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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 MVP Health Plan Large Group HMO Rates
 SERFF #: MVPH-129391759

The purpose of this letter is to provide a summary and recommendation regarding the proposed large group filing submitted by MVP Health Plan (MVPHP) for its HMO 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. MVPHP provides HMO and POS Article 44 products to employers in the large group market in New York and Vermont.
2. This filing demonstrates the premium rate development of MVPHP's large group HMO product portfolio and includes proposed rates for both the third and fourth quarters of 2014. This block of business, comprised of both high deductible health plans (HDHP) and non-high deductible plans (non-HDHP), has reduced in size over the recent years with many of the HMO members migrating to MVP Health Insurance Company's (MVPHIC) EPO/PPO products or dropping coverage. Based on enrollment as of December 2013, only an estimated 2% of HMO enrollees renew in the 3rd quarter with the remaining 98% renewing in the first quarter.
3. The proposed rates in this filing will affect approximately 400 Vermonters.

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 HMO	3Q14	4Q14
Medical + Rx	5.0%	4.8%

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 HMO	3Q14	4Q14
Medical	1.7%	1.2%
Rx Riders	1.7%	0.7%

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

MVPHP provided the methodology used in premium rate development (Exhibit 3) and details pertinent to its actuarial assumptions/experience driving the rate increase 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. *HMO Manual Pure Premium Changes:* Due to low membership in this block, MVPHP does not consider this block of business to be credible and expects it to produce volatile medical loss ratios. MVPHP is proposing to increase the approved 2nd quarter 2014 rates by the expected quarterly inflation rate adjusted for the impact of new taxes and benefit changes. Since there are no new mandated or taxes imposed since the 2nd quarter 2014 filing, the quarterly manual rate change is equal to one quarter of paid trend, which equals 1.7% for the 3rd quarter 2014. This paid trend reflects 1.5 months of 2014 paid trend and 1.5 months of 2015 paid trend to project from the midpoint of the 2nd quarter 2014 rating period (11/15/2014) to the midpoint of the 3rd quarter 2014 rating period (2/15/2015).

For illustrative purposes, MVPHP has demonstrated that the projection of the incurred claims during the experience period (August 1, 2012 through July 31, 2013 and paid through October 31, 2013) using an annual medical trend of 7.1% and annual Rx trend of 2.1% to the midpoint

of the rating period will result in a suggested rate change of 3.2%. This alternate approach results in a higher rate change than the requested rate change of 1.7% for 3Q14.

The trend factor used to derive the 4th quarter 2014 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 the third and fourth quarters).

2. *Medical Trend:* Consistent with recently submitted filings, MVPHP is utilizing a 0% utilization trend to its data. MVPHP 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 MVPHP's provider network.

MVPHP 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. MVPHP 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. MVPHP 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%

MVPHP adjusted the allowed cost trends illustrated above to account for the impact of cost

share leveraging¹ and derived the effective paid medical trend factor of 7.1% as indicated in item 1 above.

3. *Rx Trend:* MVPHP analyzes its pharmacy data by drug category (Traditional vs. Specialty). Annual trend factors by drug category, as supplied by MVPHP'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 2.1%, 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.

MVPHP 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. *HMO Manual Pure Premium Changes:* During our analysis of MVPHP'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.

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.

This block of business has been reduced to approximately 400 members (as of December 2013), with many members migrating to MVPHIC's EPO/PPO products and dropping coverage. The 12-month rolling member months in this block declined from approximately 29,700 in 2011 to 3,600 in 2012. Given the low membership, which translates to higher volatility and lower credibility of claim experience, MVPHP's proposal to increase the quarterly manual rate by one quarter of paid trend is reasonable and appropriate.

MVPHP's 2014 anticipated traditional loss ratio for the large group HMO market is 82.1% and the equivalent federal loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) is 85.3 %. This adjusted loss ratio exceeds the minimum loss ratio requirement of 85% for the large group market.

We reviewed the federal loss ratio experienced over the base experience period and the two preceding 12-month periods, as presented by MVPHP, for its large group HMO market and find the claim experience to be volatile:

- August 2010 – July 2011: 92.2%
- August 2011 – July 2012: 100.1%
- August 2012 – July 2013: 83.1%

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

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

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

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

The revised contractual arrangement between MVPHP 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 MVPHP 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:* MVPHP uses the best estimates of trend factors, split by drug category, from Express Scripts in developing its Rx trend. MVPHP 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 -17.4% to 155.7%. An average of the rolling 12-month Rx trends experienced from August 2012 through July 2013 is 78.3%.

Given the volatility of historical Rx trend experience and the diminishing membership², we believe that MVPHP's approach of using the Rx trend rates provided by Express Scripts is a reasonable approach. We find the Rx trend rate of 2.1% to be reasonable and appropriate.

4. *Experience Rating Formula:* We assessed that MVPHP's assumed general administrative load of 9.5% to be slightly higher than the MVP Health Plan's aggregate (small group and large group combined) administrative expense of 8.1% as illustrated in the 2012 Vermont supplemental health care exhibit. Given the volatility and low credibility of experience, we find the administrative load assumption to be reasonable and appropriate.

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

² We note that total large group HMO Rx membership decreased from 6,660 rolling member months ending August 2012 to 4,358 rolling member months in July 2013.

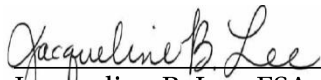
Recommendation

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,



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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations³, 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 Conduct⁴, 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 25, 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.

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.

- 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, statutes, 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.