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October 5, 2018

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

Re: MVP Health Plan, Inc.
2019 Large Group HMO Rate Filing
SERFF #: MVPH-131604445, MVPH-131604447

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 coverage year 2019 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 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, comprised of both high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and includes proposed rates for all four quarters of 2019. MVP has migrated the entire product portfolio sold on the MVP Health Insurance Company (MVPHIC) license to MVP Health Plan.

3. This filing is supplemented by products on the MVP Health Insurance Company (MVPHIC) Large Group filing (SERFF#: MVPH-131604447). 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. MVP submitted an amendment to this filing to reflect some minor changes to the available plan designs, with no material impact on rating. A new POS rider, SV3H(MB/DH)05L, is available to be added to select

HMO plans which did not previously have an associated POS rider. The pricing for this rider is consistent with the other riders and is reasonable. The classification of one plan as a Qualified High-Deductible Health Plan was changed, and an associated rider was removed.

5. As of May 2018, there were approximately 2,171 members enrolled in MVP large group plans in Vermont. Of these 2,171 members, 85% have renewal dates during 1st quarter.

6. The average requested quarterly manual rate changes are seen below, alongside previously approved rate changes. The annualized rate changes by quarter are in the second chart.

Reason for Change	1Q '19 / 4Q '18	2Q '19 / 1Q '19	3Q '19 / 2Q '19	4Q '19 / 3Q '19
Manual Rate Change	10.6%	1.5%	1.5%	1.6%
Age/Gender Factor Changes	-0.6%	0.0%	0.0%	0.0%
Change in Retention	-0.1%	0.5%	0.1%	0.5%
Total Premium Changes	***9.9%***	***2.0%***	***1.6%***	***2.1%***

Reason for Change	1Q '19 Annual Increase	2Q '19 Annual Increase	3Q '19 Annual Increase	4Q '19 Annual Increase
Manual Rate Change	22.9%	23.0%	15.3%	15.8%
Age/Gender Factor Changes	-1.6%	-1.6%	-0.6%	-0.6%
Change in Retention	-6.0%	-5.5%	0.2%	1.0%
Total Premium Change	***13.8%***	***14.4%***	***14.8%***	***16.2%***

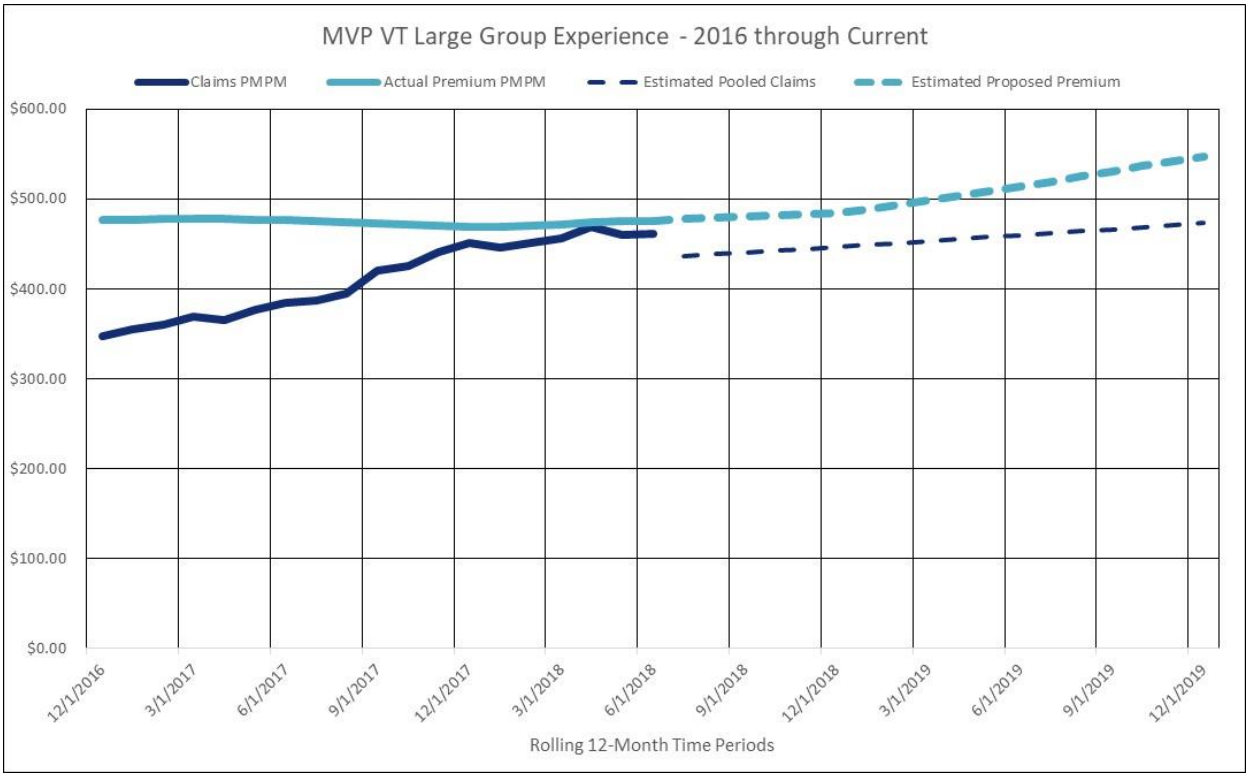
7. The initial filing materials contained miscalculations in the development of the above tables. The increases described above, while higher than the initially filed increases, are reflective of the rates proposed at that time.

8. The rate increases outlined above reflect the revenue for a manually-rated group. This is used for groups without any past coverage experience, or for groups that are too small for the experience to be used entirely. In practice, adequately large groups have premium rates based on their own claims experience. Therefore, some groups will experience higher increases, and some will experience lower increases. If a group experiences a higher rate increase, it is because their claims experience deteriorated relative to the other large groups in this block. All groups will experience the effect of changes in retention, as these components of the rate are added to the projected claims, whether those claims came from the manual rate or the group's experience.

9. The increase in the manual rate is substantially higher than trend. This is due to very unfavorable experience in the most recent experience. The chart below summarizes premiums and claims between 2016 and June 2018. It is important to keep in mind that the premiums PMPM line should be about 10% - 15% higher than the claims PMPM line to account for the retention components, such as administrative expenses.

   This chart shows that claims experience increased rapidly during 2017 and 2018, while premium revenue remained flat. Even without the effect of trend, the current claim level would produce high loss ratios even with the requested rate increase. The rates assume that claims will revert to a lower loss

ratio in 2019 and that recent experience is an aberration (see discussion of pooling charge below). [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

MVP provided the methodology used in premium rate development (Exhibit 2a-2p and Exhibit 3a-3d) 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 May 2017 through April 2018 and paid through May 2018 (with incurred estimates updated through June 2018) as the base period experience.

   Exhibit 3a illustrates both the claim projection from the experience period to the rating period and the

[1] This chart was created by L&E using historical data provided by MVP and reflects the projected revenue change, claims trend, and 2019 loss ratio from MVP.

accompanying adjustments applied in deriving the rates for 1Q19.

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 two months. The pooling charge is equal to 9.9%.

The adjusted claims were projected forward to the midpoint of the 1Q19 rating period using an annual paid medical trend assumption of 4.3% (elaborated further in item 3 below). MVP's paid medical trend is derived from its proposed allowed cost trend and the impact of cost share leveraging[2]. The prescription claims were projected forward to the midpoint of the 1Q19 rating period using an annual paid Rx trend of 14.6% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q19. These adjustments included projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting these adjustments, the quarterly manual rate change suggested by the data was 10.6% for 1Q19.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in quarterly manual rate increases of 1.5% to 1.6% in each quarter of 2019. That is, groups renewing in April will be charged premiums based on manual rates approximately 1.5% higher than groups renewing in January. As noted above, approximately 85% of groups have 1st quarter renewal dates.

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 0.6%. This means that the enrolled population was slightly older than the prior experience period, resulting in additional revenue available to cover claims. This increased revenue permits the 0.6% rate reduction.

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	Allowed Trend	Paid Medical Trend
2018	3.5%	3.8%
2019	4.2%	4.6%
2020	6.4%	4.7%

The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims

[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.

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 4.3% 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 to 1Q19.

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

	2018 Trend		2019 Trend		2020 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-0.7%	2.4%	4.9%	3.2%	4.9%	3.2%
Brand	14.3%	4.5%	12.1%	-0.4%	12.1%	-0.4%
Specialty	4.2%	7.6%	9.6%	7.8%	9.6%	7.8%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 14.6%, 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 8.9% of premium for general administrative expense. This is a material reduction from the prior filing value of 9.5% of premium. There is also an assumption of 2.0% for contribution to reserve and other miscellaneous charges similar to the previous filing that are itemized below:
    - Broker load equal to 2.3% of premiums.
    - Provision for bad debt equal to 0.3% of premiums.
    - ACA Insurer tax of 0.0% for coverage dates in calendar year 2019 and 1.0% of premium for 2020 coverage dates. This is consistent with the moratorium on insurer fee collections in 2019.
    - VT vaccine pilot charge of 0.0%. This has formerly been 0.5% of premium. MVP stated that the administrator of the program has indicated this assessment will be suspended for 2019.
    - Patient-Centered Outcomes Research Institute (PCORI) Fee of $0.00 PMPM. This fee is no longer being charged. In recent years, it amounted to approximately $0.21 PMPM.
    - The 18 V.S.A § 9374 (h)(1) billback equal to $0.91 PMPM based on MVP's projected responsibility.

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 1Q 2019)		
Period	**Traditional MLR**	**Federal MLR**
1Q 2019	86.4%	87.4%

Large group claims have increased rapidly in recent time periods. This increase in claims led to a loss ratio of 96.2% in calendar year 2017, with high loss ratios likely to materialize in 2018 as well.

MVP uses a pooling charge to mitigate the impact of catastrophic claims (i.e. those exceeding $100,000 per member per year). The purpose of this adjustment is to prevent major swings in premium resulting from a small number of cases. Regardless of the actual value of catastrophic claims, they are removed and replaced by a flat percentage. This is typical industry practice and L&E believes this is a reasonable approach, and this assumption has a material impact on this filing.

The pooling charge assumption of 9.9% in this filing is an increase from the prior filing's assumption of 9.2%. We note that claims exceeding $100,000 made up 25.3% of the base period experience. Therefore, the use of the pooling charge is reducing the projected claims by approximately 15% relative to using the base period experience without adjustment. Given the size of this block, it would have been within the scope of standard practice to request this additional 15% rate increase. However, MVP has made a good faith effort to control the volatility in premiums and ensure that the rates charged are not excessive. If the experience during 2019 is consistent with the base period experience, we would expect that the loss ratio will continue to be near 100%, and profits will be negative. Therefore, while the requested rate increase is high, MVP is taking steps to mitigate even higher rate increases.

The base period experience used in this filing has two months of claims run-out and therefore, needed to be adjusted for claims incurred but not reported ("IBNR"). The IBNR adjustment appears to be actuarially sound and is consistent with MVP's other filings.

2. *Age/Gender Factor Changes:* Since the previous filing, the average age/gender factor of the covered population has been observed to increase by 0.6%. 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 0.6% 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 1.6%. The age/gender normalization methodology appears to be reasonable and appropriate.

3. *Medical Trend:* The annual effective paid medical trend factor of 4.3% 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 assumed allowed trend factors for various benefit categories:

Service Category	2018	2019	2020
Inpatient	6.2%	6.4%	6.4%
Outpatient & Other Medical	4.5%	4.6%	4.6%
Physician	-1.5%	0.6%	0.6%
Total Allowed Trend	**3.5%**	**4.2%**	**4.2%**

Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2019 hospital budgets. The budgeted unit cost increases are lower than anticipated at the time of the filing.

Therefore, we recommend that MVP modify the filing to reflect the lower hospital budget amounts. L&E has estimated the impact of this change as follows:

Manual Rate Change	1Q '19 / 4Q '18	2Q '19 / 1Q '19	3Q '19 / 2Q '19	4Q '19 / 3Q '19
As filed	10.6%	1.5%	1.5%	1.6%
Reflecting Final Order	10.1%	1.4%	1.4%	1.4%

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 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:

2018 Trends	Unit Cost	Utilization	Total Trend
Generic	-0.7%	2.4%	1.7%
Brand	14.3%	4.5%	19.5%
Specialty	4.2%	7.6%	12.1%
Total	5.8%	6.0%	12.1%
2019 Trends	**Unit Cost**	**Utilization**	**Total Trend**
Generic	4.9%	3.2%	8.3%
Brand	12.1%	-0.4%	11.7%
Specialty	9.6%	7.8%	18.1%
Total	9.4%	5.0%	14.9%
2020 Trends	**Unit Cost**	**Utilization**	**Total Trend**
Generic	4.9%	3.2%	8.3%
Brand	12.1%	-0.4%	11.7%
Specialty	9.6%	7.8%	18.1%
Total	9.4%	5.0%	14.9%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 14.6%, 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 2019 drug rebate forecasts provided by the Pharmacy Benefit Manager (PBM). These forecasts assume that drug rebates will equal $22.15 PMPM for 1Q 2019 renewals and increasing with pharmacy trend for later quarters.

These assumptions appear to be reasonable and appropriate.

5. *Administrative Expenses:* MVP's general administrative load assumption of 8.9% is lower than the previous filing's assumption. The projected administrative expenses as a percentage of premium are equal to actual calendar year 2017 expenses. The administrative load appears to be reasonable and appropriate. The following table summarizes data taken from the Supplemental Health Care Exhibits in recent years:

Administrative Expense Summary for Large Group 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%
2017	25,372	$474.10	$42.09	8.9%

MVP indicated that the rating impact from the change in retention/target loss ratio from 4Q 2018 to 1Q 2019 is -0.1%. The target loss ratio in 4Q 2018 was 86.3%, while the target loss ratio in 1Q 2019 is 86.4%. This minimal change is primarily the result of three offsetting changes: The general administrative load has decreased by 0.6% of premium, and the VT vaccine assessment (0.5% of premium) is being suspended. MVP is increasing the contribution to reserve from 1.0% to 2.0%. All retention components are broken out by quarter as a percentage of premium in the table below:

Retention Components as % of Revenue				
Expense Category	**1Q2019**	**2Q2019**	**3Q2019**	**4Q2019**
General Administration	8.90%	8.90%	8.90%	8.90%
Broker Load	2.30%	2.30%	2.30%	2.30%
Bad Debt	0.25%	0.25%	0.25%	0.25%
VT Premium Tax	0.00%	0.00%	0.00%	0.00%
Contribution to Surplus	2.00%	2.00%	2.00%	2.00%
VT Vaccine Assessment	0.00%	0.00%	0.00%	0.00%
ACA Insurer Tax	0.00%	0.40%	0.50%	0.90%
New York Covered Lives Assessment	0.00%	0.00%	0.00%	0.00%
Comparative Effectiveness Research Tax	0.00%	0.00%	0.00%	0.00%
18 VSA 9374h Billback	0.18%	0.18%	0.18%	0.17%

Groups renewing after 1Q 2019 will have coverage years which extend into 2020, when the Health Insurer Fee will be resumed. For this reason, the premiums charged increase over the course of 2019 to appropriately fund the assessment of the Health Insurer Fee. The target loss ratio for policies renewing in 4Q 2019 is 85.5%. The assumed provisions for the Health Insurer Fee and other non-benefit expenses are reasonable and supported.

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

In prior filings, MVP stated the billback stipulated by 18 V.S.A § 9374 (h)(1) and HCA assessment as a claims expense for loss ratio purposes. Starting with the 2019 Exchange filing, MVP has begun reported this cost as an administrative expense, at the direction of the Green Mountain Care Board. While this increases the non-benefit costs, the manual rate was reduced by a corresponding amount, resulting in a net zero rate change resulting from this reporting change.

Recommendation

L&E recommends that the unit cost trends be modified to reflect the Green Mountain Care Board's orders regarding 2019 hospital budgets. The revised rate increase is as follows:

Reason for Change	1Q '19 / 4Q '18	2Q '19 / 1Q '19	3Q '19 / 2Q '19	4Q '19 / 3Q '19
Manual Rate Change	10.1%	1.4%	1.4%	1.4%
Age/Gender Factor Changes	-0.6%	0.0%	0.0%	0.0%
Change in Retention	-0.1%	0.5%	0.1%	0.5%
Total Revenue Changes	**9.4%**	**1.9%**	**1.5%**	**1.9%**

Reason for Change	1Q '19 Annual Increase	2Q '19 Annual Increase	3Q '19 Annual Increase	4Q '19 Annual Increase
Manual Rate Change	22.4%	22.4%	14.6%	14.8%
Age/Gender Factor Changes	-1.6%	-1.6%	-0.6%	-0.6%
Change in Retention	-6.0%	-5.5%	0.2%	1.0%
Total Revenue Change	***13.2%***	***13.8%***	***14.1%***	***15.3%***

L&E believes that, if modified as described above, this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.

Sincerely,

Kevin Ruggeberg, ASA, MAAA
Associate Actuary
Lewis & Ellis, Inc.

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

David M. Dillon, FSA, MAAA, MS
Vice President & Principal
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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 October 5, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 5, 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.