elaborated further in item 3 below). MVP's paid medical trend 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 3Q18 rating period using an annual paid Rx trend of 14.7% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 3Q18. These adjustments included projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting all of these adjustments, the quarterly manual rate change suggested by the data was 8.3%.

MVP developed the 4Q18 manual rate by applying one more quarter of trend to the experience period claims. This results in a quarterly manual rate increase of 1.2% in 4Q18.

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 decreased by 1.0%.

3. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. The assumed utilization trend is 0.0%. Due to concerns with the large impact that membership growth in other blocks of business was having on the total utilization trend for Vermont, MVP elected to reflect no utilization trend.

Medical Trend	Unit Cost Trend	Utilization Trend	Allowed Trend	Paid Medical Trend
2017	2.0%	0.0%	2.0%	2.3%
2018	2.5%	0.0%	2.5%	2.8%
2019	2.6%	0.0%	2.6%	2.9%

The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims cost paid by the carrier and the policyholder) and do not reflect effective paid trends which reflect the actual claim payment by carrier only. MVP 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 2.8% annually. This

[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.

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 to 3Q18.

4. *Rx Trend:* MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2017 Trend		2018 Trend		2019 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-8.3%	0.8%	-0.4%	2.7%	4.6%	3.1%
Brand	9.9%	-4.4%	14.9%	2.5%	12.5%	1.4%
Specialty	10.9%	9.6%	6.9%	7.5%	10.6%	7.4%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 14.7%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (by modeling deductible, copay and coinsurance). This blended annualized figure is used to trend the experience period claim costs to the projection period.

MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVP's pharmacy vendor. Those trend factors reflect MVP's business in the state of Vermont.

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 9.7% of premium for general administrative expense. This is consistent with the prior filing. There is also an assumption of 2.0% for contribution to reserve and other miscellaneous charges similar to the 1Q/2Q18 filing that are itemized below:
    - Fees and surcharges representing 1.25% of expected claims,
    - Retention expenses of 11.7%:
        - General administrative expense of 9.7%, and
        - Contribution to reserve of 2.0%.
    - ACA Insurer tax of 1.0% for coverage dates in calendar year 2018,
    - VT vaccine pilot charge of 0.5%,
    - Patient-Centered Outcomes Research Institute (PCORI) Fee of $0.21 PMPM.

L&E Analysis

1. *Rate Development:* During our analysis of MVP'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.

Projection Period (LG in 3Q 2018)		
Period	**Traditional MLR**	**Federal MLR**
3Q 2018	84.8%	86.6%

The pooling charge of 9.2% assumed in this filing is unchanged from the prior filing. As with the prior filing, recent experience has had fewer catastrophic claims than are assumed in this charge. It has been several years since the high-dollar claims on this block were as high as 9.2%. However, MVP provided data from

its nationwide experience demonstrating that the proposed pooling charges are reasonable. Due to the highly volatile nature of this assumption, we agree with MVP's assessment that this assumption, by definition, should not respond to short-term fluctuations. The Vermont large group experience alone does not constitute a credible source for this assumption, since it is small. The current assumption was calculated based on data from 2013 and 2014, when membership was several times as high. The impact of medical trend makes it unlikely that this factor should decrease over time. We do not recommend changes to the pooling charge at this time.

The base period experience used in this filing has three months of claims run-out and therefore, needed to be adjusted for claims incurred but not reported ("IBNR"). The IBNR factor also includes several large claims for the experience period that were received in February 2018. The IBNR adjustment appears to be actuarially sound and is consistent with MVP's other filings.

MVP offers a retrospective rating[2] product to its large group customers in Vermont. In CY2016, MVP paid out more than was collected for the retrospective rating program at its previous load of 1%. MVP chose to increase the load to 2% and added the difference between the 2% of premium and the actual payment amounts to the claim cost for 2016. This amounts to $0.76 PMPM as a capitated expense. If these payments were not addressed, MVP would not have reached its target loss ratio. The retrospective rating methodology appears to be reasonable and appropriate.

2. *Age/Gender Factor Changes:* Since the previous filing, the average age/gender factor of the covered population has been observed to increase by 1.0%. If this change were not corrected for, this would result in excess revenue being collected. To account for this change, MVP has decreased all age/gender factors by the necessary 1.0% to maintain the necessary premium level. When combined with the normalization from the prior filing, this results in an annual decrease to the age/gender factors of 1.1%. The age/gender normalization methodology appears to be reasonable and appropriate.

3. *Medical Trend:* The annual effective paid medical trend factor of 2.8% assumed in this filing represents the most up-to-date provider contracting information available at the time of the filing, resulting in slight changes from prior filings.

   The table below illustrates the allowed trend factors for various benefit categories:

Service Category	2017	2018	2019
Inpatient	4.2%	5.0%	5.0%
Outpatient & Other Medical	3.9%	4.7%	4.7%
Physician	-2.4%	-2.6%	-2.6%
Total Allowed Trend	**2.0%**	**2.5%**	**2.6%**

   We consider the development of medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. L&E has reviewed the methodology used to combine the assumptions by service category and year into a single trend assumption and found it reasonable.

   In this filing, MVP is using a 0.0% utilization trend. MVP had concerns with the large impact that membership growth in other blocks of business was having on the total utilization trend for Vermont. Because removing the other blocks would result in a block that was not considered credible, MVP elected

[2] Retrospective rating is a program where the final premium paid is based on actual losses incurred during the policy period. It has some characteristics of self-insured coverage.

to reflect no utilization trend. Based on all information available at this time including a review of historical utilization data provided by MVP, the utilization trend included in this filing appears to be reasonable and appropriate.

4. *Rx Trend:* MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2017 Trend		2018 Trend		2019 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-8.3%	0.8%	-0.4%	2.7%	4.6%	3.1%
Brand	9.9%	-4.4%	14.9%	2.5%	12.5%	1.4%
Specialty	10.9%	9.6%	6.9%	7.5%	10.6%	7.4%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 14.7%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (by modeling deductible, copay and coinsurance). This blended annualized figure is used to trend the experience period claim costs to the projection period.

MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVP's pharmacy vendor and account for MVP's Vermont specific book of business.

MVP is using 2018 drug rebate forecasts provided by the Pharmacy Benefit Manager (PBM). These forecasts assume that drug rebates will equal $18.98 PMPM for 3Q 2018 renewals and $19.19 PMPM for 4Q 2018 renewals.

These assumptions appear to be reasonable and appropriate.

5. *Administrative Expenses:* We observed that MVP's assumed general administrative load of 9.7% to be the same as the previous filing. While the assumed administrative load is higher than recent actual expenses on a percentage basis, MVP previously explained that the anticipated enrollment in 2018 is expected to be materially lower than in prior years. This decrease in enrollment leads to a higher administrative load PMPM because some costs are fixed. The administrative load appears to be reasonable and appropriate.

Administrative Expense Summary for Large Group AR42 & AR44 Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2013	118,563	$363.04	$39.18	10.8%
2014	97,084	$404.11	$38.31	9.5%
2015	68,766	$432.06	$34.13	7.9%
2016	37,858	$450.19	$36.77	8.2%

MVP indicated that the change in retention/target loss ratio from 2Q 2018 to 3Q 2018 is -4.2%. This large change is due to the migration of groups from the MVPHIC EPO/PPO block to the MVPHP HMO block. MVP assumed that groups would be on MVPHIC in 2Q 2018 and MVPHP in 3Q 2018. While this is not a possible combination from a quarterly perspective, this was done in order to measure the actual annual change to revenue for a group that purchased products on MVPHIC in 3Q 2017 and would be renewing in 3Q 2018.

The target loss ratio on MVPHIC in 2Q 2018 was 81.2% while the target loss ratio on MVPHP in 3Q 2018 was 84.8%. This was driven by two changes: state of Vermont premium tax and federal 9010 ACA insurer tax. Because MVPHP does not have to pay state premium tax in Vermont, the 2.0% of premium assumed on MVPHIC in 2Q 2018 is reduced to 0.0% in this filing. The federal ACA insurer tax assumption on MVPHIC in 2Q 2018 was 2.0% of premium as it was still assumed to be in place for 2019 coverage dates. The assumption on MVPHP in 3Q 2018 is 0.4% due to: reduced liability for 2018 coverage dates to 1.0% of premium (since a portion of the premium on non-profit companies is excluded from the tax formula) and the suspension of the tax for 2019 coverage dates.

The proposed contribution to reserve is 2.0%. In past orders, the Board has reduced the proposed contribution to reserves. We recommend that the solvency analysis performed by Department of Financial Regulation be considered if changes are made to this assumption.

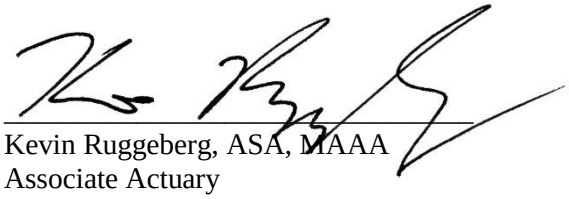
MVP has stated the billback stipulated by 18 V.S.A § 9374 (h)(1) and HCA assessment as a claims expense for loss ratio purposes. During the 1Q/2Q 2018 HMO filing review, in accordance with guidance received from CMS, GMCB provided direction that MVPHP must include such amounts within its administrative expenses, consistent with the treatment of other taxes and fees imposed by the state and federal governments. L&E notes that this instruction was not implemented in the 3Q 2018 filing and recommends that this be addressed in the filing of 2019 Vermont Health Connect rates. However, we note that this reporting issue does not materially impact the rates under review.

Notwithstanding the Billback mischaracterization, the administrative expense assumptions appear 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 proposed.

Sincerely,



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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:

- Kevin J. Ruggeberg, ASA, MAAA 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 May 22, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is May 22, 2018.

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.