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October 14, 2019

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

Re: MVP Health Plan, Inc.
2020 Large Group HMO Rate Filing
SERFF #: MVPH-132048265, MVPH-132046387

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 2020 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 2020. 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-132046387). 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 Q1 2020 manual rates demonstrates this calculation:

a) Medical Benefit VT3HMO087ZLN	$578.85	
b) Rx Benefit RXVT3HMB500ZL	$72.11	
c) Combined In-Network Manual Rate	$650.96	= a) + b)
d) POS Rider SV3HMB01L	3.60%	
e) Combined Manual Rate w/ POS Rider	$674.39	= c) * [1 + d)]

4. As of April 2019, there were approximately 1,800 members enrolled in MVP large group plans in Vermont. Approximately 80% have renewal dates during 1st quarter.

Below is the annualized rate change for the first quarter renewals in 2020:

Reason for Change	1Q '20 Annual Increase
Manual Rate Change	15.6%
Age/Gender Factor Changes	-0.5%
Change in Retention	1.5%
Total Premium Change	***16.7%***

The rate increase outlined above reflects 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, the large groups in this filing have premium rates based on a blend of their own claims experience at approximately 25% and the manual rate at approximately 75%. 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. The currently quoted average rate increase for groups renewing in the first quarter, which represents 80% of the groups, is projected to be 8.4%. We note that there is a material difference between the expected impact for groups renewing in the first quarter and the manual rate change of 16.7%, and we have outlined the drivers in detail in section 8 under the L&E Analysis.

The total premium changes for quarters 2, 3 and 4 vary slightly from the 16.7% due to quarterly trend changes and changes in health insurer fee.

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.

L&E Analysis

1. *Rate Development:* MVP utilized large group claim data (constituting HDHP and non-HDHP products) for the period from May 2018 through April 2019 and paid through April 2019 (with incurred estimates updated through June 2019) 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 1Q20.

   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 pooling charge is equal to 9.9% of claims below the pooling limit, which is consistent with the prior filing's assumption. The pooling charge was calculated using MVP's large group business in New York due to MVP's limited large group data in Vermont. 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. Pooling claims is a typical industry practice, and this assumption has a material impact on this filing

We note that claims exceeding $100,000 made up 15.8% of the base period experience. Therefore, the use of the pooling charge is reducing the projected claims by approximately 6% relative to using the base period experience without adjustment.

We reviewed the actual large group experience in Vermont and the claims above the pooling limit of $100,000 for the prior 5 years has ranged from 4.5% to 24.9%, with an average of 14.4%. This volatility demonstrates the importance of pooling claims in setting the rates each year. The Vermont only data is not fully credible and the use of New York data to set the pooling charge assumption results in more stable premiums, and it is reasonable and appropriate.

The adjusted claims were projected forward to the midpoint of the 1Q20 rating period using an annual paid medical trend assumption of 5.7% (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[1]. The prescription claims were projected forward to the midpoint of the 1Q20 rating period using an annual paid Rx trend of 9.5% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q20. These adjustments included projected cost of capitation, non-FFS claim expenses, and Rx rebates. Reflecting these adjustments, the quarterly manual rate change suggested by the data was 10.9% for 1Q20.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in quarterly manual rate increases of 1.6% in each quarter of 2020. That is, groups renewing in April will be charged premiums based on manual rates approximately 1.6% higher than groups renewing in January. As noted above, approximately 80% of groups have 1st quarter renewal dates.

Quarter	Manual Rate Change
1Q '20 / 4Q '19	10.9%
2Q '20 / 1Q '20	1.6%
3Q '20 / 2Q '20	1.6%
4Q '20 / 3Q '20	1.6%

The base period experience used in this filing has two months of claims run-out and therefore, needed to be

[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.

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:* 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 enrolled population was slightly older than the prior experience period, resulting in additional revenue available to cover claims. However, the demographic factors were re-normalized to reflect the updated experience and decreased by 0.5% to maintain the necessary premium level. The age/gender normalization methodology appears to be reasonable and appropriate.

3. *Medical Trend:* MVP analyzed its combined MVPHIC and MVPHP Vermont data for 36 months between 2016 and 2018. This data was not considered appropriate for utilization trend analysis due to concerns with the large impact that membership growth in other blocks of business (Exchange) was having on the total utilization trend for Vermont. Removing MVPHP data from the calculation would leave a block that was not considered credible. Therefore, MVP utilized the results from the L&E analysis of the entire VT marketplace that was calculated during the review of the Exchange filings and used a utilization trend assumption of 1.0%. Based on all information available at this time, the 1.0% utilization trend is reasonable and appropriate.

   The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Below are the allowed and paid medical trends including the assumed utilization trend of 1.0%:

Medical Trend	Unit Cost	Utilization	Total Allowed Trend	Paid Trend
2019	4.8%	0.0%	4.8%	5.1%
2020	4.3%	1.0%	5.3%	5.7%
2021	4.3%	1.0%	5.3%	5.7%

   The allowed cost trends illustrated above are the 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 payments made by the carrier. 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 5.7% 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.

   The annual effective paid medical trend factor of 5.7% assumed in this filing represents the most up-to-date provider contracting information available at the time of the filing.

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

Service Category	2019	2020	2021
Inpatient	6.0%	7.3%	7.3%
Outpatient & Other Medical	5.1%	6.1%	6.1%
Physician	3.2%	2.5%	2.5%
Total Allowed Trend	**4.8%**	**5.3%**	**5.3%**

Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2020 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 '20 / 4Q '19	2Q '20 / 1Q '20	3Q '20 / 2Q '20	4Q '20 / 3Q '20
As filed	10.9%	1.6%	1.6%	1.6%
Reflecting Final Order	10.7%	1.6%	1.6%	1.6%

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

	2019 Trend		2020 Trend		2021 Trend	
Tier	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Generic	17.8%	2.9%	-5.2%	2.5%	-5.2%	2.5%
Brand	11.7%	-8.9%	8.6%	-1.3%	8.6%	-1.3%
Specialty	-0.4%	6.0%	7.5%	7.4%	7.5%	7.4%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 9.5% which is shown in Exhibit 2b-d. Rx Trend, 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 benefit manager (PBM). These trend factors reflect MVP's business in the state of Vermont.

MVP is using 2020 drug rebate forecasts provided by the PBM. These forecasts assume that drug rebates will equal $21.57 PMPM for 1Q 2020 renewals and increasing with pharmacy trend for later quarters.

These assumptions appear to be reasonable and appropriate.

5. *Retention:* 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 8.2% of premium for general administrative expenses. This is a material reduction from the prior filing value of 8.9% 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 loads equal to 3.1% of premiums. The broker fees are increasing compared to 2019 due to the following:
     - two of the groups that are not renewing in 2020 did not have broker fees; and
     - one of the groups that is renewing did not have a broker in 2019 but added a broker for

2020.

- Provision for bad debt equal to 0.3% of premiums.
- ACA Insurer tax of 1.0%. This is consistent with the reinstatement of the insurer fee collections in 2020.
- VT vaccine pilot charge of 0.3%.
- The 18 V.S.A § 9374 (h)(1) billback equal to $1.93 PMPM based on MVP's projected responsibility.

The projected administrative expenses of 8.2% of premium is less than the actual calendar year 2018 expenses of 10.0%. MVP reduced the administrative expense load such that the PMPM cost of administrative expenses increase at the same 5.5% rate as MVP's Exchange filing. 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%
2018	26,765	$484.55	$48.67	10.0%

The target loss ratio is decreasing from 86.9% in the 1Q 2019 to 84.8% for 2020. This change is the result of increasing the contribution to reserve from 1.5% to 2.0%, the reintroduction of the ACA insurer fee beginning in 2020, and an increase to the billback amount.

The federal loss ratio for MVPHP in 2018 is 106.2%, and the rolling three-year average is 96.0%.

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.

6. *Changes to Benefits:* During the course of the review, MVP recognized that they did not incorporate the impact of increasing the wellness reimbursement to $200 and a new $50 per quarter benefit for meeting certain step thresholds based on a wearable device registered with MVP's vendor into the filed rates. These changes are expected to increase the cost of the wellness program by $0.19 PMPM and should be included in the final rates.

7. *OneCare Vermont:* After the initial filing, MVP continued negotiations with OneCare, and it was determined that the large group Vermont members will not be included in the risk deal for 2020 with OneCare. As a result, these costs should be removed from the rates.

8. *Rate Increase felt by Vermonters:* For calendar year 2018, MVP's large group block of business experienced a 95.7% loss ratio. Many of the groups that experienced loss ratios exceeding 100% are not renewing coverage in 2020.

Groups	2018 Loss Ratio
Q1 Renewals	89.0%
Terminated Groups & 2Q – 4Q Renewals	103.9%
All Groups Combined	**95.7%**

As a result, the 16.7% increase to the manual rate is not representative of the increase that will be felt by the groups that are expected to renew in 2020. The rate increase for groups renewing in the first quarter, which represents 80% of the groups, is projected to be 8.4%[2] due to the following:

- *Experience Period Data: +0.7%* The experience period data used to set the premium rates is on average 2.8% higher than the experience used to develop the 2019 premiums. These groups have an average credibility of 26.3% in 2020, which reduces the impact on rates to 0.7%.
- *Manual Rate Data: +10.5%* The manual rates being used to set the premium rates, after adjustments for age/gender and industry factors, is on average 14.2% higher than the manual rates used to develop the 2019 rates. These groups are 73.7% manually rates (100% - 26.3%), which reduces the impact on rates to 10.5%
- *Changes to Target Loss Ratio: +2.5%* The assumed target loss ratio for first quarter renewals is decreasing from 86.9% to 84.8%, which increases the rates by 2.5%. This is driven by an increase to the broker fees and the reinstatement of the insurer fee.
- *Underwriting Discretion: -4.9%* The average underwriting discretion factor is changing from 1.019 to 0.969, which reduces the rates by 4.9%.

[2] The quantitative impacts are multiplicative and do not add up to the 8.4%.

Recommendation
L&E recommends that the unit cost trends be modified to reflect:

- *Green Mountain Care Board (GMCB) Hospital Budget:* L&E recommends revising the trends to reflect the final orders regarding FY2020 hospital budgets.

- *Changes in Benefits*: L&E recommends adding in the $0.19 PMPM that was inadvertently excluded from the rates in the initial filing.

- *OneCare Vermont*: L&E recommends removing the $1.82 that was added for the risk deal with OneCare because subsequent negotiations after the initial filing determined that the large group Vermont members will not be included in the risk deal with OneCare.

The revised rate increase is as follows:

Quarter	Manual Rate Change
1Q '20 / 4Q '19	10.4%
2Q '20 / 1Q '20	1.6%
3Q '20 / 2Q '20	1.6%
4Q '20 / 3Q '20	1.6%

Reason for Change	1Q '20 Annual Increase
Manual Rate Change	15.1%
Age/Gender Factor Changes	-0.5%
Change in Retention	1.5%
Total Premium Change	***16.2%***

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

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:

- Josh A. Hammerquist, FSA, MAAA Vice President at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Senior 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 14, 2019. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 14, 2019.

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.