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Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
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D. Patrick Glenn, A.S.A., A.C.A.S.
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Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
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Baltimore
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April 29, 2016

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

Re: MVP VT LG HMO Filing 3Q/4Q 2016 - Abbreviated Report
SERFF #: MVPH-130467866

The purpose of this letter is to provide an abbreviated summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP) for its existing HMO products for the third and fourth quarters of 2016 and to assist the Board in assessing whether to approve, modify, or disapprove the request. We are performing an abbreviated review because currently no policyholders are affected by this filing.

Filing Description

1. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio, and includes proposed rates for both the third and fourth quarters of 2016.

2. There are currently no members enrolled in these plans. The proposed rate increase would only affect Vermont large groups which purchased HMO coverage from MVP during the second half of 2016.

3. Rates were not filed for 1Q/2Q 2016. The proposed rate changes are relative to the approved 4Q 2015 rates.

4. The requested third and fourth quarter manual rate changes are seen below, as well as 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]	3Q16 / 4Q15	4Q16 / 3Q16
Manual Rate Change	1.8%	3.3%	1.0%
Age/Gender Factor Changes	0.0%	-4.6%	0.0%
Change in Administrative Expenses	0.0%	-4.7%	-0.5%
Total Revenue Change	***1.8%***	***-6.1%***	***0.5%***

Reason for Change	3Q16 Annual	4Q16 Annual
Manual Rate Change	5.2%	4.3%
Age/Gender Factor Changes	-4.6%	-4.6%
Change in Administrative Expenses	-4.7%	-5.3%
Total Revenue Change	***-4.4%***	***-5.7%***

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

MVP provided the methodology used in premium rate development (Exhibit 2a-2d, 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 HMO claim data for the period from November 1, 2014 through October 31, 2015 and paid through December 31, 2015 as the base period experience. This data set included 2,627 member months.

   The adjusted claims were projected forward to the midpoint of the 3Q16 rating period using an annual paid medical trend assumption of 3.1%, and prescription claims were projected forward to the midpoint of 3Q16 rating period using an annual paid Rx trend of 11.0%.

   The trended claim cost was further adjusted to develop the projected claim costs as of 3Q16. These adjustments include 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 is a 0.7% increase. Due to credibility concerns, MVP has requested that the manual rates increase by one year of trend, or 3.3%, relative to the previously approved 4Q 2015 rates.

   MVP developed the 4Q16 manual rate by applying one more quarter of trend to the experience period claims. This results in a rate increase of 1.0% in 4Q16.

[1] Previously approved rate changes.

2. *Age/Gender Factor Changes:* There is no current enrollment on this block, so the age/gender factors from the 3Q/4Q PPO filing were used. These factors are 4.6% lower than the factors previously approved for the HMO products.

3. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Consistent with recently submitted filings, MVP is utilizing a 0% utilization trend to its data. MVP 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 allowed cost trends illustrated 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. MVP adjusted the allowed cost trends to account for the impact of cost share leveraging and derived a total effective paid medical trend factor of 3.1% annually.

4. *Rx Trend:* MVP 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 11.0%, 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.

   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 did not account for MVP'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.

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.

   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 all of MVP's 3Q/4Q filings, 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 experience data, trend projections, and other claim cost projections support lower rates than are being proposed in this filing. We recognize that the most recent experience data is for a small block that significantly decreased in size over the experience period and comprised entirely of groups that have since terminated coverage through this program. We concur with MVP that it is appropriate for this reason to increase the manual rate by a full year of trend, rather than relying on the limited experience available. We note also that the normalization of the age/gender factors effectively lowers the premiums for the HMO plans substantially, despite being based on changes observed in the PPO block. A premium decrease in excess of that proposed in this filing would run a serious risk of inadequate premiums and could require higher rate increases in the future.

2. *Age/Gender Factor Changes:* 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 3.1% annual medical paid trend assumption to be reasonable and appropriate.

4. *Rx Trend:* 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 did not account for MVP's Vermont specific book of business, given the partnership with this vendor is new. We consider MVP'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.

   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 intended 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 MVP 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 administrative expense assumptions appear to be reasonable and appropriate.

Recommendation

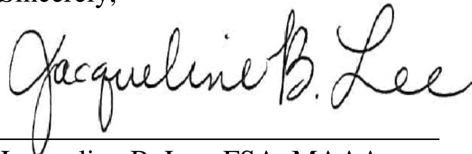
After modification, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modification:

- Modify the 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%.

The above change will decrease the 3Q16 quarterly revenue change from -6.1% to approximately -6.2% and have no impact on the 4Q16 quarterly revenue change of 0.5%. Below are the estimated annual rate changes:

Reason for Change	3Q16 Annual	4Q16 Annual
Manual Rate Change	5.1%	4.2%
Age/Gender Factor Changes	-4.6%	-4.6%
Change in Administrative Expenses	-4.7%	-5.3%
Total Revenue Change	***-4.5%***	***-5.8%***

Sincerely,



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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[2], 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[3], 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 29, 2016. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is March 28, 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.

[2] 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.

[3] 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.